



**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 Issues**

**SENATE ARMED SERVICES  
SUBCOMMITTEE ON PERSONNEL**

**March 14, 2012**

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 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  
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  
Veterans of Foreign Wars  
Wounded Warrior Project

The Military Coalition, Inc. does not receive any grants or contracts from the federal government.

## Executive Summary

### **FY2013 Budget Submission on TRICARE Fees**

The Coalition believes DoD's proposals for dramatic TRICARE fee hikes constitute a serious breach of faith with currently serving troops and families by cutting their future healthcare benefits. And if breaking faith with the currently serving is wrong, so is imposing a major "bait and switch" change on those who already completed 20-30 year careers, induced by promises of current benefits.

**TRICARE Prime Fees:** Reject any increase in TRICARE Prime fees that exceeds the COLA-based standard established in the FY2012 Defense Authorization Act.

**TRICARE Standard Fees:**

- The Coalition urges rejection of any TRICARE Standard enrollment fee unless and until the government provides guaranteed access to care for Standard beneficiaries
- The Coalition urges the Subcommittee to reject DoD's proposal to nearly double the TRICARE Standard deductible over the next five years.

**TRICARE For Life Enrollment Fee:** Sustain current law that avoids any enrollment fee for TRICARE For Life, consistent with Congress' determination in 2001 that the service and sacrifices extracted from military retirees and families over the course of their careers constituted a pre-paid premium for their TFL coverage as a Medicare supplement.

**TRICARE Pharmacy Copays:** Reject Administration-proposed pharmacy copayment increases that would inappropriately "civilianize" the military pharmacy benefit, dramatically raise costs for both retired and currently serving families, and deter beneficiaries from adhering to medication regimens that are essential to their long-term health as well as DoD's long-term cost containment.

**TRICARE Proposals Raise New Inequities:** The extremely limited categories of exemptions for survivors and disabled retirees disregard the similar or more severe situations of other survivors and disabled. The Coalition does not propose expanding the exemption, because that would imply a level of Coalition concurrence with the proposed fee hikes that does not exist. We raise this inequity issue as another reason why the proposed fee increases are grossly inappropriate for all grades and categories of beneficiaries.

**TRICARE Fee "Tiering":** Strongly oppose means-testing of military benefits, under which longer and more successful service would be penalized by progressive reduction of military healthcare benefits. The Coalition believes all retired servicemembers earned equal health care coverage by virtue of their service and that the proposed dramatic fee increases are inappropriate for servicemembers of all grades.

**TRICARE Fee Indexing:** Reject the DoD-proposed tying of annual increases in military health care fees to an index of health cost growth which would dramatically and disproportionately accelerate military healthcare fees over time.

**Military Health Care Principles:** The Coalition believes the law should be changed to explicitly acknowledge that:

- The healthcare benefit provided for members and families who endure to complete a military career should be among the very best available to any American;
- The decades of service and sacrifice rendered by career military personnel constitute a significant pre-paid premium toward their healthcare in retirement; and
- The large value of this pre-paid premium should be accounted for by minimizing fees payable in retirement and avoiding significant and arbitrary increases from year to year.

### **Leadership Accountability**

The Coalition urges the Subcommittee to hold Defense leaders accountable for their own management, oversight, and efficiency failures before seeking to shift more costs to beneficiaries. 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, Ill, and Injured Servicemember Issues**

The Coalition urges:

- Joint hearings by the Armed Services and Veterans Affairs Committees addressing the Joint Executive Council's (JEC) effectiveness in daily oversight, management, collaboration, and coordination of the Departments' wounded, ill, and injured servicemember programs.
- Permanent funding, staffing, and accountability for congressionally mandated Defense Centers of Excellence and associated mental-behavioral health, suicide prevention, caregiver, respite, and other medical and non-medical programs.
- Continued aggressive oversight of the Integrated Disability Evaluation and legacy disability evaluations systems to ensure preservation of the 30-percent threshold for medical retirement, consistency and uniformity of policies, ratings, legal assistance, benefits, and transitional services Defense-wide.

### **DoD – VA Seamless Transition**

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.
- 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 Integrated Disability Evaluation System (IDES)**

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 and accepting the VA's "service-connected" rating.
- 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.
- Directing DoD to re-engineer and redesign the front end of IDES to (1) better ensure medical evaluations are consistently based on a fully developed, accurate medical summary; (2) permit the servicemember's full participation; (3) afford each individual consistent, effective representation throughout the process; and (4) streamline the system by eliminating the redundancy of dual adjudication of disability.

### **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.
- Extending eligibility for residence in on-base facilities for up to one year to medically retired or severely wounded servicemembers and their families (or until the medically retired or severely injured service member receives a VA compensation rating, whichever is longer).
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### **Guard and Reserve Healthcare**

The Coalition recommends:

- Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60
- Authorizing premium-based TRICARE coverage for members of the Individual Ready Reserve after being called to active service for a cumulative period of at least 12 months
- 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 Prime Issues**

The 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.

