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STAKEHOLDER VIEWS ON MILITARY HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

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STAKEHOLDER VIEWS ON MILITARY HEALTH CARE

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Thursday, December 3, 2015.

The subcommittee met, pursuant to call, at 11:37 a.m., in room 2212, Rayburn House Office Building, Hon. Joseph J. Heck (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOSEPH J. HECK, A REPRESENTATIVE FROM NEVADA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Dr. HECK. Okay. I would like to call the hearing of the Military Personnel Subcommittee to order. I want to welcome everyone to the hearing.

I thank the witnesses for their flexibility.

Just to say at the outset, we are probably going to have another vote series at 12:30, which will be a one-vote vote series. So my plan is that when the bell rings whoever is speaking will finish what they are saying, we will depart, go vote that one vote, and come immediately back if we have not yet concluded the hearing.

So again, I want to thank everyone for coming to the subcommittee hearing to get the stakeholder views on proposed military health care reforms. This hearing is part of the committee's ongoing project to comprehensively review the current state of the Military Health System and military health care and, based on this information, identify areas that need improvement.

I want to be clear that this process is not being driven by budgetary concerns. We are using the same format that we used in the successful review of the military retirement changes, which were not driven by budget but driven by what will produce the best possible benefit to be able to recruit and retain the best and brightest into our All-Volunteer Force.

The overarching goal of the project is to ensure the Military Health System can sustain trained and ready health care providers to support the readiness of the force while providing a quality health care benefit that is valued by beneficiaries. To that end, the committee has heard from several experts, including current and former Surgeons General, the Under Secretary of Defense for Health Affairs, and civilian health care programs, regarding the current and future challenges of providing health care.

Today we look forward to building on the knowledge by hearing from military service organizations regarding their members' views on military health care. These incredibly important perspectives are crucial to understanding this multifaceted and complex issue.

Our purpose today is to discuss both what works and what needs to be fixed in the military health care system.

We are keenly aware that military health care is an extremely important benefit and any reforms must be thoroughly analyzed from multiple perspectives and structured to prevent unintended consequences. Our discussion today is an integral part of that process.

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

[The prepared statement of Dr. Heck can be found in the Appendix on page 27.]

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

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman.

And I also want to welcome, of course, all of you to this hearing. Your perspective and your views have always been very important to us, and particularly as we have been engaged in the health care reform discussion.

And, Admiral Ryan, I understand you will be stepping down. Is that correct? Yes—as President and CEO [Chief Executive Officer] of MOAA [Military Officers Association of America], and we just want to thank you so much for your service. I know that everyone in the organization feels the same and we appreciate very much the work that you have done.

We have had the opportunity to hear from some of you this past spring as we began working through many of the recommendations of the commission, and you know that we did address retirement reform as well as several other commission recommendations in the NDAA [National Defense Authorization Act]. And we have made progress in health care reform by instituting a pilot program on urgent care requiring the DOD [Department of Defense] to publicly post access standards and requiring DOD to improve TRICARE enrollment during duty station changes.

And I think we can all agree that there are areas of the health care system that work very, very well. And yet, there are some areas that we can improve. And so that is the challenge before us, I think, to try and make these improvements while maintaining a superior standard of care.

I know each of your organizations represent particular constituencies and particular concerns, so we are eager to have your insight and your thoughts. Thank you so much, again, for being here.

And I might say, Mr. Chairman, that I believe with the votes kind of got us off schedule that I may need to leave in the middle.

But I am hoping that we will be able to hear from all of you before that, and even some of the questions.

Thank you so much.

Dr. HECK. Thank you, Mrs. Davis.

We are joined again today by an outstanding panel. We will give each witness the opportunity to present his or her testimony and each member an opportunity to question the witnesses.

Respectfully remind the witnesses to summarize, to the greatest extent possible, the high points of your written testimony in 5 minutes or less. Your written comments and statements will be made part of the hearing record.

Let me welcome our panel: Mr. Scott Bousum, Legislative Director of the Enlisted Association of the National Guard of the United States [EANGUS]; Vice Admiral (Retired) Norbert Ryan, President and CEO of the Military Officers Association of America; and Ms. Joyce Raezer, Executive Director, National Military Family Association [NMFA].

I also ask unanimous consent to enter a statement from the National Association of Chain Drug Stores into the record.

[The information referred to can be found in the Appendix on page 95.]

Dr. HECK. Without objection, so ordered.

Who is going to go first?

Mr. Bousum. Okay. You are recognized for 5 minutes.

STATEMENT OF SCOTT BOUSUM, LEGISLATIVE DIRECTOR, ENLISTED ASSOCIATION OF THE NATIONAL GUARD OF THE UNITED STATES

Mr. BOUSUM. Well, Chairman Heck, Ranking Member Davis, esteemed subcommittee members, my opening statement is part of my written testimony, and since we have a—kind of a tight schedule with votes I am willing to just submit it for the record and not read.

Dr. HECK. Well, can you give us a quick summary in 5 minutes of what your statement says so we can move forward, so everybody has an opportunity that made not have read your——

Mr. BOUSUM. Sure.

Dr. HECK [continuing]. Statement in advance——

Mr. BOUSUM. Absolutely. Yes, no problem.

Well, on behalf of the Enlisted Association of the National Guard, it is a pleasure to testify on the critical issue of health care reform. Our membership represents over 414,000 enlisted men and women of the Army and Air National Guard, their families and survivors, and the tens of thousands of National Guard retirees.

Each and every year one of them is affected by health care when the Guard mobilizes in support of our country or when they fulfill their strategic missions. We welcome this opportunity to submit testimony for the record.

Our members appreciate the countless hours that you and your staff have devoted to ensure that our service members receive the best care.

Under committee leadership, the National Defense Authorization Act committed the Military Compensation and Retirement Modernization Commission [MCRMC].

The commissioners made recommendations to ensure—or to Congress on how to improve health care access that would eliminate problems currently encountered by Guard and Reserve members and families. We encourage the committee to consider the commission's final recommendations as they explore health care reform.

From the Guard's perspective, it is difficult to discuss health care without addressing the complexity of our duty statuses. The mili-

tary's complex personnel system directly affects Guard pay, health care, and even burial rights, based on what duty status orders are published under.

The focus of today's discussion does not include National Guard duty status reform, but I suggest that the type of health care coverage members receive should be separated from whether or not they are on Active or Inactive Duty military orders.

Service members and their families should have one health care program regardless of duty status. Separating the two would fix the continuity of care issue creating problems for members of the Guard and their families.

As you consider changes next year, please keep in mind that access is a problem because most members of the National Guard do not live on or near military installations. As a result, many of our members drive hundreds of miles for appointments, only to be referred to a specialist who may or may not be available under TRICARE.

Additionally, their frustration is compounded because appointments may not be scheduled in what you or I would consider a reasonable timeframe.

This association, in conjunction with the Reserve Officers Association [ROA] and the National Guard Association of the United States [NGAUS], circulated a health care satisfaction survey to our members. The results of the survey are enclosed with my written testimony. After reviewing the survey results, I am not prepared to say that TRICARE is broken.

I want to recognize Reserve Officers Association and the National Guard Association of the United States for their input in today's testimony. Together, our membership makes up the entirety of the Reserve Component, officers and enlisted, and all over 1.1 million members, which includes every mobilization category.

So thank you again for hosting this hearing. As the discussion continues, we look forward to working closely with you and your staff as you look at military health care reform.

[The prepared statement of Mr. Bousum can be found in the Appendix on page 28.]

Dr. HECK. Admiral Ryan.

STATEMENT OF VADM NORBERT R. RYAN, JR., USN (RET.), PRESIDENT AND CEO, MILITARY OFFICERS ASSOCIATION OF AMERICA

Admiral RYAN. Chairman Heck, Madam Ranking Member Davis, Congressman Coffman, Congressman MacArthur, Congressman O'Rourke, thank you. Good morning.

First, from my humble perspective as the president of MOAA for the past 13 years, this committee's actions have been the driving force, I believe, in sustaining the All-Volunteer Force while the Nation has been at war. Leaders make a difference. You all have made a real difference. Thank you.

As for today's subject of military health care, MOAA's first guiding principle is to do no harm. We think it is important to preserve what is working and fix what is not working.

In a category of what is working we would include: combat casualty care; the overall quality of military health care once it is de-

livered; TRICARE for Life; pharmacy programs, including the mail-order pharmacy; and TRICARE Standard, for the most part. On the latter score, MOAA's recent survey of more than 30,000 beneficiaries found Standard participants had a higher satisfaction rate and significantly lower dissatisfaction than Prime beneficiaries.

In the list of things that are not working, MOAA would include, first and foremost, the fundamental inefficiency of a system built around three separate military service programs with no single budget and oversight authority. We fight wars jointly, thanks to Congress' insistence in the 1980s, over the objection of all the Joint Chiefs.

Why can't we do the same in medical? In layman's terms, there are simply too many cooks in the kitchen.

As a result of our survey, it confirmed serious shortcomings in the TRICARE Prime appointing and referral system; the Guard and Reserve TRICARE coverage, as Scott alluded to; the patient load in military treatment facilities where military providers see far fewer patients per week than civilian providers; and inadequate case management of the higher cost for at-risk health care users.

One of the biggest problems is a serious disconnect between rhetoric and reality on DOD health care costs. Every year some defense officials offer dire budget projections of health care costs they say are out of—spiraling out of control. But recent history shows these projections have been consistently wrong.

Slide, please? I don't know if you are going to be able to put it up there.

The chart displayed reflects the reality: DOD health costs have been flat or declining for the past 5 years. Figures through fiscal year 2014 are actual expenditures; fiscal years 2015 and 2016 are projections in the latest DOD report and the fiscal year 2016 budget.

As you can see, TRICARE for Life costs have dropped significantly and purchased-care costs have been flat or declining. A prime source of cost increases has been in-house military care, which is mainly a factor of medical readiness and system inefficiency.

[The slide referred to can be found in the Appendix on page 102.]

Admiral RYAN. In assessing what changes should be pursued, our statement for the record offers a number of guiding principles. Four key ones include: First, means testing is inappropriate for military health benefits. Reducing benefits for longer and more successful service has very negative career retention effects.

Second, readiness costs should not be passed on to beneficiaries. When military providers are deployed or military facilities are inefficient and more beneficiaries are pushed into the private care, that is a cost of doing military business, not a personnel benefit.

Third, the military health benefit should be the gold standard: a top-tier program that is substantially better than those offered by the best civilian employers.

And lastly, each similar group of eligibles should be provided similar coverage. We are not in favor of an FEHBP [Federal Employees Health Benefits Program]-style system that means those with more income can buy better coverage.

Finally, our written statement offers 12 specific recommendations, but in the interest of my time and your time and the colleagues' time, I will not address those now.

Mr. Chairman, in closing I can assure the entire committee that MOAA stands ready to assist you and your staff in any way that would be beneficial. We all want to get this right.

Thank you.

[The prepared statement of Admiral Ryan can be found in the Appendix on page 47.]

Dr. HECK. Ms. Raezer.

STATEMENT OF JOYCE RAEZER, EXECUTIVE DIRECTOR, NATIONAL MILITARY FAMILY ASSOCIATION

Ms. RAEZER. Thank you, Mr. Chairman, and Ranking Member Davis, and other members of the subcommittee, for inviting me to speak today on behalf of the National Military Family Association and the families we serve about what is working and what is not working with military health care for families.

Our written statement submitted for the record contains a summary of what we hear most often from currently serving military families about their experiences, good and not so good, in accessing care and the quality of the care they receive.

We appreciate the provisions that you included in the recent NDAA as a step in addressing some of those issues about access and quality, but it has been more than 20 years since TRICARE was created. It is time for a holistic examination of TRICARE and the Military Health System, not tweaks around the edges.

But we remain committed to the concept that the reform discussion must start with how to build and deliver the best benefit possible for our military families—which I think I heard from you, Mr. Chairman—not on how much families should pay for that benefit.

Military health care must meet the unique needs of military families, such as frequent moves and deployments, as well as address the concerns of families in remote locations, individuals with complex health care needs, wounded service members, and our National Guard and Reserve members and their families. Service members must get the care they need to be medically ready.

Above all, coverage, access, quality, and cost should acknowledge the value of the service and sacrifice of troops and their families. As Admiral Ryan said, our military families deserve nothing less than the best possible health care coverage and care.

We do know that many of our families remain satisfied with TRICARE—the care they receive and the low cost of that care. Our concern for these families centers on what could happen to their care if financial pressures take a greater toll on military hospitals or the TRICARE benefit over time.

When we asked for families' input about their health care experiences, they routinely cite difficulty in obtaining timely appointments; bureaucratic hassles to obtain referrals; lack of continuity of care; difficulties in navigating the system, especially when moving from one military community to another; a lack of coverage for certain services; and poor customer service.

While most families rate "poor access" as their number one health care quality issue, some do tell us of experiences of less than

satisfactory care—examples similar to what was found in the 2014 Military Health System Review conducted by the Department of Defense.

But we do know there are models of timely access and quality improvements in pockets of the direct care system. But there doesn't seem to be a single entity with the power to drive implementation of those improvements across the system and hold those in need of improvement accountable.

Based on what we hear from military families, here is what we would like you to look at as you begin your review of TRICARE.

Changes in and enforcement of access, quality, and customer service standards must apply across the entire Military Health System, direct care and what is purchased from the private sector. Before initiating additional recapture efforts to bring more beneficiaries into the military hospital, military hospitals should be required to certify they are meeting appointment access standards for current patients.

Reconsider the concept of a unified medical command to provide a single entity responsible for ensuring consistency and quality accountability across the system. Ask how private sector coverage options, patient engagement efforts, and quality standards can inform TRICARE reform.

Consider the demographics of military families today in updating the TRICARE benefit and in managing the balance between meeting the readiness mission and delivering an employer-provided health care benefit to families. A Medicare-based reimbursement system and a focus on troop and provider readiness for war don't easily translate into a model of coverage and care for a population of young families with kids. Here is a statistic for you: Of the 1.1 million children of Active Duty service members, almost 50 percent are age 6 or younger.

Questions about any proposed changes to TRICARE should also be asked about the current system. How does this structure promote military readiness? How does it ensure timely access and quality care at the best possible price for both beneficiaries and the government?

In an era of budget constraints when military families see any proposed change in their benefits as just another attempt to cut costs, it is important to rebuild their trust and to show them their service is valued. We hope this hearing is only the beginning of a thorough discussion of how to deliver the best care benefit to military families.

Thank you.

[The prepared statement of Ms. Raezer can be found in the Appendix on page 71.]

Dr. HECK. Thank you. I appreciate all of your testimony.

And since, Mrs. Davis, you may have to leave soon I will defer my time and give you the first 5 minutes.

Mrs. DAVIS. Thank you very much.

