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**STATEMENT OF
THE MILITARY COALITION (TMC)
Submitted to the
HOUSE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL**

**concerning
FY2017 DoD Budget Proposals on Military Healthcare**

March 17, 2016

CHAIRMAN HECK, RANKING MEMBER DAVIS, 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 the FY2017 budget proposals on military healthcare reform. This statement for the record provides the collective views of the following military and veterans' organizations, which represent approximately 5 million current and former members of the seven uniformed services, plus their families and survivors:

Air Force Sergeants Association
Air Force Women Officers Associated
AMVETS
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 and Warrant Officer Association, U.S. Coast Guard
Commissioned Officers Association of the U.S. Public Health Service, Inc.
Fleet Reserve Association
Gold Star Wives, Inc.
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the United States of America
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 Military Family Association
Naval Enlisted Reserve Association
Non Commissioned Officers Association
The Retired Enlisted Association
United States Army Warrant Officers Association
United States Coast Guard Chief Petty Officers Association
Veterans of Foreign Wars

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

We are very appreciative that you and the Subcommittee are seeking to ensure military health programs sustain medical readiness; deliver timely, top-quality care; and sustain benefit and cost-share levels for active duty, Guard and Reserve, and retired members and their families and survivors that are consistent with their extended and arduous service and sacrifice in uniform.

The Military Coalition understands the current and future national security situation requires us to maintain a balance of investment in equipment, training, operational capabilities, as well as the personnel requirements which have been the cornerstone of the success of our all-volunteer force. There are finite resources for these competing demands and we strongly agree the Military Healthcare System (MHS) needs to evolve beyond what it is today, into a modern, high-performing integrated system, delivering quality, accessible care safely and effectively to its beneficiaries – while simultaneously meeting international health crises and national disasters, and honing its readiness capabilities. No other health care entity in the country is charged with these dual, yet mutually interdependent, mandates.

In our collective pursuit of needed military healthcare reforms, our guiding principle should be the first principle of medical ethics – first, do no harm.

We all share the common goals of sustaining medical readiness, delivering top-quality care, and avoiding damage to the career retention value of the military healthcare benefit.

In that context, we offer this statement for the record, which provides you with our views on the FY2017 DOD budget request.

FY2017 DOD Budget Request Health Care Reform Proposals

The Coalition is disappointed the FY17 defense budget provides only vague statements on planned program improvements, but focuses specifically on adding several new fees and raising a wide array of others, especially for the retired community.

In addition, it would require formal enrollment for DoD care, or coverage would be denied for the year.

The proposal does appear to offer somewhat lower costs for currently serving beneficiaries, but would significantly complicate healthcare programs by renaming them, creating a new network system, and instituting a complex system of different copays for different kinds of services, with different charges for in-network and out-of-network services.

The budget proposals do nothing to resolve inconsistent programs for Guard and Reserve members and families, do not address the dis-continuity of care between mobilization and demobilization, and places them at risk for even higher out-of-network fees for those who don't live near military installations or heavily populated areas.

The proposals would require retirees to pay more for care, and more rapidly escalate those charges in the future, without any assurance of improved access, quality, or wait times. The proposals offer very little specifics, or committed resources, on how the Department will improve military health care or increase its value.

Proposed Reforms That are Favorable

Aspects of the proposed budget which appear favorable in concept center on the issues of access to care and ease of referrals. The budget itself does not indicate much detail, or offer additional resources, but indicates MHS leaders have pledged to bridge gaps and fix problems by instituting and changing existing structures through:

- Issuing MTF appointments on the first call by the beneficiary
- Streamlining the specialty referral process
- Working to improve continuity of care with providers
- Increased Telehealth capabilities
- Improving services for military children
- Reforms to the Patient Centered Medical Home, to include extending hours
- Monitoring beneficiary satisfaction with access to care as the metric for success

Additionally, the proposed lower inpatient copays for TRICARE Standard/Choice and a fee structure which supports active duty military families are improvements. Active duty service members and their families do well, especially if they choose the MTF centric option, and would have no copayment for receiving care in network with a referral, and will have no charge for utilizing an urgent care center or an emergency room.

Areas of Concern on FY17 Budget Proposals

The budget proposes reconstituting TRICARE into two renamed options: TRICARE Select (currently the HMO-MTF centric option, TRICARE Prime) and TRICARE Choice (currently TRICARE Standard and Extra).