### **Additional TRICARE Standard Issues**

The Coalition urges the Subcommittee to:

- Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future. Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation to meet the threshold.
- Require a specific report on provider participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.
- Increase locator support to TRICARE Standard beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.

## Overview

Mr. Chairman and distinguished members of the Subcommittee, The Military Coalition extends our thanks to you for your strong support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors.

Congress has improved retention and readiness by addressing a number of quality of life issues for the military community over the last decade including enactment of TRICARE For Life, TRICARE Senior Pharmacy coverage, and health coverage for the Guard and Reserve community, among many other important initiatives.

Now, ironically, critics decry the growth in health care spending over the last decade, ignoring that much of that cost was driven by wartime requirements and service organizational and readiness priorities rather than cost-efficient delivery of beneficiary care.

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 over the last decade are highly misleading, because 2001 (when nearly all older beneficiaries had been pushed out of military health coverage) is not an appropriate or reasonable baseline for comparison – 2001 was the “bottom” as far as military benefits were concerned. Congressional spending to fix that problem since then was a necessary thing, not a bad thing.
- DoD health costs remain well below the 16% share health care comprises of the national GDP.
- Assertions that cutbacks for retirees don’t affect the currently serving force are a delusion. Significant benefit cutbacks for retirees reduce incentives for the currently serving to complete a career. A currently serving member who will retire next month, next year, or next decade is definitely affected by such cutbacks.
- Retired servicemembers, their families and survivors have been no stranger to sacrifice. Nearly 600,000 of today’s retirees served on active duty during the current Iraq/Afghanistan wars. Hundreds of thousands more saw service in multiple hot and cold conflicts. Older retirees endured years when the government provided them no military health coverage, and those retired between 1985 and 2005 have forfeited an average 10% of earned retired pay because they retired under pay tables depressed by decades of budget-driven capping of military raises below civilian pay growth.
- Pentagon leaders’ insensitivity to this situation is perfectly illustrated by Secretary Panetta’s answer at a recent Senate Budget Committee hearing. When asked why the proposal focuses so much on raising fees for military retirees, he answered they would accept the changes because they’re used to doing what they’re told and used to a culture of sacrifice. In other words, they’re used to abuse so we can – and plan – to abuse them again.

- Military members' and families' sacrifices must not be taken for granted by assuming they will continue to accept the extraordinary personal and family sacrifices inherent in a multi-decade service career regardless of significant changes in their career incentive package.
- At a time when Congress is focused on lowering payroll taxes and avoiding any tax increases for other Americans, including millionaires and billionaires, it's grossly inappropriate to impose a \$1,000-\$2,000 new annual tax on the one group of citizens who already have sacrificed more for their country than any other.
- The Coalition is appalled that fully 60% of the projected savings associated with the proposed TRICARE fee increases accrue from the assumption that the fee increases will be so onerous as to drive many thousands of military beneficiaries away from using their service-earned coverage. When similar assumptions were highlighted about earlier DoD TRICARE fee proposals, Congress rightly deemed it grossly inappropriate to entice members to career service with promises of care and then consciously implement plans to drive them away from using that hard-earned care. That's no less true in 2012 than it was in 2007 and 2008.
- 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.

### **FY2013 Budget Submission**

The President's proposed FY2013 budget has embraced the concept put forth by the Defense Department in past years that TRICARE benefits for retired beneficiaries should "trend toward market rates" by significantly increasing fees for retired beneficiaries and family members under 65.

The proposal would shift \$35 billion in costs to retired and some currently serving military families over the next 10 years through dramatic and disproportional healthcare fee increases. These fee levels are similar to those recommended by the Defense Department in past years, which the Subcommittee and Congress rejected as excessive on the basis that:

- Pentagon leaders need to demonstrate more effective cost management of their own before shifting significant additional costs to beneficiaries.
- Achieving savings by seeking to deter beneficiaries from using their service-earned benefits is inappropriate.

The budget proposes to raise beneficiary costs over the next ten years by:

- Raising annual fees by as much as \$1,500 or more for retired families under age 65.
- Establishing new annual enrollment fees of up to \$950 for retired couples over age 65.
- Imposing means-testing of military retiree health benefits – which no other federal employee experiences.
- Dramatically increasing pharmacy co-pays to approach or surpass the median of civilian plans.



- Tying future annual increases to an unspecified health cost index estimated to average 6.2% per year.

DoD leaders have made a great point of their intent to “keep faith with currently serving troops” by avoiding any retirement changes that would affect the current force.

But their concept of “keeping faith on retirement” doesn’t extend to retirement health care benefits, as the proposed changes would affect any currently serving member who retires the day after they were implemented. This has the same effect as reducing their retired pay by up to \$2,000 a year or more. Further, the pharmacy changes would affect hundreds of thousands of currently serving Guard/Reserve members and families, as well as the family members of currently serving personnel who don’t have access to military pharmacies.