And again, thank you all for being here.

Ms. Raezer, maybe I will—wanted to ask you really just to follow up, I think, on some of the discussion, because one of the concerns that you stated, and I think has been stated often, is about access standards. And what we know is that there isn't a whole lot of

awareness sometimes of what those DOD standards are, which the awareness may be low but the standards are high in a number of cases, and yet that is not something that I think is—people are able to relate to within the service that they are getting.

And so how would you do that? What are we missing? What is not happening to increase the standard so people really can, I think, demand, in many ways, that they get the care that they—that actually has been developed for them?

Ms. RAEZER. You are absolutely right. There isn't a lot of awareness about the standards. And unfortunately, it is not just on the military family side; it's on—and this is mostly in the direct care system, where there aren't the same kind of accountabilities that are in the purchased-care contracts—there's not a whole lot of awareness on the—among the people who are charged with giving military families an appointment.

So if a military family member, even if they—who knows about an access standard calls for an appointment for a sick child and said, "This is urgent care; the access standard is 24 hours," typically they are going to get the response, "Sorry, there are no appointments."

"Well, can you send me out for urgent care?"

"Sorry, we are not doing that right now," which is why we are so grateful for the pilot.

A military treatment facility's response to beating access standards shouldn't be to tell a military family with a sick child, "Go to the emergency room and wait for 9 hours," and that's what is happening. So there is an awareness needed on the military hospital side across the culture and a commitment to meeting those access standards.

We don't hear a lot from DOD about access standards lately. We really did a lot when TRICARE was first created, and that was the promise of TRICARE Prime: "You give up some control over your care and we will guarantee low cost and access." The low cost is still there but the access isn't.

Mrs. DAVIS. Yes.

Any others—do you have a sense, Admiral, about how do we——

Admiral RYAN. Yes.

Mrs. DAVIS [continuing]. Make that better?

Admiral RYAN. I couldn't agree more.

What our survey of over 30,000 folks says is that it all—that the real issue is with TRICARE Prime. The greatest dissatisfaction was meeting the appointment timelines or getting specialty appointments. And it is double the dissatisfaction rate in TRICARE Prime, and specifically in the military treatment facilities is where the—rather than the purchased-care part of TRICARE Prime.

So it is 15 to 19 percent dissatisfaction with the appointment—getting the timely appointment or getting a specialty appointment. It's half of that in TRICARE Standard and even less in TRICARE for Life.

And so the figures show it, exactly what Ms. Raezer was talking about.

Mrs. DAVIS. Yes. Because there are some reports that would indicate that the MTFs [military treatment facilities] are actually meeting this standard. But that is——

Admiral RYAN. Well, we have had discussions with DOD——

Mrs. DAVIS. Why this disconnect?

Admiral RYAN. Yes.

Ms. RAEZER. We have had numerous discussions with the Department on how do they measure access. If I call and ask for an appointment for a sick child and I am told, "Call back tomorrow," or, "Go to the emergency room," how does that get recorded in the system? How does that response, "Call back tomorrow," get recorded in the system as meeting or not meeting access standards?

And what we were hearing from the Department is they weren't really sure. And that was one of the things that came out in the Military Health System Review is that there were a lot of questions about how the military was measuring access.

Admiral RYAN. One of the principal problems—and I know that the health care providers and MTFs are really professional—consummate professionals and want to do a good job, but when you look at the number of appointments that they have in a day versus what you have in the purchased care, it's not even close to what is in the purchased care.

Now, that may not be the fault of any of the health care providers. Dr. Heck has been in the system. It may be the administrative requirements that are placed on them; it may be the lack of administrative support so they end up doing clerical stuff as well.

But that is an area, if we could fix one thing it would break a lot of this dissatisfaction, I think.

Mrs. DAVIS. Well. Okay. Yes. Thank you.

Mr. Bousum, did you want to comment on that?

Mr. BOUSUM. I was just going to interject quickly—I am running on a little time here—when guardsmen go onto TRICARE Prime and they are called to Active Duty and there is a switch in this continuity of care, the—our members are now deployed and their family members are left to work this convoluted nightmare with them, you know, now thinking of their family and it affects readiness, so——

Mrs. DAVIS. Okay. Thank you. Thank you very much.

Thank you, Mr. Chairman.

Dr. HECK. Thanks.

So, you know, one of the approaches that we are trying to look at from the subcommittee perspective as we tackle this is, you know, from the 30,000-foot view, what is the primary purpose of the military health care system? What is the primary reason that we have a military health care system? And then from there, try to bring it all the way down to the tactical: How do we provide that care?

So I would ask each one of you, on behalf of your association: To your association, what is the primary purpose of the military health care system?

Mr. Bousum.

Mr. BOUSUM. Well, I would say—and in our case it's not this way but it should be this way, that a guardsman should have the same health care regardless of their duty status, that it should be something that fits the needs of the service member and their family, and that it is something that they have 365 days a year until they

maybe opt to change that. But it shouldn't change at any point regardless of what happens during that year.

Dr. HECK. Okay.

Admiral.

Admiral RYAN. Well, I think you said it in—both of you and Madam Ranking Member said it in your opening statement. It is readiness.

But we think an important part of readiness is making sure that you can also take care of the family. And so the way you phrased it's the right way.

And that is why when the commission came out with this FEHBP proposal we could not see how military—the military MTFs could sustain their readiness with that proposal. And that's why we would rather—you can't evolve this system; it has to be reformed. And it can't be piecemeal.

But it has got to start with the readiness and making sure that all of those MTFs have people that are qualified to do what you have done, to deploy and take care of our troops. But an important segment of that readiness, as Scott pointed out, is when somebody goes over the horizon they want to know that their family is being taken care of and seen.

Thank you.

Dr. HECK. All right.

Ms. Raezer.

Ms. RAEZER. I agree with Admiral Ryan. It is readiness first. The system has to ensure that service members are medically ready to deploy, that they—and that they have the best possible care when they are deployed.

We don't want to mess with the successes that we have seen in combatant care. But that's prime important—of prime importance to families, as well. They want to know that their service member is well taken care of when put in harm's way.

But the Department of Defense also has an obligation to provide a high-quality employer-sponsored benefit, and where we are seeing—so there really—it is a dual-purpose, and what we are seeing is the conflict between those two goals in the Military Health System.

Too much emphasis on readiness leaves families without appointments. And pressure on readiness dollars leaves families and sometimes service members without care.

So I think the challenge for you as you do this work is saying, "How do we get rid of that conflict between those two missions of the Military Health System?"

Dr. HECK. Great. Thank you. I will save my second question for the next round since it is going to take longer than a minute and a half.

Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman.

I am more familiar with the VA [Veteran Affairs] health care system—I have been on the VA Committee for 3 years and on this committee for almost a year—than I am the TRICARE and DOD system. But you mentioned something that caught my attention because we have heard it so often on the VA side, which is access standards and accuracy in measuring access standards.

In the VA it was wait times. And, you know, we were told with all certainty by the VA 2 years ago that we were seeing everybody within 14 days, and there was a—the infamous wait-time scandal in Phoenix.

So I would love for you to expand on that a little bit and tell me what your members are seeing, or what the concerns are, or what your recommendations are for assuring that we are meeting the standards and that we are measuring those accurately.

In our case in El Paso we bypassed the VA and just asked veterans directly and did a survey of veterans in El Paso to find out what their real wait times were. And instead of 14 days we found for primary care it was 81 days on average; for mental health care, 74 days.

So that, and then the second question for you and then anyone else who would like to address it, one of the MCRMC's recommendations was having greater interoperability between VA and DOD. And there is the DOD/VA Joint Executive Committee to standardize and enforce collaboration, so any thoughts on that would be appreciated.

And I will start with you, Ms. Raezer.

Ms. RAEZER. Yes. I will start with the access question. We haven't heard of families having the same length of wait as what some of the worst stories that came out of the VA are.

But that said, we are hearing from families who not only are being told they have to wait for care, where there is no mention of an access standard, but there is also what I term as "silly rules"—processes and procedures at military hospitals and clinics that vary but that put barriers up between a patient and the provider in accessing care from that provider, rules about when you are transitioning on a military move from one installation to another, what do you—you know, the enrollment process from TRICARE contractor to TRICARE contractor is pretty seamless.

Where our families are having problems is getting that first appointment with a primary care manager in a military hospital. Or if you have come in with an existing health condition, we—one of the examples we referenced in our written statement was a spouse late term—late in her pregnancy who moved from one military community to another, and even though she was obviously pregnant, had her records with her showing she was high-risk, was told she had to take a pregnancy test before she could get an appointment with an OB [obstetrician].

She came at 28 weeks, didn't see the doctor until 36 weeks. That's just wrong.

And we hear that—we have heard that from other military families, that the process they have to go through when they move creates a barrier between them and care that doesn't show up readily on access standards.

Just a bit on the other—on your issue about interoperability between DOD and the VA, our families who are going through transitions say the process has to be seamless. Especially if you have a wounded service member it is—there are still too many unmanaged processes for that individual, too many different case managers, too many barriers.

You are fixing some with the drug formulary, for example, but there's still some other ways that that could be made better. So we agreed with the commission on that.

Mr. O'ROURKE. Too many different systems.

Ms. RAEZER. Yes.

Mr. O'ROURKE. Admiral Ryan.

Admiral RYAN. Well, I go back to the President's first term. He cared enough about this that he called about six of us into a room, major VSOs [veteran service organizations], and said, "This is important if we get this joint DOD–VA medical record, and I want it to be a medical record." He called the Secretary of Defense and the Secretary of VA out of separate meetings to be there to look everybody in the eye and said, "We need to get this done."

Unfortunately, there has been—it's been well documented that leader after leader on both sides have not been over—able to overcome the intransigence of the bureaucrats over there. You all have wasted a lot of money on this, and the latest is now they are publicizing that you can look at the other person's record, but it's really an embarrassment.

And I see well-intentioned people at the top say, "We are going to be involved in this," but they get overtaken by events and I think they leave it to other folks and they don't have the clout to get it done.

Mr. O'ROURKE. Yes.

Unfortunately I am out of time, but I would love to get your thoughts either offline or on the record.

And with that, I'll yield back to the chair. Thank you.

Mr. MACARTHUR. Thank you, Mr. Chair.

Thank you for being here.

We got a lot of hearings now on this subject. We have met with the commission, active and retired members of the services and the DOD, the Surgeons General, the private sector, the public sector, and now stakeholder groups. And I am reminded that the purpose of walking is to get somewhere, and we are getting to that point where I think we need to come to some kind of a landing, and that is what we are working on.

And as I think about our objectives, it's clearly readiness and it's clearly keeping our end of the bargain—family care and providing for people. And I think those two are front and center to me.

Rather than asking you detailed questions, I'd actually like to lay out a broad framework that is beginning to gel in my mind and I would like you to react to it. And that framework is a couple of changes to the current system.

One would be a consolidation of the medical health system into a consolidated command, rather than having each service run their own hospitals. And then the Surgeons General would focus on training, equipping, and supporting, not running a system.

Two would be granting broad authority to this central command to change plans, to change delivery within broad cost constraints that we would define here.

Three would be investing in centers—military centers in areas of concentration of troops and families and increasing—in other areas where there is less concentration, increasing access to private health care.

And then lastly would be ensuring a vibrant military health Reserve system so that we can make use of health care professionals in the private sector who agree to be on Reserve status and go wherever whenever.

Could you each take—I have only got 3 minutes left. Could you each take a few moments to talk about pros and cons to that framework?

Admiral RYAN. You didn't get a chance to talk, so——

Mr. BOUSUM. So actually, a part of the—my written testimony, my organization would actually support the basically FEHBP plan and bringing everything over to OPM [Office of Personnel Management]. They manage for Federal employees, and that there could be a structure in place that they could support that for service members.

In terms of access—you know, better access to private care, we would—from a readiness perspective we would have to ensure that doctors understand readiness levels for the different services. There are different standards for every service member, and so in order to do that, that is asking more—putting the onus on them. So if a service member comes in, perhaps, with the flu but they look to be overweight, then a doctor would say, "Okay, you know, I am taking care of, you know, your flu symptoms but, you know, I also am now responsible for reporting this."

One thing, and this is, you know, as you are looking at reform this is somewhat outside the box, but in order to, you know, in order to go that route, perhaps a cost offset for that doctor would be that the Federal Government reimburse some portion of their Federal student loans.

Mr. MACARTHUR. I am going to stop you there because I want the——

Mr. BOUSUM. Okay.

Mr. MACARTHUR [continuing]. Other two—I would invite written responses to this, as well. But let me hear from the other two of you briefly.

[The information referred to can be found in the Appendix on page 105.]

Admiral RYAN. Well, thank you, Congressman.

We would definitely like to explore this with you and the committee. Actually, as you know, you were very supportive of a unified command and a single budgeting authority. We think that makes imminent sense.

Consolidation, I think, would have to be under DOD. We would get nervous if it went—our association—if it went to OPM. I am sure they are fine people; they do a good job for civil servants. But as Joyce said, we think DOD has the responsibility there.

Access is going to be a problem for everybody. We see it in the private sector now, too. It is a big deal. We think getting the military treatment facilities more efficient would really help with the access.

And then having a much more collaborative relationship between the MTFs, the managed care, and the purchased care. It is almost nonexistent now. It is at arm's length. We waste a lot.

Ms. RAEZER. Yes. I agree. I think I would make one point. I would love to talk to you more about the idea of investing more ca-

pacity in military centers where large populations are and doing that better coordination in other areas. I think military hospitals——

Admiral RYAN. Your mike——

Ms. RAEZER. Oh, sorry.

I think military hospitals should be staffed not just based on readiness needs but the—what the community capacity is or isn't. So if you are sending a lot of military families with their service member to a remote location then maybe the military does have to put in a few more family practice docs and pediatricians than they would other places.

But and so it is not just on, "We'll let the private sector do what the military can't," but how does the private sector work with the military facility in that location to build that capacity in the community?

Mr. MACARTHUR. I thank you.

I yield back, Mr. Chairman.

Dr. HECK. Thanks.

So I was going to—my follow-on question was going to be, you know, how we kind of look at the three ups and three downs of the system. What are the three things you think they are doing well? What are the three things, if you could wave a wand, you would want to improve?

Actually, Admiral Norbert, I think you did that, actually, in your opening statement, and if I had them right you kind of said the ups were combat casualty care, TRICARE for Life, pharmacy benefits, TRICARE Standard, and the quality of care.

Admiral RYAN. Yes, sir.

Dr. HECK. And the three downs were inefficiencies of three separate programs, TRICARE Prime, and TRICARE Reserve Select.

Admiral RYAN. Yes——

Dr. HECK. Do you have anything else that you would add to either of those two columns?