TRICARE Select beneficiaries would pay reduced fees and co-payments, and would use primarily military hospitals and clinics. Enrollees in this option would have no cost sharing for care received in those locations. DoD hopes to drive down expenses with this option because it costs DoD less when beneficiaries use military treatment facilities (MTF) compared to receiving civilian care. The reduced cost structure is also designed to incentivize beneficiaries to obtain their care in the MTFs with the goal of maximizing MTF use and enhancing training/professional skills of military providers.

The Coalition concurs with the goal but remains deeply concerned regarding the MTFs' ability to absorb new beneficiary demand with existing capacity. Inflexible appointing processes, readiness requirements and provider un-accountability for open appointing practices all serve

to undermine a MTF or clinic's capacity. It's one thing to say those chronic problem areas will be fixed; it's another thing entirely to ensure those fixes are implemented successfully. The Coalition is very concerned these proposals are built upon so-far-unfulfilled commitments to fix them.

The second option, **TRICARE Choice**, would provide an un-managed plan for the largest share of beneficiaries. It proposes to arrange for PPO-style provider networks, with the stated goal of establishing networks sufficient to provide care for 85% of participating beneficiaries. This arrangement poses the most risk for those in rural areas, including many Guard and Reserve members and families.

In regard to fee and co-payment adjustments, DoD's budget hits retirees under age 65 the hardest, by charging steep enrollment fees for participating in either TRICARE option.

Retirees would be charged an annual enrollment fee of \$350 for an individual or \$700 for a family using TRICARE Select, **a 24% increase from the current fee.** TRICARE Choice – or Standard, which currently has no enrollment fee – would require a \$450 fee for individual coverage and \$900 for families, and still would provide no guaranteed access to care. Of particular concern, the TRICARE program has had a long history of providers reluctant to accept TRICARE's lower reimbursements. This poses significant questions regarding how robust the PPO networks would be.

TRICARE for LIFE (TFL) beneficiaries would also see controversial increases under the budget proposal. For the first time, new TFL entrants as of 1 January 2017 would be required to pay an enrollment fee. The Coalition believes enrollment fees should be reserved for programs like TRICARE Prime, which guarantees access.

Of particular concern, TFL beneficiaries would also be subjected to means-testing, with fees initially set at 0.5% of retired pay, rising to 2% of retired pay for a TFL-eligible couple, to be phased in over 5 years. It would be accompanied by a complicated system of fee caps, one for flag officers and one for lower grades. ***The Coalition does not support means-testing, which imposes financial penalties for longer and more successful service on a population that is already paying the highest fees of any military beneficiaries.***

The Coalition believes strongly in the original intent of Congress, which expressly prohibited a separate enrollment fee for TFL, acknowledging this group already incurs higher costs than other military beneficiaries by virtue of being required to pay Medicare Part B premiums. The proposed new fee is particularly inappropriate since DoD's costs for TFL have declined precipitously, from \$11 billion in FY11 to an estimated \$6.4 billion in FY17.

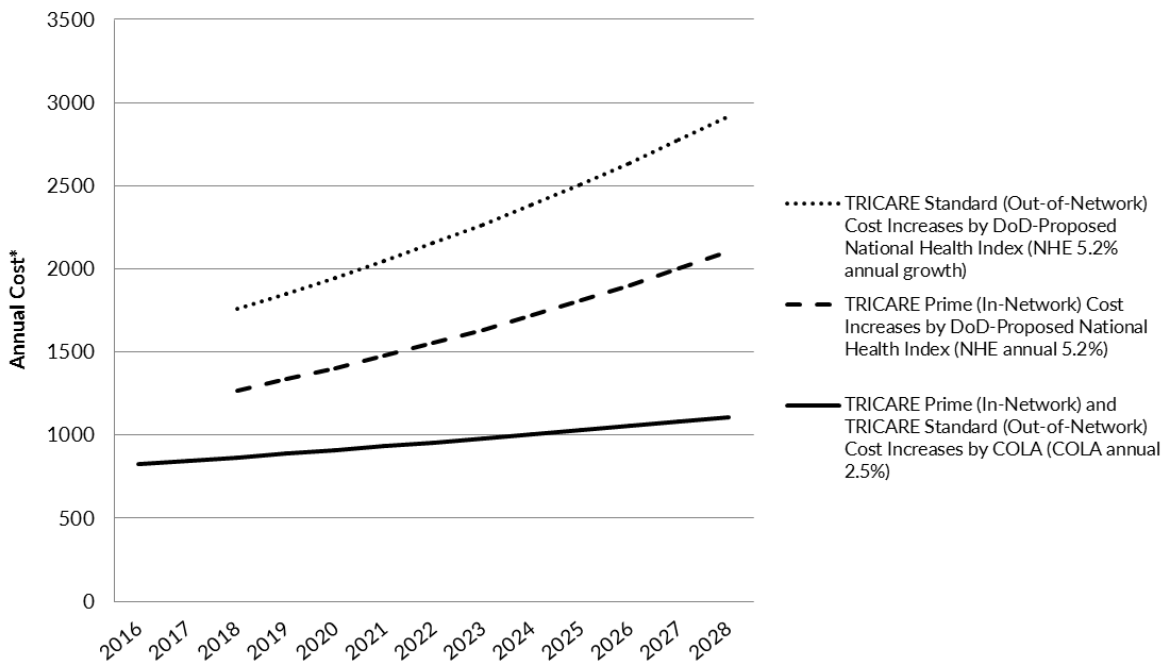
Raising the catastrophic cap (maximum out-of-pocket expenses) to \$1,500 per year for currently serving families and \$4,000 for retired families (vs. current \$1,000 and \$3,000)