*The Coalition believes DoD’s proposals for dramatic TRICARE fee hikes constitute a serious breach of faith with currently serving troops and families by cutting their future healthcare benefits. And if breaking faith with the currently serving is wrong, so is imposing a major “bait and switch” change on those who already completed 20-30 year careers, induced by promises of current benefits.*

**TRICARE Prime Fees.** The Administration’s TRICARE Prime Fee proposal for FY2013 is a radical departure from the new fee structure the Administration proposed and Congress accepted for FY2012.

Last year, finally acknowledging Congress’ long-standing concerns about the inappropriateness of dramatic increases in beneficiary fees, the Administration proposed a 13% increase in TRICARE Prime fees. In the absence of congressional objection, the increase was implemented as of October 1, 2011.

The new proposal for FY2013-2017 is a dramatic departure, proposing to triple or quadruple fees over the next five years, as indicated in the chart below.

<u>Retired Pay**</u>	<b>DoD-Proposed TRICARE Prime Enrollment Fee for Retired Beneficiaries Under Age 65 (Family Rate)*</b>					
	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>	<u>FY2017***</u>
\$0-22,589	\$520	\$600	\$680	\$760	\$850	\$893
\$22,590-\$45,178	\$520	\$720	\$920	\$1,185	\$1,450	\$1,523
\$45,179 or more	\$520	\$820	\$1,120	\$1,535	\$1,950	\$2,048

\*Single rate is 50% of family rate

\*\* Retired pay thresholds to be indexed to COLA increases

\*\*\* Fees for FY18 and outyears to be indexed to health cost inflation

This proposal flies in the face of the specific language of the FY2012 Defense Authorization Act – signed into law less than three months ago – requiring that the percentage increase in TRICARE Prime fees for FY2013 and later years shall not exceed the percentage growth in military retired pay.

The logic behind the COLA cap has not changed in the last three months. Its purpose was to protect retirees against arbitrary, budget-driven initiatives to impose dramatic new fee increases.

The COLA cap was intended to help recognize that:

- Military retirees already pre-paid very large premiums for their health care in retirement through their decades of service and sacrifice in uniform, and that
- They shouldn't be subjected to a double penalty by having their fees raised dramatically after they've already rendered a career of service induced by long-standing government retirement and healthcare promises.

***The Coalition urges the Subcommittee to reject any increase in TRICARE Prime fees that exceeds the COLA-based standard established in the FY2012 Defense Authorization Act.***

**TRICARE Standard Fees.** The Administration proposes two changes to TRICARE Standard that are not authorized under current law: a new enrollment fee that would increase significantly over time, and a significant adjustment to the Standard deductible, which is set by current law at \$150 for a single person and \$300 for a family.

<b>DoD-Proposed TRICARE Standard Annual Fees for Retired Beneficiaries Under Age 65 (Family Rate)*</b>						
<b><u>Enrollment Fee</u></b>	<b><u>FY 2012</u></b>	<b><u>FY 2013</u></b>	<b><u>FY 2014</u></b>	<b><u>FY 2015</u></b>	<b><u>FY 2016</u></b>	<b><u>FY2017**</u></b>
	\$0	\$140	\$170	\$200	\$230	\$250
<b><u>Deductible</u></b>	\$300	\$320	\$400	\$460	\$520	\$580

\*Single rate is 50% of family rate

\*\* Fees for FY18 and outyears to be indexed to health cost inflation

The Coalition strongly opposes any enrollment fee for TRICARE Standard. An enrollment fee is only appropriate when the beneficiary is guaranteed a certain level of care. While the Defense Department has specified standards for TRICARE Prime, it's definitely not the case with TRICARE Standard.

According to DoD's own surveys, there are localities where finding a provider who will accept Standard patients is very difficult. This is particularly true for some high-demand specialties such as psychiatry.

In the absence of guaranteed access to care, there should be no enrollment fee.

Establishing an explicit enrollment requirement also would change the fundamental character of this service-earned healthcare benefit by forcing a choice between military health coverage and other available coverage. Many use TRICARE as a contingent coverage that is there as a fallback if they lose their civilian job, if their civilian insurance offers limited coverage, etc. Throughout their careers, they were told they would have this coverage. The Coalition objects to a system that backs them into a situation that implies it's a reasonable decision to forfeit that earned protection because they have other insurance that may or may not endure. In other words, their military ID card is and should continue to

represent their automatic enrollment in the default military healthcare option unless they choose to enroll in Prime or age into TRICARE For Life.

The Coalition also objects strongly to the proposal to nearly double the annual Standard deductible over the next 5 years. Standard-eligible retired beneficiaries who are able to find a participating provider already are absorbing a 25% copay, and so their costs have risen as allowable charges have risen.