Admiral RYAN. I would just say, in relation to Scott, what he said, that we think one of the recommendations we have in there is if you want to actually look at an FEHB-type of program, doing it with the Guard and Reserve might not be a bad idea because right now it is so—lack of continuity, disjointed, they don't get equal treatment. So that is one of our thoughts.

Dr. HECK. Okay.

So, Ms. Raezer, what would be your three ups and three downs?

Ms. RAEZER. I think my three ups would start with the combat care. This has been a success story.

I think the military families say they want to go to a military hospital because they believe the providers understand their life, so that cultural competency. And I think for military families—for currently serving military families, the cost of the care to—it's important for our very young military families to have that low, low predictable cost.

I think the three downs, it is access, inconsistency, and access. If you can't get an appointment, everything else is a problem.

Dr. HECK. Right.

And, Mr. Bousum.

Mr. BOUSUM. Yes. I honestly, for the most part I echo that sentiment. I have an example from the previous line of questioning.

I have a member filled out our survey. There was room for additional comments. They had a torn ACL [anterior cruciate ligament]. Took 5 months. Ended up having to do it at a, you know, at an outside hospital, a civilian hospital.

In fact, the doctor—this was someone in the National Capital Region, obviously, because a doctor at Fort Belvoir actually said, "With your age being 64 years old, you should just wait till closer to 70 and have your knee replaced." I mean, that is not something that is said.

Dr. HECK. And then, you know, in one of the previous panels we had the former Surgeons General, one of which was Admiral Cowan. And, you know, he talked about, you know, obviously his longitudinal perspective that he has had from being involved for so long that, you know, when TRICARE was originally envisioned, you know, the idea was that all of the health care actually would be provided in MTFs until the military staffing in that MTF had to deploy, and then the care would go to, you know, out into the community until those returning physicians, nurses, medics were coming back to the MTF.

And he had this idea, or his thought was that we should try harder within DOD to recapture more of the care that we've let go outside the gate via TRICARE back into the MTFs.

Now, I understand the point that you brought up, Ms. Raezer, that, hey, if there are no appointments to take care of the current beneficiaries, how are they going to provide appointments for those outside the gate? But assuming that could be fixed—that is a big assumption, but let's say assuming that could be fixed—what degree of reticence do you believe there would be amongst your beneficiaries, your members, of wanting to come back into the gate?

I mean, would they need to be incentivized to come back in if they have been getting care outside the gate? Or how do you think we would be able to accomplish that, to get them to understand or want to come back into the MTF?

Ms. Raezer.

Ms. RAEZER. Well, I think it is important to remember that most of our Active Duty families are already in the MTF to varying degrees. Air Force has downsized a lot of facilities to clinics, so there is a lot more care out in the purchased side for Air Force families in many locations.

I think our Active Duty families look to the military for care. They believe this is something they have earned. As I said, these are providers who supposedly understand their life. But you have to convince them.

We have also heard from a lot of military families that they are making the switch to Standard because they want more control, they want more access, and so the military hospitals are going to have to convince them that they offer the care that they need. That includes things like after-hours care; that includes other options than waiting with a sick child in the emergency room; that includes getting rid of some of these silly rules.

So I think our military families can be convinced, but it is up to the military hospitals to show they understand what families need.

Dr. HECK. When you talk about cultural competency and the providers understanding the life of the duty member, do your members talk about hospitals or military health care facilities that are primarily staffed with civilian contractors nowadays, versus actually Active Duty health care professionals?

Ms. RAEZER. They actually like the places that have more civilian providers because generally hours are better and there—it is easier to get an appointment.

Admiral RYAN. I think we are rowing up the stream and it is going to be very difficult. Our survey of over 30,000 indicates that with TRICARE for Life, which retirees are very important, 84 percent say it is not very important to go to a military hospital; Standard, 90 percent say not very important; and then Prime, 61 percent not very important, including currently serving.

As Joyce said, they're most interested in access and choice. So it is not something that is working well right now, and it is not going in the right direction.

Admiral Cowan is a great American, but you know, Dr. Heck, and even in your area that purchased care provides 58 percent of the care on the west and only 42 percent is done in the MTFs. So it's a big hurdle.

Dr. HECK. Mr. O'Rourke, another question?

Mr. O'ROURKE. Yes. Thank you, Mr. Chairman.

Admiral Ryan, I just want to tell you that your comments are spot on in terms of the need to force interoperability between DOD and VA And it is really encouraging, actually, the anecdote that you told us of the President calling in the two secretaries responsible, and yet deeply disheartening that as we enter the final year of his term nothing's happened. And he really is the only person who can referee this dispute.

But I would love to join my colleagues on this committee to do everything we can from a legislative perspective to try to force this. However, as you probably know, that there has been legislation requiring this, mandating it, that the administration, for lack of a better word, has just refused to implement.

And there is no excuse for it. And it is, in your words, very embarrassing. And the consequence is that you have wasted taxpayer resources and you're not maximizing the health systems—the two largest health systems in this country.

And just one last anecdote: We had a hearing on this with the Government Oversight Committee couple months back and the excuse from DOD's perspective for not doing this is that their systems need to work on a submarine, which, you know, to me makes no sense. We can have it work on a submarine; we can have it work in a VA clinic.

But, Mr. Bousum, you didn't get a chance to answer that question on access and interoperability between DOD and VA and where you see some opportunities, so I'd love to give you a chance to respond.

Mr. BOUSUM. Well, the point I was going to make was actually about that ACL surgery, so I was able to work it into another answer.

As far as interoperability goes—and the comment was made that I think that there are decisions being made at high levels that

don't actually make it down to the people who end up, you know, at the base level, so that's a particular problem that we are seeing.

I would say that as far as—it is unfortunate that there are numerous members of the Guard and their families that aren't allowed to use an MTF, and so I think that that should be across-the-board access. And I think that our members would welcome that because it is a one-stop shop, it is—they are around other service members, they are—they would be more willing to go, and they feel more comfortable and they would like their primary care provider. And so, yes.

Mr. O'ROURKE. Let me ask Ms. Raezer a question, and this is slightly dangerous because it is based on anecdote. But my sister is an ER [emergency room] nurse in El Paso, and we have William Beaumont Army Medical Center, which is an excellent Army medical center, and they are just completing a $1 billion new William Beaumont Army Medical Center 9 miles east. And she said it really struck her the number of military families who showed up at the ER to get primary care for non-emergencies that I assume TRICARE is paying for, despite there being a world-class Army medical facility on base.

Any thoughts on that, in terms of reforms that could address that? If true, it doesn't seem like, perhaps, the best use of resources and love to get your thoughts.

Ms. RAEZER. Well, I think it's—when one new hospital that I am not going to mention opened, military families who went there said, "Beautiful new building; same old military customer service."

Mr. O'ROURKE. So it is the access——

Ms. RAEZER. It becomes an access issue.

So the question for me is how late are Beaumont's primary care clinics, pediatric clinics open? Do they have after-hours? What's the provider workload? Do they—how are they augmenting military staff with civilian staff to help promote access?

But if she's seeing military families for primary care in a civilian ER, those families are probably there because they didn't feel they had any other options.

Mr. O'ROURKE. That makes sense. And great questions for me to ask of William Beaumont, in terms of their hours and availability.

Thank you, Mr. Chairman.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. Admiral, I had a follow-up question for you. You mentioned that you thought consolidation should be under the DOD, not OPM. I agree with that, but I am wondering, briefly, what your reasons for that are.

Admiral RYAN. Well, because, first of all, with the All-Volunteer Force, the people that should have ownership of retention should be DOD. And so we start out—we are an officer association, but we start out concerned most about what about the E–5, 10 years of service, combat experience, sitting around a table, family of four—what do they think of this or that? And I just think that that member, when they go over the horizon, he or she, they want to know that somebody's got their back, and that has got to be DOD with the All-Volunteer Force.

OPM does a great job with the civil service, but DOD ought to be responding to DOD.

Mr. MACARTHUR. Okay. Thank you. And I think there are meaningful cultural changes between the two population groups.

Admiral RYAN. Yes. One of the things that we have found, and it is in regard to the chairman's question too, about what should we do in the MTFs, we did a study with UnitedHealthcare called "Ready to Serve," and that was done by RAND [Corporation], and it shows that the families really do have concerns about do the people understand us.

But guess what? The practitioners have even more concern, particularly in the mental health area, that they don't feel that they are qualified to help somebody coming from a military situation if they come in for a mental health issue.

So a lot of people are trying to work on that. Some States are doing a better job. It is not only the concern of the family, but the providers themselves, they are split between the 1 percent and the 99 percent. They want to do the right thing but they are worried that they don't know what that right thing is if that patient comes to see them as a civilian.

Mr. MACARTHUR. Yes.

My other question was for Ms. Raezer and then Mr. Bousum. The admiral—admiral, excuse me, mentioned that you polled very high—your members polled very high on access and choice being the highest priorities. I think that was you that said that.

And it seems to me as I'm listening that training of physicians and other health care professionals is vital on the readiness side of the objective, and access and choice is vital on the family care side, and how do we balance those two?

I wondered if your members would—if you have polled them, do you think they would poll as high—or maybe you have already done that work and you can answer—would they be in the 80 percentile, as well, that access and choice are the highest priorities?

Ms. RAEZER. I think for currently serving—and we are in the process of polling. We also sent families to MOAA's survey to fill that out, and we are in the process of polling a larger sample of military spouses.

What we hear from military spouses is access. If they can't get access then choice becomes important, and that's why we are hearing of families who are making the choice to assume more out-of-pocket costs for their health care so that they have more options under TRICARE Standard.

Mr. MACARTHUR. I thank you.

And, Mr. Bousum.

Mr. BOUSUM. So I am flipping through here. Our poll shows that, "Does TRICARE Reserve provide health care in a quick and timely manner?"

"All the time" is 46 percent, and "very little of the time" is about 5 percent.

And then, let's see, "Does TRICARE provide a good selection of network providers to meet medical needs?" This one's really across the board. It just depends on when it works as advertised, which some of our members say, "TRICARE works and it is great when I get it, but otherwise no," so I'm happy. It should be in front of you on, let's see, it's about the fourth question.

Mr. MACARTHUR. Okay.

Since I have a moment, Admiral, I'd like to say that your representatives in southern New Jersey, which is what I represent, have done a superb job of making me aware of the issues that matter to your members. Whether it is concurrent receipts or other things, they really have been very, very effective in being in front of me on those.

And, Mr. Chairman, I yield back with that.

Dr. HECK. Well, I am going to keep going because we have got you here and I want to totally exploit the opportunity to get your perspective.

So again, as we have been working through this—and, you know, this has been a very iterative process. Each time we get another panel before us we pick up another pearl, or at least I pick up another pearl that sometimes changes the entire calculus that I had before that committee hearing.

I was impressed that each of you said that, you know, the primary goal is to maintain combat casualty care, right, as the primary goal of the military health care system. And I would certainly agree with that, certainly when we look at the advances we've made over the last 14, 15 years.

So here's, I am throwing out—and I probably shouldn't do this on the record, but I am throwing out a concept, okay? So I don't want this—you know, this shouldn't be publicized in any newspaper article that that's my idea, but a concept. Too late. Otherwise my phones are going to start lighting up already.

So with the idea of trying to maintain combat casualty care, right, which basically comes into the idea you need a health care provider force that's ready to be able to provide that care, and you need a medically ready force to be able to deploy. It would seem that the—and that comes at cost—readiness comes at a cost, and I think that is one of the things that DOD fails to recognize. Well, they recognize it when they write the check, but they don't realize that if you want to be ready you have got to spend money to do it.

And I use the analogy of like a civilian trauma center. Civilian trauma centers know that they are going to lose money. It is because, you know, you have got to have all those resources ready to go at the flip of a switch 24/7, whether you are using them or not, and that comes at a cost.

So if we want to say that the primary goal is to have that medically ready force, medically trained and ready providers, and maintain combat casualty care, that perhaps, as Mr. MacArthur said, we focus providing that at centers of—military medical centers of excellence. That would be the full impatient capability MTF, and those would be located in areas of high troop concentration, right?

If we downscale other facilities, then, to let's say outpatient clinics with no inpatient capability and we want to—well, the—I should go back. To do that we need to recapture all the care in those areas into those facilities so that those medical health care providers can get the training that they need, not just on combat casualty care but, you know, we do humanitarian missions. It is delivering babies, taking care of pediatric patients, taking care of, you know, asthmatics and everything—heart failure and heart attacks.

If I'm hearing correctly, in order to do that we've got to increase access, which is the hours of operations, the number of appointment slots, and the staffing and the specialists available within the MTF.

Outside of those areas of concentration, then, perhaps more of the care is provided through military outpatient clinics—so on a post, base, or camp there would be an outpatient clinic with no inpatient capability and inpatient services would be provided on the economy.

And then to address the Guard and Reserve issue that perhaps—so that there's not an issue with changing in duty status, that they are allowed to enroll in FEHB or FEHB-type equivalent. Honestly, I mean, previously—actually right now the law says that if you are eligible for FEHB you are not allowed to enroll in TRICARE Reserve Select.

So perhaps, you know, as a broad framework—and again, I know there are a lot of holes in that, but give me your first, you know, response to a system that would look potentially like that.

Ms. Raezer.

Ms. RAEZER. I think there's some merit in it. I would have just a couple questions.

My first would be even if you concentrated a lot of that readiness care in a few locations, would our population still be big enough on its own to allow military medical providers to get the skills they need to remain combat-ready? And there is a lot of discussion about—and there is a model in San Antonio where the military facility is a level-one trauma center, helping, you know, supporting the community as well as the military. So I think that is one question that would have to be considered.

The other would be, as I said earlier, in designing where those smaller facilities, what's the interaction between the military system and the civilian provider network? Would there be enough civilian capability in the providers and the specialties that our families would need to meet the demand from the military folks?

So I think that would be my caution in designing that is making sure that capacities and access is still there in those smaller facilities. But and then the other is the bigger question. I mean, what will it take to keep our providers ready and trained?

Dr. HECK. Okay.

Admiral.

Admiral RYAN. It is a very interesting concept and we would like to talk to your staff about it some more.

One big thought: You know, the VA has their polytrauma centers at the different geographical areas, and so there is kind of a lesson that could be learned maybe about that. Do they get enough inflow for the spinal cord and brain injuries and all to stay current while they are doing everything else and pulling in the regular patients, as you said—not the babies necessarily, unless it is one like Chicago where they do both. So you have got a little bit of something here you could get some experience from.

I think no question, right now the military does an awful impressive job. I would say they are leading the country in this type of casualty competency. That part of it is working well right now.

I wonder going forward if we could really get the trust of the people to come into the thing when you are going to then just deploy them when something happens. And so it would have to be—it couldn't be with the three Surgeon Generals the way it is now.