Pharmacy co-payments would double over ten years. The budget proposal creates a multi-year schedule which would double most pharmacy copays, which have increased five-fold over the recent few years. In many cases, current copayments already are at or above corporate insurance medians.

Indexing fees to medical inflation is another key component of the DoD proposal. It would provide for annual adjustments of the aforementioned fees and co-payments to the national health expenditure index, which is projected to rise at 5.2% per year. This is noted in the budget in small print – but has very large ramifications for beneficiaries. It would result in both active duty family and retiree co-payment increases of nearly 50% by 2025. This growth rate is significantly faster than the growth in TRICARE payments to providers, which means beneficiaries paying flat fees (rather than the current 20% or 25% of TRICARE-approved charges) likely would end up paying ever-increasing shares of TRICARE-approved charges.

The following charts illustrate how the new proposals would not only impose a significant fee increase immediately, but would rise dramatically in the future compared to current COLA-based adjustments.

Proposed Index Would Escalate Beneficiary Costs



*Annual cost estimate for a retired family of four assumes: annual enrollment fee; annual deductible; 6 primary care visits, 3 specialty care visits, and 1 outpatient surgery; and 2 brand name and 2 generic prescriptions per month (initial fill retail; refills by mail-order).

The Coalition believes strongly that military beneficiary fees should not grow faster than their military compensation does. We agree with the methodology previously approved by this

committee that annual increases should not exceed the percentage growth in military retired pay (i.e., inflation as measured by the Consumer Price Index).

The Coalition also is concerned that many cost-shares that are now expressed as a percentage of the TRICARE-approved provider payment would be converted to flat fees, and then adjusted annually by the 5.2% annual health index.

The reality is that Medicare-based payments to providers have increased very modestly over the years as Congress has sought to keep Medicare costs down. Assuming this trend will continue, the proposed schedule would steadily increase the patient’s relative share of the payment.

The chart below shows how this would happen, assuming a 5.2% increase in the flat-fee cost-share vs. a 1.5% annual increase in TRICARE payments to providers (which is actually more than payments have increased over the past decade).

	TRICARE Pays Doctor	Patient Pays*	Patient Cost Share
2018	\$100	\$25	25%
2019	\$102	\$26	26%
2020	\$103	\$28	27%
2021	\$105	\$29	28%
2022	\$106	\$31	29%
2023	\$108	\$32	30%
2024	\$109	\$34	31%
2025	\$111	\$36	32%
2026	\$113	\$38	33%
2027	\$114	\$39	35%
2028	\$116	\$42	36%

*If adjusted by annual National Health Expenditure index (5.2% a year) as the FY 2017 budget proposes.

Imposing an annual enrollment requirement and denying care to those who don’t enroll is a key element of the FY17 proposal. According to DOD, failure to explicitly opt in during an annual open enrollment would eliminate coverage for the beneficiary and family for that year. The Coalition strongly opposes this requirement, which effectively would deny a service-earned healthcare benefit. As outlined above, some members may find it preferable to use VA facilities for certain care, but use their earned TRICARE benefit for family care. Others may use spousal or employer insurance for certain care, but TRICARE for things the other insurance doesn’t cover. The DoD argument that it needs to be able to plan for who will use DoD care is spurious. DoD knows every claim and every penny spent on each eligible TRICARE beneficiary, and has full capacity to track trends and make future projections. The fact DoD healthcare costs have

been flat and DoD is typically able to reprogram funds at the end of the year provide ample evidence of that. The practical reality is Standard beneficiaries are used to just showing their ID card as proof of eligibility. Many would discard notices of a requirement to enroll, especially in the first year, assuming it was junk mail. The consequences in some cases would be far worse than being told at a medical appointment they are not covered. The first time some sponsors could learn of the requirement is upon having a family member suffer a potentially life-threatening injury/illness or require an extended hospital stay, and find they are denied coverage for failure to enroll. That should be an intolerable scenario for DoD as well as the beneficiary. ***In the Coalition’s view, no eligible beneficiary should be denied their service-earned healthcare coverage. If there is to be an enrollment requirement, any eligible beneficiary should be enrolled automatically upon seeking care.*** As it has for decades, the military ID card should serve as proof of enrollment.