*The Coalition urges the Subcommittee to reject any TRICARE Standard enrollment fee unless and until the government provides guaranteed access to care for Standard beneficiaries*

*The Coalition urges the Subcommittee to reject DoD’s proposal to nearly double the TRICARE Standard deductible over the next five years.*

**TRICARE For Life Fees.** The Administration proposes a new TRICARE For Life (TFL) enrollment fee for beneficiaries age 65 and older, with successive annual increases as indicated in the chart below:

**DoD-Proposed TRICARE-for-Life Annual Enrollment Fee  
(Per Individual Beneficiary Age 65+)**

<u>Retired Pay*</u>	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>	<u>FY2017**</u>
\$0-22,589	\$0	\$35	\$75	\$115	\$150	\$158
\$22,590- \$45,178	\$0	\$75	\$150	\$225	\$300	\$317
\$45,179 or more	\$0	\$115	\$225	\$335	\$450	\$475

\*\* Retired pay thresholds to be indexed to COLA increases

\*\*\* Fees for FY18 and outyears to be indexed to health cost inflation

Again, the Coalition believes strongly that an enrollment fee is only appropriate when there is a guarantee of timely access to quality healthcare. While that is the case with TRICARE Prime, there is no such guarantee for TFL beneficiaries.

Because TFL is available only if the beneficiary enrolls in Medicare Part B and acts as second-payer to Medicare, it provides coverage only in the case of providers who accept Medicare patients.

In many localities around the country, more and more providers are limiting the number of Medicare patients they serve. In some localities, providers are refusing to accept any new Medicare patients.

In the event a provider refuses to accept Medicare, the beneficiary must absorb the full cost of the care, as Medicare will not reimburse the beneficiary for any share of the charges.

The reality is that Medicare patients already pay significantly more for their care than beneficiaries under 65 do because of the statutory requirement to enroll in Medicare Part B to be eligible for TFL. This means a TFL-eligible couple already is paying premiums of at least \$2,400 per year in 2012. Couples in higher income brackets may pay up to \$7,680 per year in Part B premiums alone.

Further, large numbers of these retired members already suffer severe and permanent financial penalties as a result of past government budget crises that caused depression of their annual pay raises while on active duty. Depression of military pay over time caused military pay scales to lag up to 13.5% behind private sector pay. Members who retired under those depressed pay scales already are being made to forfeit thousands of dollars per year, and those penalties will last through their lifetimes. Adding a TFL enrollment fee would add further financial insult to that grievous injury.

TFL was enacted in 2001 to rectify the previous decade's disenfranchisement of older military beneficiaries from virtually all military healthcare coverage in the wake of the BRAC-driven closure and downsizing of hundreds of military hospitals and clinics.

When Congress enacted TFL, it did so with the explicit acknowledgement that an enrollment fee for this program is inappropriate.

In passing the new law, Congress acknowledged that the premium for this Medicare-supplemental coverage already had been paid in full through decades of service and sacrifice.

The Coalition believes strongly that the experience of the last decade – during which the military community has been required to bear 100% of the nation's wartime sacrifice – only reinforces the rightness of Congress' 2001 acknowledgement that imposing an enrollment fee for TFL is inappropriate.

***The Coalition urges strongly against imposing any enrollment fee for TRICARE For Life.***

### **Proposed Fees Raise New Series of Inequities**

The Coalition appreciates that some modest effort was made to accommodate human concerns by exempting medical (Chapter 61) retirees and survivors of members who died on active duty.

However, these very restricted exemptions create a whole new series of inequities that demonstrate a gross lack of appreciation for the circumstances of various beneficiary populations.

Limiting survivor exemption to cases of deaths on active duty ignores that other categories of survivors, most of whom are older, typically have far less resources than survivors of recent active duty deaths. Thousands of these older survivors have no income at all from the military or the VA, and received dramatically lower Servicemen's Group Life Insurance settlements than are available today -- yet they would be subjected to the higher TRICARE fees.

Among retirees, the sole exemption of chapter 61 (medical retirement) cases similarly ignores the realities of the disabled retiree population.

Medical retirees include not only the severely disabled, but also many with disability ratings of 30% (or lower in some cases, since members with 20+ years of service can be medically retired under chapter 61 with disability ratings as low as zero).

As the Subcommittee is only too well aware in the wake of multiple recent reviews and commissions in recent years, far larger numbers with significant disabilities were denied medical retirement under service policies and told to “see the VA for any disability issues.”

So a 20-year retiree with a zero-to-30% medical retirement would be exempted from the higher TRICARE fees that would be imposed on a similar 20-year non-medical retiree who is immediately acknowledged by the VA as 100% disabled.

*The Coalition does not raise these inequity issues in order to propose expanding the exemption, because that would imply a level of Coalition concurrence with the proposed fee hikes that does not exist. We raise them as another reason why the proposed fee increases are grossly inappropriate for all grades and categories of beneficiaries.*

**Pharmacy Co-Payments.** The Administration proposes dramatic increases in retail and other pharmacy copays, as shown in the chart below.