You would have to have a unified command where it is in the plan that we are going to have a much more collaborative—for example, these six areas of concentration right now, they are committees. Nobody has the authority to move the dollars around; nobody is really in charge. They try and work together, but you have got to have somebody in charge and somebody who can move dollars around.

And then you have got to embrace the community, the purchased care, and have, you know, a system where it is visible—the appointment system is visible to everybody that is trying to meet that need.

I think it is doable. You almost have it right now, but what you don't have is the unity of command to make those systems—the incentive for those military systems to be as efficient as the purchased care.

Dr. HECK. Great. Thank you.

Mr. Bousum.

Mr. BOUSUM. Well, you know, we know that this is a multiple-year effort and we know that, you know, you and your staff are going out in the field and meeting with service members, Reserve Component, and Active Component. What I can say—I don't really want to speculate. What I would say is I will just, you know, continue to work with your staff and to, you know, get a better idea of this concept and perhaps tailor the survey we are already sending to our members in a way that could better get results for you.

Dr. HECK. Right.

Admiral RYAN. Mr. Chairman, I would just say based on that, our recommendation that 15 other associations in The Military Coalition have supported is try it in one of the major six areas and give DHA [Defense Health Agency] the authority to actually move the dollars and control it, and do the same thing with the Guard and Reserve. Try that. And if it works then, wow.

Dr. HECK. Okay. And that is perfect timing on that note, as the bell has just rung, and since I am the last man standing.

So I want to, again, thank you all for taking time to be here and to offer your insights and opinions. They are very valued and we certainly will take them into deep consideration as we move forward. And I am sure you will be back as we start moving forward with the actual proposal.

So again, thank you, and the hearing is adjourned.

[Whereupon, at 12:38 p.m., the subcommittee was adjourned.]

A P P E N D I X

December 3, 2015

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

DECEMBER 3, 2015

Opening Remarks – Chairman Heck
Military Personnel Subcommittee Hearing

Stakeholder Views on Military Healthcare Reform

December 3, 2015

I want to welcome everyone to this hearing of the Military Personnel Subcommittee to receive stakeholder views of military healthcare reform.

This hearing is a part of the committee's on-going project to comprehensively review the current state of the Military Health System and military healthcare, and based on this information, identify areas that need improvement. The overarching goal of this project is to ensure the Military Health System can sustain trained and ready healthcare providers to support the readiness of the force, while providing a quality healthcare benefit that is valued by beneficiaries.

To that end, the committee has heard from several experts, including current and former Surgeons General, the Under Secretary of Defense for Health Affairs, and civilian health programs regarding the current and future challenges of providing healthcare. Today, we look forward to building on the knowledge by hearing from military service organizations regarding their members' views on military healthcare. These incredibly important perspectives are crucial to understanding this multi-faceted issue.

Our purpose today is to discuss both what works and what needs to be fixed in the Military Health System. We are keenly aware that military healthcare is an extremely important benefit, and any reforms must be thoroughly analyzed from multiple perspectives, and structured to prevent unintended consequences. Our discussion today is an integral part of that process.

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

ENLISTED ASSOCIATION OF THE NATIONAL GUARD OF THE UNITED STATES (EANGUS)

STATEMENT FOR THE RECORD

HOUSE ARMED SERVICES COMMITTEE

MILITARY PERSONNEL SUBCOMMITTEE

on

Stakeholder Perspectives on Military Health Care

December 3, 2015

Enlisted Association of the National Guard of the United States
3133 Mount Vernon Avenue
Alexandria, Virginia 22305
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OPENING STATEMENT

Chairman Heck and Ranking Member Davis, esteemed members of the committee, thank you for allowing the Enlisted Association of the National Guard of the United States (EANGUS) to testify on the critical issue of health care. Our membership represents over 414,000 enlisted men and women of the Army and Air National Guard, their families and survivors, and tens of thousands of National Guard retirees. Each and every one of them is affected by health care when the Guard mobilizes in support of our country or when they fulfill their strategic mission. We welcome this opportunity to submit testimony for the record regarding military health care.

Our members appreciate the countless hours you and the professional staff have devoted to ensure that our servicemembers receive the best care. Under committee leadership and, the National Defense Authorization Act created the Military Compensation and Retirement Modernization Commission. The commissioners made recommendations to Congress on how to improve health care access that would eliminate problems currently encountered by Guard and Reserve members and their families.

EANGUS encourages the committee to consider the commission's final recommendations as they explore health care reform.

From the Guard's perspective, it is difficult to discuss health care without addressing the complexity of our duty statuses. The military's complex personnel system directly affects Guard pay, health care, and even burial rights based on what duty status orders are published under.

The focus of today's discussion does not include National Guard duty status reform, but I suggest that the type of health care coverage members receive should be separated from whether or not they are on active or inactive duty military orders. Servicemembers and their families should have one health care program regardless of duty status. Separating the two would fix the continuity of care issue creating problems for members of the Guard and their families.

As you consider changes next year, please keep in mind that access is a problem because most members of the National Guard do not live on, or near large military installations. As a result, many of our members drive, hundreds of miles to appointments only to be referred to a specialist, who may or may not be available under TRICARE. Additionally, their frustration is compounded because appointments may not be scheduled in what you or I would consider a reasonable timeframe.

EANGUS, in conjunction with the Reserve Officers Association (ROA) and the National Guard Association of the United States (NGAUS) circulated a health care satisfaction survey to our members. The results of the survey are enclosed with my written testimony. After reviewing the survey results, I am not prepared to say that TRICARE is irretrievably broken.

I want to recognize ROA and NGAUS for their input in today's testimony. Together, our memberships make up the entirety of the Reserve Component – officers and enlisted.

Thank you again for hosting this hearing. As the discussion continues today and next year, EANGUS looks forward to working closely with your staff on military health care reform.

MR. SCOTT BOUSUM, LEGISLATIVE DIRECTOR

Scott Bousum is the Legislative Director at the Enlisted Association of the National Guard of the United States (EANGUS). As the Legislative Director, Scott works with the enlisted state associations to advocate on behalf of Guardsmen on Capitol Hill, specifically on issues related to compensation, health care, retirement, and National Guard weapons and equipment programs. Before joining EANGUS, Scott was the Director of National Security Policy and Procurement Policy at TechAmerica, a technology industry association. While at TechAmerica, he focused on supply chain security, regulatory affairs, and the federal acquisition process. Prior to joining TechAmerica, Scott worked on the House Armed Services Committee from 2009 to 2013, supporting the Tactical Air and Land Forces Subcommittee. Scott is from Oklahoma and worked for former U.S. Senator Tom Coburn of Oklahoma. He is a graduate of the University of Tulsa and received his Masters' degree in National Security Strategic Studies from the United States Naval War College.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Enlisted Association of the National Guard of the United States (EANGUS) does not currently receive, nor has the association ever received, any federal money for grants or contracts. All of the association's activities and services are accomplished completely free of any federal funding.

STAKEHOLDER PERSPECTIVES ON MILITARY HEALTH CARE HEARING

Overview

According to the Department of Defense (DOD) 2014 Demographics report, there are 831,992 Selected Reserve personnel and of that 42.6% are Army National Guard (ARNG) and 12.8% are Air National Guard (ANG). The remaining personnel are in the five reserve components, to include the Coast Guard Reserve.

Of the eight TRICARE plans, there are four TRICARE plans in which the majority of members of the National Guard participate: TRICARE Prime; TRICARE Reserve Select (TRS); TRICARE Retired Reserve (TRR); and TRICARE for Life (TFL).

TRICARE Prime is for Reservists on active duty status: mobilized, Active Guard and Reserve (AGR), Active Duty Operational Support (ADOS), Full Time National Guard Duty (FTNGD), or active duty for training over 30 days, but not annual training. Active duty members do not pay premiums or fees for TRICARE Prime. Active duty retirees and all retirees age 60-64 who are not Medicare eligible may also enroll in TRICARE Prime, but must pay an annual fee. The fee, adjusted each fiscal year, is $282.60 per year for a servicemember per year and $565.20 per year for a servicemember and his or her family. The annual fee is not tied to the actual cost of the plan, it is a fee computed by the Defense Health Agency (DHA). Fees have increased 17.3% since 2011. Overall, there are 4,931,544 people enrolled and of that total, there are 1,562,658 enrolled who are retirees or family members under age 65.

TRICARE Reserve Select is similar to TRICARE Standard. It is for Reservists not eligible to enroll in Federal Employee Health Benefit Plan (FEHBP). DHA estimates that 112,188 Reservists are using FEHBP. TRS requires a monthly premium payment, adjusted annually, equal to 28% of the cost of the plan as determined by DHA. For servicemembers only, the cost is $50.75 per month. For servicemembers and family members it is $205.62 per month for calendar year 2015. For calendar year 2016, the rates are $47.90 per month for servicemembers only and $210.83 per month for a servicemember and his or her family. According to DHA, there are 119,775 TRS plans covering 326,710 people, equating to a 25.6% take rate of those eligible.

TRICARE Retired Reserve is also similar to TRICARE Standard and is for retired Reservists under age 60 who want to remain on TRICARE. The retiree must pay 100% of the cost of the plan as determined by DHA, adjusted annually on the calendar year. Current costs are $390.89 per month for a Servicemember and $961.35 per month for a servicemember and his or her family. For calendar year 2016, the costs will be $388.79 per month for a servicemember and $957.44 per month for a servicemember and his or her family. According to DHA, there are 1,860 TRR plans and 5,100 covered individuals. There are no annual fees associated with TRR.

TRICARE for Life is for retired military members and spouses who are Medicare eligible. TFL works as a Medicare supplement, a second payer to Medicare, for the most part paying what Medicare does not. There is no cost to the retiree for this plan. TFL requires the payment of

Medicare Part B premiums. There are 2,086,353 people enrolled in TFL. EANGUS does not recommend that Congress make changes to TFL.

Issue Areas

Continuity of Care: Congress should not address military health care reform without first reviewing a very complex personnel system and the 30 different types of Reserve Component duty statues. Members of the National Guard and their families are adversely affected by a multitude of duty statuses that are unfortunately tied to health care programs and other benefits. The fourth recommendation in the Military Compensation and Retirement Modernization Commission (MCRMC) final report suggested Congress consolidate 30 Reserve Component duty statuses into six broader statuses sighting disruptions in pay and benefits during transition periods and gaps in coverage during breaks in orders.

Recommendation: Congress should consider separating health care and duty statuses. Every servicemember, regardless of component, should have access to a health care that provides coverage for the servicemember and their families at all times, without having to change primary care or specialty care providers when duty statuses change. This recommendation is not a direct endorsement of MCRMC Recommendation 6 regarding duty status consolidation, it is a recommendation that Reserve Component health care options be removed entirely from a convoluted personnel system.

Use of Assured Access Authority: 10 U.S.C. 12304b: Other than during times of war or national emergency for preplanned missions, up to 60,000 members of the Reserve Component can be involuntarily activated by service secretaries in support of a combatant command for no more than 365 days. EANGUS has advocated for the continued use of 12304b to deploy members of the National Guard to respond to for missions like the 2014 Ebola response in Africa. However, 12304b provides health care coverage for families only during the time the servicemember is deployed. All other activation authorities provide access to TRICARE Prime health care before and after deployment. Not allowing for TRICARE Prime access before and after deployment leave families scrambling to find a health care provider while the servicemember is away. Not only are family members left without help from the military member to navigate the bureaucratic DOD personnel system, the forward deployed servicemember is distracted from their duties because they are worried about their family at home, and military readiness suffers.

Recommendation: Reserve Component servicemembers called to duty under 12304b should be eligible for TRICARE Prime for themselves and their families before and after deployment.

Limited Access to Care: Members of the National Guard who do not leave on or near a major military installation have poor access to care.

Recommendation: The contract requirement for a pre-authorization (i.e. referral) to use urgent care clinics should be eliminated. Unlike hospital emergency rooms, urgent care clinics have faster response times and less cost. In rural areas that don't have urgent care clinics, a simpler process is needed to eliminate the need for Reservists to pay upfront costs of emergency room

visits and have to seek reimbursement from TRICARE. TRICARE should effect payment directly to the hospital before exacting co-payments from the member.

Direct Employer Premium Payment: Members of the National Guard who choose to opt out of employer based health care plans are often reimbursed for their TRICARE payments. Currently, monthly TRICARE payments must be made by the servicemember via allotment, an electronic funds transfer (i.e. debit or credit card), or paid directly online. Sometimes small and medium size businesses will allow the employee to charge a corporate card, but larger business do not have streamlined processes in place. Allowing direct employer payment would increase efficiency and incentive the hiring and retention of Reservists.

Recommendation: Congress should authorize the payment of TRS premiums from employers.

Infrastructure: Should the committee consider MCRMC recommendation number 5 regarding DOD construct a medical infrastructure similar to FEHBP, we would recommend collapsing DHA and providing DOD manpower to the Office of Personnel Management (OPM) and allow OPM to subsume the DOD population into the FEHBP system. OPM is very effective in managing FEHBP with much smaller overhead. Of course, readiness and research may remain with DOD control, and Military Treatment Facilities may become authorized providers under the revised system.

Fees: Should the committee consider MCRMC Recommendation 6 regarding TRICARE Prime fee increases for working age retirees, our association believes that the ramp recommended by MCRMC is achievable by the majority of our retirees who pay that fee (on the annual fee of $565.20, 1% would be $5.65 per year, less than the cost of one cup of coffee and scone at Starbucks). However, the fee increase should not just be a cash cow and only come after a proper audit of DHA finances and should not be a substitute for proper oversight and internal controls of the program. EANGUS members have stated that affordability is a retention factor, therefore the 25% cost share per MCRMC Recommendation 6 would help to offset pharmacy and co-pay increases.

Infrastructure Oversight: EANGUS members are aware of oversight and program management shortfalls. One example is DHA mishandling of compounding prescription drugs. In 2014, DHA spent roughly $5 million on compounding prescription drugs. In the first four months of 2015, DHA spent nearly $1 billion on compounding prescription drugs and then requested a reprogramming from the Congressional Defense Committees.

Recommendation: Before increasing pharmacy co-pays, DOD must prove it can fix oversight shortfalls so it does not take multiple months to recognize cost overruns.

Enclosure

TRICARE Reserve: Access and Quality of Health Care Survey Results

TRICARE Reserve: Access and Quality of Healthcare Survey

Military Service Organizations Participating:

- Reserve Officers Association (ROA)
- National Guard Association of the United States (NGAUS)
- Enlisted Association of the National Guard of the United States (EANGUS)

145

Total Responses from Association Members

Date Created: Wednesday, August 26, 2015

Powered by SurveyMonkey

Q1: Are military treatment facilities relatively accessible to you?