Net Impact of DoD-Proposed Fee Changes on Military Families

The complexity of the proposed fee changes can be bewildering, especially since all of the program names would be changed as well. The actual impact of the changes on military families could vary widely, depending on the family’s usage of various kinds of care.

The following charts show how the changes would affect typical currently serving, retired families under age 65, and Medicare-eligible families compared to the fees they pay in 2016, assuming a specific set of provider visits and prescriptions. For the sake of simplicity and transparency, the charts use the current program names.

In general, the changes would be financially beneficial for active duty families, but far less so for Selected Reserve families.

The changes hit retired families under age 65 the hardest, imposing increases of 50% or more for those using in-network providers and 100% increases for those who don’t – or can’t -- use network providers. The Coalition believes these fee increases are disproportionately high, especially when there are no guarantees of improved access or service.

Currently Serving - Family of Four			
Fee Component	2016		2018
	TRICARE Standard	TRICARE Prime	TRICARE Standard
Enrollment Fee	\$0	\$0	\$0
Deductible ¹	\$300	\$0	\$0
Network Copays ²	\$0	\$0	\$195
Rx Cost Shares ³	\$188	\$260	\$260
Yearly Total	\$488	\$260	\$455

¹ Under proposal, deductible applies for out-of-network care only

² Assumes 8 network visits per year (3 Primary, 2 Specialty Care, 2 Urgent Care, 1 ER)

³ Assumes 2 brand name and 2 generic prescriptions per month (initial fill retail; refills by mail-order)

TRICARE Prime¹ - Retiree Family of Four

Fee Component	2016	2018 In Network	2018 Out of Network
Annual Enrollment Fee	\$565	\$700	\$700
Annual Deductible	None	None	\$600
Doctor Visit Copays ²	\$72	\$310	--
Rx copays ³	\$188	\$260	\$260
Yearly Total	\$825	\$1,270	\$1,560

TRICARE Standard¹ - Retiree Family of Four

Fee Component	2016	2018 In Network	2018 Out of Network
Annual Enrollment Fee	None	\$900	\$900
Annual Deductible	\$300	None	\$600
Doctor Visit Copays ²	\$338	\$355	--
Rx copays ³	\$188	\$260	\$260
Yearly Total	\$826	\$1,515	\$1,760

¹ Under proposal, TRICARE Prime will be known as TRICARE Select, and TRICARE Standard will be known as TRICARE Choice

² Assumes 6 primary care visits, 3 specialty care visits, and 1 outpatient surgery.

³ Assumes 2 brand name and 2 generic prescriptions per month (initial fill retail; refills by mail-order)

TRICARE For Life - Married Couple

Fee Component	2016	2018
Annual Medicare Premium ¹	\$2,520	\$2,570
TFL Enrollment Fee ²	None	\$300
Rx copays ³	\$376	\$520
Yearly Total	\$2,896	\$3,390

¹ Assumes 1% annual COLA. Medicare premium based on lowest income bracket fee, many pay more.

² O-5 with 20 years of service turning 65 in 2018 (fee would double by FY2021)

³ Assumes 4 brand name and 4 generic prescriptions per month (initial fill retail; refills by mail-order)

While the initial fee for TRICARE For Life seems relatively small, it would grow over time. The Coalition believes such a fee (means-tested or not, but especially means-tested) is inappropriate for TFL-eligibles, since:

- This population already pays substantially more for their health coverage than any other members of the military community

- Medicare pays 80% of TFL-eligibles' health costs, so DoD is only responsible for the other 20%
- DoD costs for TFL, as reflected in DoD trust fund contributions have dropped almost 50% over the last several years as defense actuaries have now gained 15 years of experience measuring the actual cost of providing this care vs. their original very conservative (from DoD's standpoint) estimates.

Mr. Chairman, Madam Ranking Member, and members of the Subcommittee, thank you for this opportunity to present our inputs on these important issues. We stand ready to work with you and your staff in any way that would be helpful.