**DoD-Proposed Pharmacy Co-Payments  
(For All Retirees, Survivors, Guard/Reserve and Active Duty Family Members)**

	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>	<u>FY2017</u>
<b>Retail (1 mo fill)</b>						
Generic	\$5	\$5	\$6	\$7	\$8	\$9
Brand	\$12	\$26	\$28	\$30	\$32	\$34
Non-Formulary*	\$25	N/A	N/A	N/A	N/A	N/A
<b>Mail-Order (3 mo fill)</b>						
Generic	\$0	\$0	\$0	\$0	\$0	\$9
Brand	\$9	\$26	\$28	\$30	\$32	\$34
Non-Formulary	\$25	\$51	\$54	\$58	\$62	\$66

\* Non-Formulary pharmaceuticals will have limited availability in retail pharmacies

Again, these are dramatic increases from the copayment rates the Administration proposed for FY2012, and implemented on Oct 1, 2011 in the absence of congressional objection.

For FY2012, the Administration imposed increases of \$2 to \$3 (e.g., from \$9 to \$12 for retail brand-name drugs and from \$3 to \$5 for retail generics.)

Now, only a year later, the proposal would more than double the new retail rates and triple the mail-order rates for brand-name medications.

In subsequent years, copays would rise for generics in the retail venue, and the copay the Administration just eliminated for mail-order generic drugs last year would not only be restored, but tripled.

These purely budget-driven proposals are inappropriate on several levels.

- The current \$5 retail generic copay already exceeds the \$4 generic copay widely available to any civilian who walks through the door at dozens of retail pharmacies. Proposed further increases in the outyears only exacerbate the relative disadvantage for military beneficiaries.
- The proposed brand-name and non-formulary copays would make the TRICARE pharmacy benefit little or no better than the median of civilian employer plans. In 2011, for example, 56% of civilian plans provide brand-name medications for a copay of \$25 or less, compared to the DoD-proposed \$26.
- Contrary to DoD assertions about exempting currently serving personnel from fee hikes, the pharmacy copay increases would apply to hundreds of thousands of drilling Guard and Reserve personnel, as well as to active duty, Guard and Reserve family members who don't have access to military pharmacies.
- DoD has expended relatively little substantive effort to increase use of the mail order system other than seeking to impose an ever-bigger "stick" of higher fees on those who use other venues. The Coalition has urged DoD to create positive incentives such as eliminating copays for maintenance medications (see next paragraph) and work with the Coalition to develop better communication materials to address real-world concerns that deter beneficiaries from mail-order use, and will continue to do so even with higher copays. These initiatives could save DoD hundreds of millions a year, but Coalition offers to partner on such efforts have been rebuffed.
- Such dramatic pharmacy copay increases will only discourage adherence to medication regimens for chronic conditions like asthma, diabetes, and more. Studies show that even modest copayment increases deter use of maintenance medications that are essential to preserving wellness and holding down far more expensive care when the conditions deteriorate. The Coalition has endorsed reducing or eliminating copays for maintenance medications to hold down long-term costs. This new proposal would fly in the face of that objective, sacrificing long-term beneficiary health for short-term cost savings.

The Coalition believes strongly that the TRICARE pharmacy benefit should be a top-tier benefit, not merely one that approaches the median of plans offered by civilian employers, and that it should enhance wellness goals rather than posing a new impediment to them.

***The Coalition urges the Subcommittee to reject Administration-proposed pharmacy copayment increases that would inappropriately "civilianize" the military pharmacy benefit, dramatically raise costs for both retired and currently serving families, and deter beneficiaries from adhering to medication regimens that are essential to their long-term health as well as DoD's long-term cost containment.***

**Means-Testing Plan Discriminates Against Military Retirees.** The Administration proposal envisions establishing graduated enrollment fees for TRICARE Prime and TFL, based on the amount of the retired servicemember's retired pay, as indicated in the charts previously shown.

This proposal would impose blatant and dramatic discrimination against military retirees.

No other federal employee or retiree pays income-based fees for service-earned health coverage. The President, the Secretary of Defense, and the Speaker of the House pay the same premiums as the lowest-paid federal civilian retiree.

Means-tested fees also are rare in the private sector. This is because healthcare has long been recognized as a service-earned benefit.

Means-testing healthcare as DoD proposes would turn the concept of service-based benefits on its head, so that the longer and more productive the service, the less the earned benefit.

This need-based mentality may be appropriate for social welfare programs, but its application to benefits that are earned by service and sacrifice is inappropriate and counterproductive.

The proposal also discriminates against the military by failing to apply the same protections provided to VA healthcare programs and beneficiaries.

No such fee increases are envisioned for VA care, and Congress expressly exempted VA healthcare and other programs from any reduction under sequestration.

In past years, Congress has strongly rejected far smaller VA fee increases proposed for non-disabled veterans who had served as few as two years.

In those contexts, imposing fee hikes of up to \$2,000 a year for those who have served and sacrificed for two or three decades is grossly inconsistent and inappropriate.

*The Coalition urges the Subcommittee to oppose means-testing of military benefits, under which longer and more successful service would be penalized by progressive reduction of military healthcare benefits. The Coalition believes all retired servicemembers earned equal health care coverage by virtue of their service and that the proposed dramatic fee increases are inappropriate for servicemembers of all grades.*

**Indexing of TRICARE Fees.** The Administration's FY2013 budget request proposes to index, either immediately or following some transition period, a variety of TRICARE fees to a health care cost index.