Answered: 143 Skipped: 2

Answer Choices	Responses	
Yes	**35.66%**	51
No	**64.34%**	92
Total		**143**

Q2: Do you have access to qualified specialists (pediatrics, oncologists, pulmonary, etc.) through TRICARE Reserve to meet your medical needs?

Answered: 141 Skipped: 4

Answer Choices	Responses	
All of the time	**42.55%**	60
Some of the time	**29.79%**	42
Very little of the time	**4.96%**	7
None of the time	**4.26%**	6
N/A	**18.44%**	26
Total		**141**

Q3: Does TRICARE Reserve provide healthcare in a quick and timely manner?

Answered: 133 Skipped: 12

Answer Choices	Responses	
All of the time	**46.62%**	62
Some of the time	**37.59%**	50
Very little of the time	**6.77%**	9
None of the time	**9.02%**	12
Total		**133**

Q4: When I want to use them, TRICARE Reserve provides a good selection of network providers to meet my medical needs.

Answered: 135 Skipped: 10

Answer Choices	Responses	
Strongly Disagree	**8.89%**	12
Disagree	**11.85%**	16
Neutral	**22.22%**	30
Agree	**38.52%**	52
Strongly Agree	**18.52%**	25
Total		**135**

Q5: The quality of my healthcare through TRICARE Reserve is:

Answered: 131 Skipped: 14

Answer Choices	Responses	
Awful	**1.53%**	2
Very poor	**3.05%**	4
Poor	**6.11%**	8
Satisfactory	**21.37%**	28
Good	**14.50%**	19
Very good	**29.01%**	38
Excellent	**24.43%**	32
Total		**131**

Q6: Do you agree or disagree with this statement: Military treatment facilities do not provide healthcare as efficiently and effectively when they know I am reservist.

Answered: 133 Skipped: 12

Answer Choices	Responses	
Strongly Disagree	**8.27%**	11
Disagree	**14.29%**	19
Neutral	**48.12%**	64
Agree	**19.55%**	26
Strongly Agree	**9.77%**	13
Total		**133**

Q7: Are medical costs more affordable on TRICARE or through a private medical provider?

Answered: 131 Skipped: 14

Answer Choices	Responses	
TRICARE costs are more affordable	**77.86%**	102
Private medical provider costs are more affordable	**7.63%**	10
They are about the same	**14.50%**	19
Total		**131**

Q8: Do you believe seeking and/or receiving treatment for mental health issues has affected your career advancement?

Answered: 135 Skipped: 10

Answer Choices	Responses	
Yes, it has affected my career advancement a lot.	**5.93%**	8
Yes, it has affected my career advancement, but only a little bit.	**4.44%**	6
No, it has not affected my career advancement.	**18.52%**	25
N/A	**71.11%**	96
Total		**135**

Q9: How would you rate access to mental health services through TRICARE Reserve?

Answered: 136 Skipped: 9

Answer Choices	Responses	
Excellent	**4.41%**	6
Very good	**4.41%**	6
Good	**8.82%**	12
Satisfactory	**7.35%**	10
Poor	**2.94%**	4
Very poor	**2.94%**	4
Awful	**0.74%**	1
N/A	**68.38%**	93
Total		**136**

DISCLOSURE FORM FOR WITNESSES
COMMITTEE ON ARMED SERVICES
U.S. HOUSE OF REPRESENTATIVES

INSTRUCTION TO WITNESSES: Rule 11, clause 2(g)(5), of the Rules of the U.S. House of Representatives for the 114th Congress requires nongovernmental witnesses appearing before House committees to include in their written statements a curriculum vitae and a disclosure of the amount and source of any federal contracts or grants (including subcontracts and subgrants), or contracts or payments originating with a foreign government, received during the current and two previous calendar years either by the witness or by an entity represented by the witness and related to the subject matter of the hearing. This form is intended to assist witnesses appearing before the House Committee on Armed Services in complying with the House rule. Please note that a copy of these statements, with appropriate redactions to protect the witness's personal privacy (including home address and phone number) will be made publicly available in electronic form not later than one day after the witness's appearance before the committee. Witnesses may list additional grants, contracts, or payments on additional sheets, if necessary.

Witness name: SCOTT BOUSUM

Capacity in which appearing: (check one)

○ Individual

◉ Representative

If appearing in a representative capacity, name of the company, association or other entity being represented: ENLISTED ASSOCIATION OF THE NATIONAL GUARD

Federal Contract or Grant Information: If you or the entity you represent before the Committee on Armed Services has contracts (including subcontracts) or grants (including subgrants) with the federal government, please provide the following information:

2015

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant

2014

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant

2013

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant

Foreign Government Contract or Payment Information: If you or the entity you represent before the Committee on Armed Services has contracts or payments originating from a foreign government, please provide the following information:

2015

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment

2014

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment

2013

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment

Scott Bousum

Digitally signed by Scott Bousum
DN: cn=Scott Bousum, o=EANGUS, ou, email=Scott@EANGUS.org, c=US
Date: 2015.11.23 08:31:00 -05'00'

STATEMENT OF

THE MILITARY OFFICERS ASSOCIATION OF AMERICA (MOAA)

before the

HOUSE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

DECEMBER 3, 2015

Presented by

Vice Admiral Norbert R. Ryan, Jr., USN (Ret)
President

Chairman Heck, Ranking Member Davis, and members of the Subcommittee, on behalf of the 390,000 members of the Military Officers Association of America (MOAA), we welcome this opportunity to provide our views concerning the reform of TRICARE and recommendations regarding military health benefits.

This statement also reflects the views of the following associations:

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
Chief Warrant and Warrant Officers Association, USCG
Fleet Reserve Association
Gold Star Wives of America, Inc.
Jewish War Veterans
Marine Corps Reserve Association
Military Chaplains Association
National Association for Uniformed Services
Non Commissioned Officers Association
The Retired Enlisted Association
US Army Warrant Officers Association
US Coast Guard Petty Officers Association and Coast Guard Enlisted Association
Veterans of Foreign Wars

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

We are very appreciative that you and the Subcommittee have been particularly vigilant in 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.

This Subcommittee and its staff have consistently been sensitive to the views of beneficiaries, and we welcome the opportunity to continue productive discussions with you on these important issues.

MOAA understands that 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 that the military's health care 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.

You asked for our inputs on which elements of current military healthcare programs are working and which ones are not, so let us start with that general assessment.

What Is Working

Combat Casualty Care. Battlefield care, evacuation systems, and treatment and rehabilitation for multiple and traumatic injuries have significantly reduced combat deaths and improved the quality of life for thousands of combat veterans. In many cases, members who would have died in previous conflicts have even been able to return to active service.

Quality of Care. Beneficiaries of all ages are satisfied with the quality of care they receive from both military and civilian providers, once they are able to access the care. MOAA's survey of more than 17,000 beneficiaries generated "mostly satisfied" or "very satisfied" responses from 85% of TRICARE Prime enrollees, 88% of TRICARE Standard beneficiaries, and 95% of TRICARE For Life beneficiaries.

TRICARE For Life (TFL). TFL worked as intended, and perhaps even better than anticipated, from the start. ***We strongly believe this was due in large measure to the unprecedented outreach by the Defense Department at the time to include beneficiary organizations in the planning and implementation process. A joint TFL Working Group comprised of TRICARE officials and Military Coalition representatives met virtually weekly for many months*** to identify and resolve technical and policy issues, and develop processes and communication strategies to ensure smooth operational implementation. A key aspect was the collective effort to educate beneficiaries and providers alike on exactly how the new program would work, including real-time integration with Medicare systems, ease of enrollment and elimination of paperwork for beneficiaries, and ease of claims processing/rapidity of payment for providers. A recent MOAA survey of more than 10,000 TFL beneficiaries showed dissatisfaction rates in the low single digits across the board on ability to choose providers, access to care, and beneficiary costs. TFL is truly fulfilling the longstanding promise of lifetime military healthcare in return for a career of service.

Pharmacy Programs. Pharmacy programs are successful in meeting beneficiary needs. MOAA's past surveys of the home delivery system have indicated 95% satisfaction with that program. The home delivery policy was an excellent example of the beneficiary community partnering

with DoD with the goal to lower health care costs and sustain the quality of the benefit. However, recent copay increases, for retail pharmacies in particular, are a source of dissatisfaction.

TRICARE Standard (mostly). For under-65 beneficiaries frustrated with various aspects of TRICARE Prime, the Standard option provides significantly higher satisfaction – and perhaps more importantly, much lower dissatisfaction – on issues of beneficiary control. For example, Standard beneficiary participants in MOAA's survey indicated 83% satisfaction and 7% dissatisfaction (with 10% neutral) with their ability to choose providers, compared to 63% and 17%, respectively among Prime enrollees (20% neutral). Standard and Prime beneficiaries were roughly equally satisfied on ease and timeliness of appointment-making, but Standard dissatisfaction rankings on these scores (6-10%) were roughly half those reported for Prime (10-18%).

Problem Areas

TRICARE Prime Appointing. Prime enrollees' feedback has been generally consistent that "the quality of my care has been excellent....once I can get in." Appointing systems vary by location, but it has been well documented that too many Prime beneficiaries are being told such things as, "we have no more appointments this month; call back again [on some future date]" or "it will be [months] before we can get you in." Too often, appointing offices are either ignorant of or ignore TRICARE Prime's timely access standards in failing to offer more timely appointments with civilian providers as an alternative to an appointment in the military facility.

TRICARE Prime Referrals. The bureaucratic process of obtaining a specialty consult in a timely and efficient manner remains a source of significant beneficiary dissatisfaction. The problem is mainly with referrals from military treatment facilities for outside care. Beneficiaries complain about how long it takes to get a referral. They may have to talk with several people for this to happen, and the beneficiary often has to be the lead advocate to complete the referral process. In other cases, beneficiaries receive a referral to a provider that is significantly inconvenient for them in terms of distance or timeliness, and the report of the specialty visit often does not make its way back into the beneficiary's medical record. The new electronic health record is touted as addressing these problems, but the record of implementing such programs does not inspire confidence.

Guard/Reserve TRICARE Coverage. MOAA believes there are significant inconsistencies and inequities in the level and continuity of coverage provided to Guard and Reserve (G/R) beneficiaries at various points in their careers, mostly because of the piecemeal addition of various programs, and the availability of funding at the time each element was enacted. The Subcommittee's recent authorization of transition coverage for separating TRICARE Reserve Select enrollees was one step in the right direction. But continuing problems include:

(a) Delay in activation of TRICARE coverage when members are activated under various types of orders, or interruption when activation orders are changed to another category;

(b) Disruption of family health coverage continuity for G/R members who would prefer to keep private employer coverage for their families upon activation rather than switching the families to TRICARE;
(c) Ineligibility of TRICARE Reserve Select families for TRICARE Prime, even when that option would be both beneficial for the government and helpful to the beneficiary;
(d) Denial of equal TRICARE eligibility to all members drawing retired pay, in that G/R members who begin receiving retired pay before age 60 as a result of qualifying deployments are the only retired-pay recipients deemed ineligible for full TRICARE Standard/Prime; and
(e) The unsubsidized nature of TRICARE Retired Reserve coverage, which means annual individual/family enrollment fees for G/R members rise abruptly from $575/$2,530 to $4,665/$11,489 upon entering "gray area" status.

Military Treatment Facility Patient Load. This issue is at the core of the TRICARE Prime appointment problems and a significant factor in DoD healthcare costs. The fact is that military providers see far fewer patients per day than civilian providers do. There are some budget, staffing and other issues that contribute to that situation, but the fact is that increasing patient loads to be more comparable with civilian providers' would improve military providers' medical skills while also reducing DoD costs. Constraining in-house caseloads drives more beneficiaries to private-sector care, which drives up DoD costs…for which DoD seems to be blaming beneficiaries and trying to raise their fees. Simply put, beneficiaries shouldn't be blamed and have their cost-shares raised because military facilities are not efficient providers of care.

Pediatric Coverage. Too often, TRICARE reimbursement policy is based on Medicare policy, which does not make sense for children. In many cases, the payment codes do not reflect the value of the "covered services." In such instances, TRICARE tells providers and families certain care is covered, then refuses to pay after the care is provided. Examples of this circular policy in which treatment is "covered" but reimbursement is not included in the amount paid to the provider include melody heart valve, conscious sedation (e.g., for wound care or MRI for young children or children with special needs), and emerging technology. Further, TRICARE has an "inpatient only" list, designating procedures that must be performed inpatient. Again, it often adopts the lists straight from Medicare. The list includes many procedures commonly performed on an outpatient basis for children. This places physicians and hospitals in the untenable position of performing the procedures outpatient in the best interests of the child (and receive NO payment for services rendered) or satisfying TRICARE's requirement to hospitalize the child, with attendant family disruption, burdens, and a less than optimal care setting. Neither option reflects good health care policy for military families. Ironically, the inpatient care is typically triple the cost of the outpatient procedure. TRICARE should not ask pediatric providers to absorb the cost of medically appropriate care for children or to choose inappropriate, elder-based care options when the best pediatric practice calls for something different. TRICARE has acknowledged these problems for more than four years, but has provided no relief.

Special-Needs Families. The Military Compensation and Retirement Modernization Commission (MCRMC) noted that military programs for family members with special needs often fall short, especially because frequently relocating military families are repeatedly pushed to the back of waiting lists for crucial state Medicaid programs. We agree with the MCRMC recommendation to assist these families by aligning services under the Extended Care Health Option (ECHO) with those of state Medicaid waiver programs. Guard and Reserve families are particularly vulnerable during transitional periods and should have an extension of support. Further, it is imperative that the benefit must include members of all seven of the uniformed services.

Medical Record Systems. The failure to create a joint interoperable electronic health record useable by both DoD and the VA is a well-documented problem, with no viable plan to meet congressional requirements on the horizon. In effect, the Defense Department effectively has abandoned the effort and is pursuing its own new system. As long as this is the case, DoD will continue to disadvantage transitioning servicemembers, and will continue to have great difficulties providing continuity of care and coordinating care provided in military facilities with care obtained from civilian providers.

Health Care Budgeting/Oversight. MOAA continues to believe the current structure built around three different service healthcare programs and multiple different contract providers, with no single point of budget control and program oversight, effectively is designed to promote inefficiency. The MCRMC proposal to create a Joint Readiness Command with oversight of medical readiness would add another administrative layer without addressing the need for a single budget/program oversight. MOAA agrees with the Subcommittee's past proposals to create a Unified Medical Command to address this fundamental shortcoming.

TRICARE Young Adult (TYA) Costs. Unlike commercial insurers that spread the cost of young adult coverage across all beneficiaries, TYA is the only coverage program for young adults that requires the individual (or often the parents) to bear the full cost of his or her incremental coverage. The recent 2016 TYA premium increase from $2,172/$2,496 (TRICARE Standard/Prime) per person to $2,736/$3,672 – a 26%/47% rise -- is particularly onerous for families with more than one eligible child in this category. The TRICARE practice stands in stark contrast to the invisible differential experienced by parents with private insurance, where the cost of the added young adults' coverage is shared across all beneficiary families, so that all pay slightly more rather than placing the entire burden on the relatively small number of individual young adults.