The specifics of how that cost index would be calculated, what beneficiary population it would account for, and who would be responsible for calculating it, have not yet been revealed to us.

Last year, DoD sources indicated an expectation that such an index would yield annual adjustments on the order of 6.2% per year.

The Coalition objects strongly to tying TRICARE fee growth for military beneficiaries to any measure of healthcare cost changes.

Indexing fees to healthcare cost growth would far outstrip annual retired pay increases and greatly erode retired compensation value.

During congressional debate on this topic last year, Congress rejected the health cost growth index and capped year-to-year percentage increases in TRICARE Prime fees at the percentage growth in military retired pay, reflecting the belief that the latter measure was fairer considering the very large, up-front premium already extracted from career military personnel over decades of service and sacrifice.

The chart below shows how DoD-proposed increases in TRICARE Prime enrollment fees, tied in the outyears to the proposed health cost index, would vastly exceed the COLA-based standard approved by Congress last year, imposing large beneficiary losses that would continue and accelerate with each passing year.

### 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)
2012	\$520	\$520	\$0	2029	\$859	\$3,135	\$2,275
2013	\$536	\$720	\$184	2030	\$885	\$3,329	\$2,444
2014	\$552	\$920	\$368	2031	\$912	\$3,535	\$2,624
2015	\$568	\$1,185	\$617	2032	\$939	\$3,755	\$2,815
2016	\$585	\$1,450	\$865	2033	\$967	\$3,987	\$3,020
2017	\$603	\$1,523	\$920	2034	\$996	\$4,235	\$3,238
2018	\$621	\$1,617	\$997	2035	\$1,026	\$4,497	\$3,471
2019	\$640	\$1,718	\$1,078	2036	\$1,057	\$4,776	\$3,719
2020	\$659	\$1,824	\$1,165	2037	\$1,089	\$5,072	\$3,983
2021	\$678	\$1,937	\$1,259	2038	\$1,121	\$5,387	\$4,265
2022	\$699	\$2,057	\$1,359	2039	\$1,155	\$5,721	\$4,565
2023	\$720	\$2,185	\$1,465	2040	\$1,190	\$6,075	\$4,886
2024	\$741	\$2,320	\$1,579	2041	\$1,225	\$6,452	\$5,226
2025	\$764	\$2,464	\$1,701	2042	\$1,262	\$6,852	\$5,590
2026	\$787	\$2,617	\$1,831	2043	\$1,300	\$7,277	\$5,977



2027	\$810	\$2,779	\$1,969	2044	\$1,339	\$7,728	\$6,389
2028	\$834	\$2,952	\$2,117	2045	\$1,379	\$8,207	\$6,828

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

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

***The Coalition urges the Subcommittee to reject the DoD proposal to index military health care fees to an index of health cost growth.***

### **Annual Financial Impact of Fee Hikes on Military Families**

The following chart highlights how the cumulative impact of the DoD-proposed fee changes would roughly double or triple annual health costs for the bulk of the affected force (grades E-7 to O-4). Cost growth would be significantly larger for grades W-4 and O-5 and above.

This chart assumes average use of medications. Many older families and those with disabled or otherwise at-risk children require significantly more medications, and the proposed doubling and tripling of pharmacy copays would increase those families' annual expenses substantially above those shown in the chart.

The chart also highlights what many overlook – that Medicare-eligibles already are required to pay significant Medicare Part B premiums in addition to the proposed new TFL and pharmacy fees.

### **Impact of DoD-Proposed FY2013 TRICARE Fees on Military Families (E-7 to O-4) (Recommended by DoD in the President's Budget)**

#### **E-7 / O-4 Retiree\* Under Age 65, Family of Three**

<b>TRICARE Prime**</b>	<b>Current</b>	<b>FY 2013 Proposed</b>	<b>FY 2017</b>
Enrollment Fee	\$520	\$720	\$1,523
Doctor Visit Copays	\$60	\$60	\$60
Rx Cost Shares***	\$408	\$744	\$1,032
<b>Yearly Cost</b>	<b>\$988</b>	<b>\$1,524</b>	<b>\$2,615</b>

#### **Retiree Under Age 65, Family of Three**

<b>TRICARE Standard</b>	<b>Current</b>	<b>FY 2013 Proposed</b>	<b>FY 2017</b>
Enrollment Fee	\$0	\$140	\$250
Deductible	\$300	\$320	\$580
Rx Cost Shares***	\$408	\$744	\$1,032
<b>Yearly Cost</b>	<b>\$708</b>	<b>\$1,204</b>	<b>\$1,862</b>

\* Enrolled in 2<sup>nd</sup> Retirement Income Tier (W-4s, O-5s and higher grades would pay even more)

\*\*Enrolled to the network and assumes 5 doctor visits per year.

\*\*\*Assumes 2 generic and 2 brand name prescriptions per month in retail pharmacy

### E-7 / O-4 Retiree\* Over Age 65 and Spouse

<b>TRICARE For Life**</b>	<b>Current</b>	<b>FY 13 Proposed</b>	<b>FY 2017</b>
Medicare Part B	\$2,398	\$2,494****	\$2,917*****
Enrollment Fee*	\$0	\$150	\$634
Rx Cost Shares***	\$756	\$1,428	\$1,956
<b><i>Yearly Cost</i></b>	<b><i>\$3,154</i></b>	<b><i>\$4,072</i></b>	<b><i>\$5,507</i></b>

\*Enrolled in 2<sup>nd</sup> Retirement Income Tier (W-4s, O-5s and higher grades would pay even more)

\*\*Assumes lowest tier Medicare Part B premium for new enrollee in 2012.

\*\*\*3 generic and 4 brand name prescriptions per month purchased at retail pharmacy

\*\*\*\*Assumes Part B increases of 4% per year

### Currently Serving Family of Four

<b>TRICARE Standard*</b>	<b>Current</b>	<b>FY 13 Proposed</b>	<b>FY 2017</b>
Enrollment Fee	\$0	\$0	\$0
Deductible	\$300	\$300	\$300
Rx Cost Shares**	\$264	\$432	\$624
<b><i>Yearly Cost</i></b>	<b><i>\$564</i></b>	<b><i>\$732</i></b>	<b><i>\$924</i></b>

\* Spouse and 2 children use Standard.

\*\*Assumes 2 generic and 1 brand name prescriptions per month at retail pharmacy.

### Military vs. Civilian Cash Fees Is “Apple to Orange” Comparison

The Coalition continues to object strongly to simple comparisons of military vs. civilian cash fees. Such “apple to orange” comparisons 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 a grateful Nation provides to the small fraction of the population who agree to subordinate their personal and family lives to protecting our national interests for so many years.

For all practical purposes, those who wear the uniform of their country are enrolled in a 20- to 30-year pre-payment plan that must be completed to earn lifetime health coverage. 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 believes the TRICARE 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.

Current law gives the Secretary of Defense broad latitude to adjust 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 to triple or quadruple fees, as in this year's budget proposal.

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.

It's true that many private sector employers are choosing to shift more healthcare 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.

Efforts to paint this in a negative light (i.e., implying that working-age military retirees with access to civilian employer plans should be expected to use those instead of military coverage) belie both the service-earned nature of the military coverage and the long-standing healthcare promises the government aggressively employed to induce their career service.

*The Coalition believes the law should be changed to explicitly acknowledge that:*

- *The healthcare benefit provided for members and families who complete a military career should be among the very best available to any American;*
- *The decades of service and sacrifice rendered by career military personnel constitute a significant pre-paid premium toward their healthcare in retirement; and*
- *The large value of this pre-paid premium should be accounted for by minimizing fees payable in retirement and avoiding significant and arbitrary increases from year to year.*

### **DoD Should Fix Inefficiencies, Not Punish Beneficiaries**

Unlike civilian healthcare systems, the military health system is built mainly to meet military readiness requirements rather than to deliver needed care efficiently to beneficiaries.

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 sustaining capacity to treat casualties from military actions. That model is built neither for cost efficiency nor beneficiary welfare.

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. This shift in the venue of care and the associated costs are completely out of beneficiary control.

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.

The Coalition strongly rejects Defense leaders' efforts to seek dramatic beneficiary cost increases as a first cost-containment option rather than meeting their own responsibilities to manage military healthcare programs in a more cost-effective manner.

Instead of imposing higher fees on beneficiaries as the first budget option, DoD leaders should be held accountable for fixing their own management and oversight failures that add billions to defense health costs.

- Decades of GAO and other reports demonstrate DoD cost accounting systems are broken and unauditible.
- More than a dozen reports have recommended consolidated oversight of three separate service medical systems, four major contractors, and innumerable subcontractors that now compete for budget share in counterproductive ways.
- DoD-sponsored reviews indicate more efficient organization could cut health costs 30% without affecting care or beneficiary costs
- DoD's inexplicable refusal to partner with associations to expand mail-order pharmacy above the current low level has cost hundreds of millions per year (each prescription switched from retail to mail saves DoD \$125).
- Improve and expand focus on management of chronic diseases.
- Reduce inappropriate and costly emergency room use by expanding clinic hours, urgent care venues, open access appointing, and phone/web-based access to providers after hours.
- Reform the TRICARE contracting and acquisition process.
- Base incentives to providers on quality-driven clinical outcomes that reward efficiency and value.
- Eliminate referral requirements that add complexity and inhibit timely delivery of needed care.
- Fix broken appointing system that inhibits beneficiary access to care.

These are only some of the examples demonstrating that more effective management, oversight and reorganization of military healthcare delivery could dramatically reduce defense health costs without affecting care or costs for beneficiaries.