Case Management/Wellness. DoD has some projects underway on these topics, but much more can and should be done. Congress excluded Medicare-eligibles from requirements for selected wellness pilot projects (e.g., smoking cessation) because of mandatory spending considerations, but there is no constraint on DoD including them by policy to reduce long-term costs. There are any number of high-cost/chronic healthcare consumers among Medicare-eligibles, TRICARE Reserve Select enrollees, TRICARE Standard users or others not eligible for TRICARE Prime who likely would be happy to be included in coordinated-care or other case

management programs, either inside or outside military facilities. Outreach efforts to provide more structured and coordinated care to non-Prime eligibles with special needs, or other high-use or chronic medical conditions could provide a better quality of life and less appointment/referral hassles for the patient/family while simultaneously reducing short- and long-term government costs.

DoD/VA Seamless Transition. The problems in this area are well-documented. After more than a decade in the spotlight, the issues that are left are the more intransigent of the bureaucratic problems. While no one questions the collective desire to see them resolved, the question is whether there is a continued leadership will and priority to overcome the insular disagreements and competing agendas and budget priorities that have thus far stymied, delayed, or diminished solutions.

TRICARE Standard vs. Prime Confusion. To at least some extent, healthcare access problems have been exacerbated by DoD and contractor emphasis on TRICARE Prime, to the frequent exclusion of any mention of the substantive differences between Prime and TRICARE Standard. Managed care contractors are paid to establish Prime networks, so "TRICARE" means only "TRICARE Prime" to many civilian providers and to many (especially currently serving) beneficiaries. That means many civilian providers have only known TRICARE as a program that requires them to accept discounted payments below Medicare rates. When TRICARE Standard beneficiaries go where they are directed to help them find providers – the contractor web sites – they see listings of only Prime network providers, whose appointments may be fully booked by Prime patients. But unlike Prime, TRICARE Standard does *not* entail any discount from Medicare rates. Once providers understand the difference, many who refuse to accept TRICARE Prime will accept Standard patients. The reality is that most providers who accept Medicare (and the vast majority still do) also will accept TRICARE Standard, though some limit the numbers to a specific percentage of their practice. But better education on and articulation of the distinction between Prime and Standard, and more effort to help Standard patients find providers beyond the limited availability of the Prime network listing, would improve access among Standard beneficiaries. We very much appreciate the efforts the subcommittee has made to monitor and improve provider participation in Standard.

Mental Health Care. This subcommittee, DoD and others have gone to great lengths to ease access to mental health providers. Stigma remains a deterrent and will remain so as long as self-identification has a significant potential to result in loss of security clearance and/or dismissal from service. The situation is exacerbated by a nationwide shortage of psychiatrists and other mental health providers, and by a growing tendency among providers to opt out of accepting any insurance at all, requiring patients to pay high charges in full and file their own insurance claims for partial reimbursement.

Non-uniformity of TRICARE Prime. Establishment of different contractors for different TRICARE Prime regions has created problems for currently serving beneficiaries and others who relocate between regions. Aside from fundamental issues of transferring enrollment, each contractor has its own set of rules and policies that create inconsistencies between regions.

MOAA is grateful to the Subcommittee for the provision in the FY2016 NDAA aimed at reducing these inconsistencies and improving portability across TRICARE regions.

Rhetoric vs. Reality On DoD Health Care Costs

The Rhetoric. For years, Defense leaders have trumpeted dire statements to the effect that military health costs are spiraling out of control. They've highlighted cost growth since the year 2000 and claimed that, if this trend continues, health costs will bankrupt the defense department or turn the Pentagon into merely a benefits delivery system.

Every year, in justification of such claims, Administration defense budget submissions show costs growing significantly in the outyears.

Many in the public, the media and the Congress understandably have accepted these claims at face value. One story begets another, and the cloud of such rhetoric has become self-perpetuating, with all the stories and quotes referencing each other as proof of the proposition.

MOAA is extremely grateful that this subcommittee has taken its responsibility seriously to focus on the reality rather than the rhetoric. More than any other body, you have worked to get at the facts of the matter and look at the actual spending history rather than the inflated projections.

The Military Compensation and Retirement Modernization Commission's review confirmed what MOAA has been saying all along…that the reality belies the rhetoric.

The Background. While costs did grow over the first decade of the new century, this was because Congress made a conscious decision that the protracted and compounded pay and benefit cutbacks of the 1980s and '90s had gone too far.

On the healthcare front, hundreds of military hospitals and clinics had been closed during two rounds of base closures, and military beneficiaries over age 65 had been summarily locked out of virtually any military health coverage, leaving them only the same Medicare coverage available to any civilian who never served a day in uniform. The retired military community was understandably outraged at the wholesale breach of decades of promises that serving a multi-decade military career would earn lifetime military healthcare for themselves and their families and survivors.

As a result of this and a number of other pay and benefit cuts, retention and readiness was suffering in the late 1990s to the point that the Joint Chiefs of Staff urged Congress to act on multiple fronts, including restoration of military coverage for older beneficiaries.

That led to enactment of TRICARE For Life (TFL), effective in 2001, as second-payer to Medicare, provided the beneficiary enrolled in Medicare Part B. In doing so, Congress specified that there should be no enrollment fee for TFL, in acknowledgement that qualifying beneficiaries had already earned/paid for this Medicare supplement coverage through extended and arduous service and sacrifice.

The TFL law also specified establishment of a TFL trust fund, through which the Treasury would fund the unfunded TFL liability for already-retired members, and the Defense Department would make actuarially determined annual deposits to the fund to cover the cost of providing future TFL coverage for members of the currently serving force.

Accordingly, the substantial cost of restoring coverage for the previously disenfranchised over-65 population reappeared in the defense budget, albeit in a new form (trust fund deposits). The change was lauded as both appropriate and needed, not only by the Legislative Branch, but by the new Administration entering office at the time.

Several years later, some of these same officials began looking back and expressing concern over the cost growth – as if anyone had actually expected that restoring health and pharmacy benefits for nearly two million older beneficiaries would be cheap.

The Reality. DoD leaders in the intervening years began their "spiraling health costs" arguments with qualifiers like "if this trend continues,". But the trend was never going to continue. Enactment of TFL was a one-time change. The post-2000 growth trend would only continue if Congress approved a new TFL-equivalent program every few years, which was never a possibility.

While annual DoD budget submissions have continued to forecast substantial health cost increases in the outyears, those forecasts have proven consistently wrong.

When trust funds are first begun, the actuaries responsible for establishing the amounts to be deposited in the fund to cover future liabilities are necessarily very, very conservative, and the deposits started out quite large. But several years of actual experience with health costs for the TFL population have generated progressively more realistic actuarial assumptions, along with other initiatives, such as mandatory mail-order pharmacy use, that have dampened DoD costs.

Over the past six years, DoD costs for TRICARE For Life (i.e., trust fund deposits) dropped nearly 40%, and they are still falling, as indicated by the FY2016 budget.

	FY10	FY11	FY12	FY13	FY14	FY15	FY16
DoD TFL Trust Fund Deposit	$10.8B	$11.0B	$10.9B	$8.5B	$7.4B	$7.0B	$6.6B

Costs for the overall DoD Unified Medical Program have remained essentially flat for the last five years.

	FY10	FY11	FY12	FY13	FY14	FY15
DoD Unified Medical Prog.	$49.9B	$51.6B	$52.9B	$48.4B	$49.3B	$48.5B

DoD costs for purchased care have remained essentially flat for the last five years.

	FY10	FY11	FY12	FY13	FY14	FY15
DoD Purchased Care	$14.3B	$14.8B*	$15.4B*	$14.7B*	$14.8B	$14.8B

**DoD actually underspent the budget in this account by a total of $3.8B for FYs11-13.*

Pharmacy costs have risen some, but should be moderated by copay changes and just-enacted expansion of mandatory use of the much-cheaper mail-order system.

	FY10	FY11	FY12	FY13	FY14	FY15
DoD Pharmacy Program	$6.6B	$7.0B	$7.1B	$7.1B	$7.7B	TBD*

**One-time Rx costs are expected to be substantially higher due to a spike of gross overcharges for compounded medications, which DoD has since brought under control.*

The other area of actual cost increases is the direct care system, which is under direct DoD control, addresses mainly readiness needs, and sees the fewest patients per provider.

	FY10	FY11	FY12	FY13	FY14	FY15
Direct Care Program	$16.1B	$16.9B	$17.4B	$16.1B	$17.9B	$17.6B

Health Costs in Perspective. Some defense leaders and others have stated, and continue to state, that the military's health care costs absorb a "disproportionate" 10 percent, non-war share of the DoD budget. These assertions should be viewed in proper context in that healthcare costs comprise 23 percent of the nation's budget, 22 percent of the average state budget, 16 percent of household discretionary spending, and 16 percent of the U.S. gross domestic product. In this context, a 10 percent share of DoD's budget is not disproportionate, particularly when health costs over the last five years have remained flat.

MCRMC Proposals

The MCRMC advanced four over-arching proposals for significant changes to the MHS. We are generally in support of two of them but have significant concerns regarding the other two.

Extended Care Health Option (ECHO). We applaud the Commission for addressing issues experienced by military families with special needs. We generally agree with the recommendations and the intent to improve support for these beneficiaries by aligning services offered under the ECHO program to those of state Medicare waiver programs. Guard and Reserve families are particularly vulnerable during transitional periods and should have an extension of support. It is imperative that the benefit must include members of all seven of the uniformed services.

DoD-VA Collaboration. We also support dramatically improving collaboration between the DoD and VA, and there exist some excellent examples of success, such as the joint DoD/VA health care facility in North Chicago. For years MOAA has advocated for legislation to grant the existing Joint Executive Committee additional authority and responsibility to enforce collaboration. Many of the issues impeding progress, ranging from a common electronic medical record to joint facility and acquisition planning, can be accomplished in a transparent manner. Similarly, the issue of a transitional formulary for service members leaving the DoD and enrolling into the VA system should be immediately corrected. We're grateful the Subcommittee acted to address the latter issue in the FY2016 NDAA.

Joint Readiness Command. We have significant reservations that the Commission proposal to create a new Joint Readiness Command (J-10) would create a new level of bureaucracy without addressing the fundamental issue of joint medical operations. ***The largest barrier to a truly efficient and highly reliable healthcare organization is the current three-service system organization.*** This arrangement is directly responsible for extensive costs through the duplication of technology services, medical equipment, lack of common procedures and processes, especially in the much touted multi-service market areas. Literally millions are wasted each year due to the inefficiencies of this type of structure.

MOAA for years has joined this Subcommittee in supporting the concept of a unified medical command that has a single budget authority over the three military systems. We believe there is an initial opportunity to test this concept in the large multi-service market areas (MSM's). An example is the military's integrated referral and management center which serves the multiple clinics and hospitals in the National Capital Area. It is charged with making specialty referrals and appointments for the geographical market area. However, they only end up making approximately 20 percent of the total appointments, due to the fact that there is no unified policy and process in appointing beneficiaries into all of the military clinics and hospitals. The hospitals and clinics still report to three different service commands under three or more different sets of orders and varying budgets. This wastes millions in missed and untimely referrals.

A single budget authority, to include human resources and infrastructure oversight and control, will yield huge cost savings and efficiencies. Throughout the years, numerous studies have recommended the consolidation of medical budget oversight and execution, and this can be done while maintaining the readiness responsibilities of the Surgeons General under Title 10.

FEHBP-Style Replacement for TRICARE. In the belief that the TRICARE system is irretrievably broken, the MCRMC recommended eliminating it and moving all beneficiaries except those over age 65 and active duty members into a commercial premium-based insurance model, similar to the Federal Employee Health Benefit Program (FEHBP). The new program, called TRICARE Choice, would offer beneficiaries an array of plan options to choose from based upon their location. MTFs would be offered as one of the providers in the plan. It is envisioned that DoD would have the authority to adjust MTF billing for civilian reimbursements and co-payments for insurers as needed to meet the MTF's readiness requirements.

MOAA is not convinced TRICARE is unfixable or that this radically different concept would sufficiently support military readiness, particularly if DoD moves away from the three-service structure to a unified system of managing and budgeting for health care. One principle we have endorsed is providing a uniform benefit for equal service. Because military families endure frequent locations and military beneficiaries are dispersed across the country, we have concerns about imposing a system that inherently entails different costs and benefits for different localities.

The Commission proposes leaving the TRICARE pharmacy program unchanged. But virtually all FEHBP plans include levels of pharmacy coverage, and practical experience is that the TRICARE pharmacy program is virtually unusable if other coverage exists. MOAA believes this would entrap military families between significantly higher costs for civilian coverage or extraordinary bureaucratic problems if they seek to use TRICARE pharmacy programs.

The needs of a military family today can be dramatically changed by the demands of service. It is not clear that the wide variety of commercial plans under an FEHBP-like scenario would be sensitive to or responsive to a military family's unique needs. *"Ready to Serve,"* the title of MOAA and United Healthcare Foundation's recent survey on civilian providers, conducted by RAND and released in December 2014, shows civilian mental health providers are not equipped with the necessary knowledge or cultural sensitivity required in the care of military and veterans populations. Applied Behavioral Analysis therapy that Congress has worked to authorize for military families with autistic children, is generally not provided for in FEHBP plans.

Putting this major military health benefit under the administration of the Office of Personnel Management (OPM) appears to be a significant step toward treating military beneficiaries like

federal civilians for health care purposes. Military beneficiaries incur unique and extraordinary sacrifices unlike the service conditions of any civilian, and their health benefits have been intended to be significantly better than civilian programs.

An additional concern of MOAA centers on the potential premium working-age retirees would pay. The Commission-proposed 20 percent premium cost share is substantially too high in MOAA's view, regardless of any phase-in period. A 20 percent cost share is not far off from the 28 percent cost share for federal civilians using FEHBP. Military retirement and medical benefits are the primary offset for enduring decades of arduous service conditions. Career retirees pre-pay huge "up front" health care premiums through 20 to 30 years or more of service and sacrifice, and this needs to be better recognized in the level of cash fees they pay.

Those concerns all stated, MOAA could support testing the MCRMC-proposed system for drilling and gray-area Guard/Reserve beneficiaries who are, in fact, significantly disadvantaged under current TRICARE programs. An FEHBP-style system, appropriately subsidized, could well be an improvement over the inconsistent TRICARE coverages and fees currently experienced by Guard and Reserve beneficiaries under age 60.

Key Principles

MOAA believes healthcare adjustments going forward should take into account the following key principles.