***The Coalition urges the Subcommittee to hold Defense leaders accountable for their own management, oversight, and efficiency failures before seeking to shift more costs to beneficiaries. 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, Ill, and Injured Servicemember Care**

Though the war in Iraq has officially ended and the country seeks an exit strategy in Afghanistan, the Coalition has great and continuing concerns about the longer-term stability and viability of the policies, programs, and services intended to care and support our wounded, ill, and injured and their families-caregivers.

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, and injured troops; disabled veterans; and their family caregivers.

Since 2007, every National Defense Authorization Act has built upon institutionalizing a seamless and unified approach to caring and supporting America's wounded, ill, and injured and their families-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.

***TMC strongly urges:***

- ***Joint hearings by the Armed Services and Veterans Affairs Committees addressing the Joint Executive Council's (JEC) effectiveness in daily oversight, management, collaboration, and coordination of the Departments' wounded warrior programs.***
- ***Permanent funding, staffing, and accountability for congressionally mandated Defense Centers of Excellence and associated mental-behavioral health, suicide prevention, caregiver, respite, and other medical and non-medical programs.***
- ***Continued aggressive oversight of the Integrated Disability Evaluation and legacy disability evaluations systems to ensure preservation of the 30-percent threshold for medical retirement, consistency and uniformity of policies, ratings, legal assistance, benefits, and transitional services Defense-wide.***

**DoD – VA Seamless Transition**

**Institutional Oversight** – While many legislative changes have improved the care and support of our wounded, ill, and injured servicemembers, 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, integrated 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, ill, injured, 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 Integrated Disability Evaluation System (IDES)** – 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 IDES pilot has been implemented and expanded, but experience under IDES has shown that the fundamental goals it was to achieve – to be more streamlined, faster, less complex, and non-adversarial -- have for the most part yet to be realized. The service member, typically without effective assistance, must navigate a still-complex adversarial system that is compromised by incomplete medical evaluations, overlooked conditions, and examinations omitting diagnoses – resulting in gaps in care, delays in decision-making, and lack of timely adjudication.

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 provisions in both the FY2011 and FY2012 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 VA rated the condition as “service-connected” and 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 “service-connected” conditions as rated by the VA 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 former 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 and accepting the VA’s “service-connected” rating.***
- ***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.***
- ***Directing DoD to re-engineer and redesign the front end of IDES to (1) better ensure medical evaluations are consistently based on a fully developed, accurate medical summary; (2) permit the servicemember’s full participation; (3) afford each individual consistent, effective representation throughout the process; and (4) streamline the system by eliminating the redundancy of dual adjudication of disability.***

**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 caregivers of wounded, ill, and injured veterans.

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 medical power of attorney and other authorities documented in the member's records.

Congress, DoD and the VA have worked to get essential information to the wounded, ill, and injured 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 wounded, ill and injured servicemembers typically rests with the caregivers, who must be kept involved and informed on all aspects of these members' treatment, appointments, and medical 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 wounded, 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 eligible caregivers of medically retired or separated members.***

- *Extending eligibility for residence in on-base facilities for up to one year to medically retired or severely wounded, ill, and injured servicemembers and their families (or until the servicemember receives a VA compensation rating, whichever is longer).*

**Guard and Reserve Health Care 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 for actively drilling Guard/Reserve families and TRICARE Retired Reserve for "gray area" retirees.

But some deserving segments of the Guard and Reserve population remain without needed coverage, including post-deployed members of the Individual Ready Reserve and early Reserve retirees who are in receipt of non-regular retired pay before age 60.

In other cases, the Coalition believes it would serve Guard/Reserve members' and DoD's common interests to explore additional options for delivery of care to Guard and Reserve families. As deployment rates decline, for example, it would be cost-effective to establish an option under which DoD would subsidize continuation of employer coverage for family members during (hopefully less-frequent) periods of activation rather than funding year-round TRS coverage.

TMC continues to support closing the remaining gaps to establish a continuum of health coverage for operational reserve families.

***The Coalition recommends:***

- *Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60*
- *Authorizing premium-based TRICARE coverage for members of the Individual Ready Reserve after being called to active service for a cumulative period of at least 12 months*
- *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 Prime Issues** – 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-Third Generation (T-3) contracts under the current Managed Care Support contract program.

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.*

**Additional TRICARE Standard Issues** – 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 grateful that the FY2012 Defense Authorization Act extended through 2015 the requirement for DoD to survey participation of providers in TRICARE Standard.

However, we are 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 intervention.

Further, the Coalition believes the Department should be required to take action to increase provider participation in localities where participation falls short of the standard.

A source of continuing concern is the TRICARE Standard inpatient copay for retired members, which now stands at \$708 per day or 25% of billed charges. The Coalition believes this amount already is excessive, and should be capped at that rate for the foreseeable future.

*The Coalition urges the Subcommittee to:*

- *Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future.*
- *Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation to meet the threshold.*
- *Require a specific report on provider participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.*
- *Increase locator support to TRICARE Standard beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.*