Maintain and Improve Readiness. No other healthcare system has the dual role of supporting warfighting capabilities and serving the broad spectrum of beneficiary needs and interests. Readiness includes more than care for currently serving personnel. Sustaining needed care and access for family members directly affects the readiness of the servicemember. There is also a vital readiness element to maintaining a retirement benefits system strong enough to help sustain career retention, even in the face of protracted war and multiple deployments.

Fees Must Appropriately Reflect Pre-Paid Premium Value of Career Service/Sacrifice. Nothing is more inappropriate than a simple comparison of cash fees paid by military vs. civilians for healthcare. For a true appreciation of what career servicemembers and their families pay, one should ask the civilian if he/she is willing to visit a recruiting station and sign up for two or three decades in uniform, with the potential to spend two or three or more of those years in a war zone. Only then does one appreciate how steep a pre-paid premium is extracted over a career of service and sacrifice in uniform. This is the fundamental point of military service organizations' opposition to past steep fee increases proposed by the Defense Department "to better reflect civilian practice." ***Simple comparisons of military vs. civilian cash fees fundamentally devalue servicemembers' and their families' decades of service and sacrifice for America.***

Means-Testing Is Inappropriate for Military Health Benefits. Proposals to vary military retiree healthcare fees based on grade, retired pay, or other measure of income deny the service-earned nature of the benefit. Such practices are nearly unheard of in any other employer-provided health coverage. The President, Secretary of Defense, Senate Majority Leader, and Speaker of the House are eligible for the same federal health benefit and premiums as the lowest-grade federal civilian retiree. Means-testing of service-earned benefits would progressively and perversely reduce benefit value the longer and more successfully a uniformed person served. That is not an appropriate career incentive structure.

No Enrollment Fee for TRICARE For Life or TRICARE Standard. An enrollment fee is reasonable for a managed care plan like TRICARE Prime, which (at least nominally) guarantees access to care within certain standards. MOAA strongly opposes an enrollment fee for TRICARE Standard and TRICARE For Life, which offer no such guarantees. In the case of TRICARE for Life, Congress expressly prohibited an extra enrollment fee, in recognition that TFL-eligibles must pay an enrollment fee to Medicare as first payer, and DoD is only liable for the beneficiary's Medicare cost-share. In the case of TRICARE Standard, beneficiaries already are liable for a 25% cost-share.

Beneficiaries Should Not Be Compelled to Forfeit Service-Earned Coverage. In previous years, there have been proposals from the Pentagon and elsewhere to limit TRICARE eligibility for working-age retirees with access to employer health plans. Other proposals envisioned requiring an explicit annual enrollment in TRICARE Standard (with or without an enrollment fee) and denial of care to those who failed to enroll. Others would have forced an annual choice for dual-eligibles between DoD- and VA-provided care. MOAA believes strongly that all such proposals are inappropriate. DoD actively promotes retention by emphasizing that career service earns lifetime health care. Nowhere in retention materials has there ever been a caveat – nor should there be – that adds "unless you take post-service employment with some kind of health benefits." Dual VA and DoD eligibles may be willing to drive 100 miles to a VA facility to see a spinal or other specialist for service-caused conditions, but still should be able to use local providers for routine and urgent care. Similarly, arguments that DoD needs annual enrollment to project costs are patently spurious. DoD already knows exactly who is in its beneficiary pool by virtue of their military ID cards, and has detailed history of every beneficiary's TRICARE treatment and cost. The only practical effect of an annual enrollment requirement would be denial of needed care for beneficiaries who didn't get the word or otherwise overlooked the required enrollment date.

Readiness Costs Should Not Be Passed to Beneficiaries. MOAA strongly agrees with the MCRMC proposal to strictly separate readiness-driven medical costs from those attributable to benefits for beneficiaries. The costs of maintaining readiness are necessary costs of doing business. One of MOAA's great frustrations has been the lack of transparency of DoD assertions about what share of DoD costs are borne by beneficiaries. MOAA does not accept any such assertions without transparency of what costs are included in the denominator of the fraction.

When military providers are deployed in wartime and more beneficiaries are forced to civilian providers, MOAA views those increased costs as directly due to readiness requirements. Attributing them to beneficiary benefits is no different that attributing battlefield care as benefits. Similarly, ***when the military healthcare system is deliberately or inadvertently inefficient (such as maintaining three separate military delivery systems, having military providers see half as many patients per day as civilian providers, or having sequestration-driven hiring freezes that drive more patients to private sector providers), the resultant higher cost of care cannot be considered as having any benefit value. The extra costs result purely from the way the military or the government chooses to do business, and often result in extra cost-shares for beneficiaries, too.***

No User Fee/Copay for MTF Care. MOAA believes virtually all care provided in military facilities should be deemed readiness costs. That, after all, is the primary reason for maintaining these facilities, and the reason DoD wishes to capture care in the facilities is to ensure military providers have enough practice to maintain their professional skills. Any benefit value associated with in-house care is ancillary to the main readiness purpose. For this reason, MOAA vigorously opposes imposition of copays or user fees for in-house care.

Fees Should Not Be Set in Ways That Deter Care-Seeking. When the Defense Department first proposed substantial increases in TRICARE fees, an express part of the rationale and the associated savings was to drive some beneficiaries away from using their military health coverage. Others have asserted that military beneficiaries use more healthcare than civilians do, and proposed higher fees so military beneficiaries would have "more skin in the game" and presumably be more hesitant to seek care. One concern MOAA has with recent substantial increases in pharmacy copays is that past studies have shown that higher copays deter patients with chronic conditions from seeking care or filling their prescriptions. MOAA believes strongly in positive incentives to encourage beneficiaries to seek needed care in the most appropriate venues. We do not support imposing fees to deter use of their service-earned benefits.

Military Health Benefit Should Be "Gold Standard". MOAA agrees with the many, many DoD and other government leaders who have said the military health benefit should be second to none. Those who spend decades subject to being put in harm's way deserve no less. This is another reason why MOAA objects to fee increases based on rationale that the result would be more in line with private sector practice. Military benefits are supposed to be not "more in line with" or "somewhat better than" civilian benefits, but very substantially better.

Each similar group of eligibles should be provided similar health coverage. We are not in favor of an FEHBP-style system that means those with more income can buy better coverage. We make an exception in the case of Guard/Reserve coverage mainly because, our concerns aside, the MCRMC-recommended option offers an improvement in continuity of care and consistency of coverage over the wildly inconsistent programs now in effect for this population.

We Don't Need Another Trust Fund. When Congress established a trust fund for TRICARE For Life in 2001, its stated intent was to ensure the program would always be fully funded. That

was a laudable intent, but the process created a significant practical drawback. Under congressional budget rules, any law change that increases trust fund spending is considered mandatory spending. That means the Armed Services Committees cannot make even the slightest needed adjustment to TFL coverage without being forced to make an equivalent cut elsewhere in TFL, military retirement, survivor benefits to pay for it. This is true even if the change would save money in the long run. For example, when this Subcommittee initiated a requirement for the defense department to initiate wellness programs (e.g., paying for smoking cessation programs), you were forced to exclude TFL-eligibles. So for lack of a small short-term funding need, DoD and Medicare will be hit with larger, longer-term smoking-related care bills.

Some have proposed establishing a trust fund to cover the cost of care for beneficiaries under age 65. MOAA strongly opposes doing so, based on the TFL experience that it would bring inflexible rules into play that prohibit almost any program improvements, even those that would be very beneficial for the government in the long term.

Health Care Benefits Should Apply Equally to All Uniformed Services. Too often when healthcare and certain other legislation is being drafted to improve one program or another, its language includes the term "Armed Forces." Use of this terminology inadvertently omits two of the seven uniformed services – the commissioned corps of the US Public Health Service (USPHS) and the National Oceanographic and Atmospheric Administration (NOAA) – from coverage. All seven uniformed services fall under the purview of title 37 and title 10 of the United States Code, and the clear objective is to provide members of all seven services the same pay, allowances, and benefits under these titles.

Wounds/Injuries Should Not Cause Extra Beneficiary Costs. Never is the sacrifice inherent in military service so clear as it is in time of war. MOAA believes strongly that no military beneficiary should have to incur higher health costs simply because that very service caused the member to become disabled. The clearest example of this is the young warrior who is so wounded, ill or injured as to become totally disabled and eligible for Medicare. Under current law, TRICARE is second payer to Medicare, and any Medicare-eligible must enroll in Part B…and incur at least the current $105 monthly ($1,260 annual) enrollment fee. Had the member not become disabled, he or she would not have been required to incur this fee until age 65.

Recommendations

Preserve What Works Well, and Focus on Fixing Problem Areas. MOAA fully understands there are many programs that would look much different than they do today if we were starting from scratch to design them. But the practical reality is we are not starting from scratch. The challenge is working out how we can get to where we want to be -- starting from where we are today. It's tempting for critics to say "toss the whole system out and start over." But the critics are rarely the people who have to take responsibility for continuing to carry out the current mission while changing systems to meet tomorrow's needs. Radical overhauls have their own high potential for unintended consequences. In that regard, MOAA is not convinced TRICARE is so irretrievably broken that it must be discarded entirely.

Provider Payments Should Reward Quality Care. Any number of studies have identified the shortcomings of fee-for-service payment programs, including TRICARE. MOAA concurs with the MCRMC belief that both Medicare and TRICARE need to move to payment systems and treatment bundles that reward providers for meeting standards of quality and healthy outcomes rather than simply paying them for the number of patient encounters they have.

Focus on the Causes of Problems, Not the Symptoms. The mere fact that a particular beneficiary cost is rising doesn't mean the beneficiary had a hand in raising the cost or that the solution is to make the beneficiary pay more. This is particularly true if the real reason behind the cost increase is program inefficiency, DoD or service decision-making, the exigencies of national conflict, or arbitrary hiring freezes or other conditions caused by sequestration. The solution should be to focus on addressing those problems rather than making beneficiaries pay more simply because it's budgetarily or programatically easier.

Consider Implementing a MCRMC-Style Insurance System for the Guard/Reserve. First of all, the current hodgepodge of makeshift healthcare programs for the under-60 G/R community makes it one program where it actually is possible to start over from scratch. Second, the current G/R systems are not meeting the needs of the majority of G/R beneficiaries. Third, the subsidy levels envisioned by the MCRMC would provide a better deal for many G/R beneficiaries than they have today – especially "gray area" retirees and those drawing retired pay before age 60 because of deployment credit, who now have no subsidized care. Part and parcel of this change would be giving Selected Reservists who prefer to keep family coverage through an employer the opportunity to retain that coverage upon activation, with the premium paid or subsidized by DoD.

Consider Establishing a Joint HASC/HVAC Subcommittee on DoD/VA Transition. Many of the problems with this transition stem from the two departments' separate funding priorities…which also reflect in some measure the views and priorities of their respective oversight committees on the Hill. If the HASC and HVAC can cooperate in a joint subcommittee – even a temporary one -- to devise joint policy, program, and budget solutions on such issues as a joint interoperable electronic healthcare record, there is a far greater chance this joint resolve can be reflected in DoD and VA programs.

Require DoD to Implement the MCRMC Recommendation to Expressly Allocate Readiness and Benefit Costs. A thoughtful and rational dialogue on beneficiary cost sharing absolutely requires an agreement on exactly which expenses are a cost of doing national defense business vs. a benefit value delivered primarily for the sake of the beneficiaries. This in itself is purely an accounting change so that all parties can be on the same page in assessing readiness vs. benefit costs and from there assessing what is a reasonable cost-sharing mechanism for beneficiaries.

Seek Some Form of Agreement on the Premium Value of a Service Career. This issue is at the crux of every disagreement between DoD and its beneficiaries over how much the latter should be expected to pay for their healthcare benefits, and why. The legislative history of CHAMPUS,

TRICARE Prime, and TRICARE For Life allows at least some starting inferences on this thorny topic. We understand that some may wish to avoid any explicit valuation, lest future conditions require a change. From MOAA's standpoint, that's one important reason at least some general agreement should be established. The problem is that beneficiaries remember what they were told and must adapt to and live with what they were told. Executive and Legislative Branch officials and military leaders, by contrast, change every few years and their views are driven more by current budget conditions than past history. A primary reason for beneficiary outrage at proposals for steep fee increases are current-year assertions that military beneficiaries are somehow undeserving of current benefit levels or that their benefits should be more like civilians'. Such arguments fly directly in the face of what the military retirees were told in order to induce them to stay for a career in uniform. Acknowledging what retirees were promised doesn't mean current circumstances will never change, or that some changes might be needed in the future. ***But coming to at least some kind of general consensus on what constitutes an appropriate service-earned differential will serve several important purposes from beneficiaries' standpoint.*** First, it will offer a public and verifiable acknowledgement of the promises used to induce them to serve decades in uniform despite the extraordinary sacrifices involved, so these can't be denied or dismissed by future leaders. Second, it hopefully will give at least some degree of pause to those who want to change the rules retroactively, and cause a conscious consideration of what kind of grandfathering might be feasible. Finally, in the event that some particularly difficult cutback cannot be avoided in the future, it would hopefully increase the chances the change would at least be accompanied by an apology rather than infuriating assertions or implications that military retirees didn't earn and don't deserve the existing level of benefit.

Test the Concept of Unified Budget and Oversight Authority in MSMs. The Defense Health Agency is in an excellent position to oversee establishment of pilot project to test the concept of a single budgetary/operations oversight authority in at least two of the multi-service market areas (MSMs). Such a test should offer some insight into the feasibility and potential savings associated with unified vs. multiple-service oversight of budget, appointing/referral, and other operational and support programs. MOAA believes this issue is important enough that it should be pursued at the earliest possible date.

Promote More Balanced Patient-to-Provider ratios in MTFs. Undertake efforts to assess and change support staffing and other factors that lead military providers to see significantly fewer patients per week than their civilian counterparts. If, as defense health officials often assert, it is more cost-effective to see beneficiaries in MTFs, it should be worthwhile investing in whatever is necessary to promote a more balanced patient-to-provider ratio. This should also substantively ease the appointing and referral problems reported by Prime enrollees.

Require Leadership Oversight/Training on Appointment Timeliness. It is beyond understanding that the TRICARE Prime appointment process apparently ignores DoD access standards on a routine basis at many facilities. This is in substantial measure a leadership problem, in MOAA's view. To the extent such action hasn't been taken already, there should be a full retraining of all involved in the appointing process that appointments that cannot be

made in the MTF within DoD timeliness standards must be offered a civilian provider appointment within those standards. It also should be made clear to MTF commanders and others in leadership positions over appointing offices that it is their responsibility to monitor appointment timeliness and take necessary corrective action when standards are not being met.

Focus Managed-Care Outreach Efforts on High-Use/Cost Beneficiaries. Under current rules, priority is given in MTFs to active duty members and families, TRICARE Prime enrollees, other under-65 beneficiaries, and TFL-eligibles, in that order. TRICARE Prime is mostly focused on beneficiaries who live within 40 miles of an MTF. MOAA believes first priority for managed care or case management should be given to beneficiaries with a history of high-cost care and those with chronic conditions that have the greatest potential for incurring high costs in the future. For example, a TRICARE Reserve Select family with multiple children requiring complex care would have a high incentive to be seen in a managed-care environment, but is not eligible for Prime enrollment. Similarly, certain TFL-eligibles or other non-Prime enrollees may have chronic conditions posing long-term cost risks far higher than a majority of Prime enrollees. These high-cost care users are readily identifiable from existing cost records. Surely there are savings to be realized by shifting to include a care-cost factor and creating outreach programs to bring such families into a more active managed-care or case management system.

Pursue Public-Private Partnerships to Reduce TFL and Other Costs. Several innovative cost-saving programs around the country have potential application to military beneficiaries and facilities. MOAA would encourage DoD to investigate the potential for partnerships with civilian contractors to establish TFL-specific Medicare Advantage programs in locations where there are large retiree populations and significant military medical facilities. The partnership agreement would establish the military facility as the preferred provider for certain surgeries or other conditions to help sustain military providers' readiness skill levels. These programs should include outreach efforts to identify high-cost users and those with chronic conditions to bring them into a case management environment. This system would reduce the contractor's cost and allow addition of other program elements (e.g., vision or dental) to incentivize TFL-eligibles' participation. The military facility, in turn, could be reimbursed at some level through the TFL trust fund. This would seem to have a winning potential for the government, DoD, contractors, and beneficiaries alike. Anthem's Care More program is an exceptional and proven model, and Humana and United Healthcare offer similar programs. The MCRMC staff cited another successful model in the Las Vegas area.

Adopt pediatric-centered payment policies that let providers to make optimal care decisions for children. Because TRICARE payment systems are based on Medicare systems designed for older people, the systems often don't work for pediatric care and don't properly reimburse providers for needed and delivered care. Reimbursement should follow appropriate care, not form the basis for care decisions. In situations where emerging technology is clearly providing compelling options for patients and families, TRICARE should allow payment to follow the needs of the patient instead of driving the type of care the patient receives. When there is a known issue with translation of policy or payment from Medicare to pediatrics, there must be

an efficient process for resolving the difference. Continued innovation and research will ensure this issue is at the forefront in the coming years, with genetic testing, gene therapy, and individualized medicine as examples of prevention, intervention, and treatments that will need to be covered and reimbursed appropriately.

Do More to Connect TRICARE Standard Beneficiaries with Providers. One way to improve TRICARE Standard beneficiaries' access to providers is to educate them that they are not limited to seeing network providers. It's preferable if they do, because that saves money for both DoD and the beneficiary. But if a beneficiary is having trouble getting an appointment with a network provider, there should be a method to put them in touch with a non-network provider who is willing to accept non-discounted rates payable under Standard. We understand that there is little incentive for current managed care contractors to facilitate use of non-network providers. We appreciate this Subcommittee's efforts to require DoD surveys of provider participation in Standard, and to establish measures of provider participation by locality. The next logical step is to require DoD to establish participation thresholds below which DoD must take direct efforts (through higher payments or other methods) to increase provider participation to levels consistent with healthcare needs of active duty, Guard/Reserve, and retired beneficiaries residing in that locality.

Ease the Cost Burden on TRICARE Young Adult (TYA) Beneficiaries. Unlike civilian insurance programs, which spread the cost of adding children under 26 by raising family premiums slightly across the board, TYA requires each TYA-eligible (or the parents) to pay the full individual premium cost of his or her care. With the 26% (TRICARE Standard) and 47% (Prime) premium increase for 2016, the $2,500 to nearly $3,700 annual cost of this program is particularly onerous, especially for families with more than one qualifying child. MOAA encourages the Subcommittee to explore alternative ways to spread this cost across the entire population, in hopes that this could be done via a relatively inconsequential increase. As currently implemented, the high individual cost of the coverage deters many beneficiaries from using it, which defeats the purpose of the program.

Mr. Chairman, Madam Ranking Member, and members of the Subcommittee, thank you for providing MOAA 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.

Vice Admiral Norbert R. Ryan Jr., USN (Ret)
President and CEO
Military Officers Association of America

VADM Ryan is a 1967 graduate of the United States Naval Academy and a graduate of George Washington University with a Master of Science Degree in Personnel Administration as well as the Senior Officials in National Security Program at Harvard University's John F. Kennedy School of Government.

Ryan has commanded aviation units at the squadron, wing, and fleet levels and has directed the Navy's Office of Legislative Affairs. He served as the 52nd Chief of Naval Personnel before retiring and assuming his current position in September 2002.

Ryan is the recipient of the 2014 Military Hero Award from the Pentagon Federal Credit Union Foundation (PenFed Foundation) honoring those who have demonstrated leadership in providing support and services to returning servicemembers and veterans and their families. He was named the 2010 Association Executive of the Year by Association TRENDS, a national trade publication. He is the first military officer to win this award in its 39-year history. In 2015, Ryan was recognized as one of HillVets 100 most influential and impactful veterans, service members and supporters from 2014.

Additionally, under Ryan's leadership, MOAA has been named a "Top Lobbyist" by The Hill newspaper for the past nine years, and the only military service organization so listed for the last five years.

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COMMITTEE ON ARMED SERVICES
U.S. HOUSE OF REPRESENTATIVES

INSTRUCTION TO WITNESSES: Rule 11, clause 2(g)(5), of the Rules of the U.S. House of Representatives for the 114th Congress requires nongovernmental witnesses appearing before House committees to include in their written statements a curriculum vitae and a disclosure of the amount and source of any federal contracts or grants (including subcontracts and subgrants), or contracts or payments originating with a foreign government, received during the current and two previous calendar years either by the witness or by an entity represented by the witness and related to the subject matter of the hearing. This form is intended to assist witnesses appearing before the House Committee on Armed Services in complying with the House rule. Please note that a copy of these statements, with appropriate redactions to protect the witness's personal privacy (including home address and phone number) will be made publicly available in electronic form not later than one day after the witness's appearance before the committee. Witnesses may list additional grants, contracts, or payments on additional sheets, if necessary.

Witness name: VADM Norbert Ryan, Jr. (USN-Ret)

Capacity in which appearing: (check one)

○ Individual

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If appearing in a representative capacity, name of the company, association or other entity being represented: Military Officers Association of America

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2015

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant
None			

2014

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant
None			

2013

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant
None			

Foreign Government Contract or Payment Information: If you or the entity you represent before the Committee on Armed Services has contracts or payments originating from a foreign government, please provide the following information:

2015

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment
None			

2014

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment
None			

2013

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment
None			

Statement

of the

NATIONAL MILITARY FAMILY ASSOCIATION

Before the

Subcommittee on
Military Personnel

of the

UNITED STATES HOUSE OF REPRESENTATIVES
ARMED SERVICES COMMITTEE

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Not for Publication Until Released by
The Committee

The National Military Family Association (NMFA) is the leading nonprofit dedicated to serving the families who stand behind the uniform. Since 1969, NMFA has worked to strengthen and protect millions of families through its advocacy and programs. They provide spouse scholarships, camps for military kids, and retreats for families reconnecting after deployment and for the families of the wounded, ill, or injured. NMFA serves the families of the currently serving, retired, wounded or fallen members of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA.

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

The Association does not have or receive federal grants or contracts.

Our website is: *www.MilitaryFamily.org.*

Joyce Wessel Raezer, Executive Director
Joyce became the Executive Director of the National Military Family Association in 2007. In that position, she leads the Association's programs and initiatives to meet the needs of the families of the seven Uniformed Services and promote improvements in their quality of life. She is frequently called on by government officials, other organizations, and the press to share her expertise on the issues facing military families. She began her work with the Association in 1995 as a Volunteer in the Government Relations Department and subsequently served in various staff positions, including Government Relations Director.

Joyce has represented military families on several committees and task forces for offices and agencies of the Department of Defense (DoD) and military Services. Joyce has served on several committees of The Military Coalition, an organization of 32 military-related associations. She was co-chair of the Coalition's Personnel, Compensation, and Commissaries Committee from 2000 to 2007. In 1999 and 2000, she served on a Congressionally-mandated Federal Advisory Panel on DoD Health Care Quality Initiatives. From June 1999 to June 2001, Joyce served on the first national Board of Directors for the Military Child Education Coalition. In 2004, she authored a chapter on "Transforming Support to Military Families and Communities" in a book published by the MIT Press, Filling the Ranks: Transforming the U.S. Military Personnel System.

In 2006, Joyce received the Gettysburg College Distinguished Alumni Award. She was the 1997 recipient of the Association's Margaret Vinson Hallgren Award for her advocacy on behalf of military families. She also received the "Champion for Children" award from the Military Impacted Schools Association in 1998. In 2007, Military Spouse Magazine listed her on its Who's Who of Military Spouses. In 2012, she was honored as a Daily Point of Light by the Points of Light Foundation.

A Maryland native, Joyce earned a B.A. in History from Gettysburg College, and a M.A. in History from the University of Virginia. The spouse of an Army retiree, she is the mother of two adult children. She is a former teacher and served on the Fort Knox Community Schools Board of Education from 1993 to 1995. She was an active volunteer parent in her children's schools. She plays hand bells and sings in her church choir, the Northern Virginia Chorale, and the Ron Freeman Chorale.

Chairman Heck, Ranking Member Davis, and Distinguished Members of the Subcommittee, the National Military Family Association (NMFA) thanks you for the opportunity to present this statement regarding family perspectives on military health care. We appreciate that you have listened to beneficiary concerns regarding the Military Health System (MHS) and are gratified Congress wants to make the system work better for all beneficiaries via TRICARE reform. We hope the changes you enact will truly make a difference in military families' ability to access the right care, at the right time and in the right place. Our families deserve no less.

We endorse the recommendations presented in the statement of the Military Officers Association of America. In this statement, we will expand on the particular health care needs of the families of those who serve our Nation.

The State of the Military Family

For military families, although combat operations in Iraq and Afghanistan have officially ceased, it certainly doesn't feel like the wars are over. Thousands of service members continue to deploy across the globe facing hazardous conditions and lengthy family separations. Looming worldwide threats lead military families to anxiously consider how their service members might be deployed in response. On top of this, our families are also grappling with job insecurity due to military downsizing and financial stress as a result of compensation and benefit cuts. Perhaps most worrisome for today's military families is there seems to be no end in sight to either global military conflicts or threats to their financial security.

Importance of Health Care for Military Families

Affordable and timely access to health care is important to all families, but it is vital for military families. Repeated deployments; caring for the wounded, ill, and injured; the stress and uncertainty of military life; and the need to maintain family readiness demand quality and readily available health care. Families need a robust and reliable health care benefit in order to focus on managing the many challenges associated with military life versus worrying about how they are going to access and pay for essential health care. The military health care benefit must address the unique conditions of service and the extraordinary sacrifices demanded of service members and their families.

Service members and their families consistently rate health care as one of the most valued aspects of the military compensation and benefits package, even as they also share stories of delayed access and confusing procedures. As such, the impact of health benefit changes on recruiting and retention must also be considered as part of TRICARE Reform.

Why TRICARE Reform Now?

Our Association believes now is the time to tackle TRICARE Reform. We agree with the Military Compensation and Retirement Modernization Commission (MCRMC) report that the TRICARE status quo is unsustainable. TRICARE—both the benefit and the system in place to deliver the

benefit—faces pressure on multiple fronts and beneficiaries will continue to feel pressure as they access care and in the cost of that care. Specifically, TRICARE's beneficiary satisfaction and fiscal sustainability have both declined. Further dilution of the current TRICARE benefit seems inevitable as DoD nibbles around the edges, making incremental changes while increasing beneficiaries' out-of-pocket costs. **We appreciate that Congress has made TRICARE Reform a priority for the upcoming year and trust reform efforts will focus on ensuring both the benefit and the system charged with delivering the benefit work better for military families.**

Acknowledgement of Dual Readiness and Benefit Missions

The MHS is unique in that it has dual readiness and benefit provision missions. The MHS readiness mission must achieve both a medically ready fighting force that is healthy and capable of deploying as needed and a ready medical provider force capable of delivering health and combat-casualty care for service members in operational environments. The MHS benefit provision mission is to provide the earned health care benefit to family members, retirees, and survivors. The two missions intersect when military medical personnel provide care to family members and retirees in Military Treatment Facilities (MTFs) honing their medical skills in the process.

With our Association's mission and expertise in advocating for military families, we have clear perspectives on how TRICARE Reform must address beneficiary issues. However, we acknowledge benefit reform efforts must not preclude the MHS from achieving its military medical readiness goals.

Our Association strongly asserts TRICARE Reform efforts must make a distinction between readiness costs and benefit costs. The MHS budget associated with service member medical readiness, medical provider readiness, wartime operations, and the care of wounded, ill, and injured service members **should not** be included in the cost structure of providing a health care benefit to the children, spouses, and surviving family members of service members and retirees. Our Association believes DoD has not effectively differentiated health care readiness costs from the costs of providing the employer-sponsored benefit. **This failure, we believe, puts both the readiness function and access to care for family members, retirees, and survivors at risk.**

Requirements for Providing the Earned Health Care Benefit to Military Families

The MHS should provide health care on par with that available via high quality commercial plans, tailored to address military families' unique needs, but at a significantly lower cost to acknowledge the value of service. We will consider TRICARE Reform a success if it achieves the following:

Access to High Quality Care

TRICARE Reform should ensure military families have ready access to primary care including urgent, routine and preventative care. Primary care should also include care coordination services as needed. Another requirement is easier access to specialty care. We realize there are medical specialist shortages in many civilian and military communities, particularly among pediatric and behavioral health providers. We don't expect the TRICARE program to work miracles where

specialties are scarce, but we do expect robust networks that provide access and choice to the extent possible. TRICARE Reform must consider service members are ordered to all parts of the U.S. and the world with varying degrees of access to Military Treatment Facilities (MTFs) and civilian medical assets. The MHS must provide military families with access to care regardless of where they live.

The Department of Defense (DoD) has already published Access Standards for Care[1] including urgent care (24 hours), routine care (7 days), and specialty care (4 weeks.) While we believe the Access Standards provide a good benchmark for acceptable access to care, we also note awareness of the standards is low among the beneficiary population and compliance is variable at the MTF level.

Access to care also includes coverage that is appropriate for all beneficiary populations and aligns with the most current medical best practices. TRICARE Reform must allow coverage policies to evolve with innovations in technologies and treatment protocols and ensure it meets the needs of all beneficiary segments.

We thank Congress for the FY16 NDAA provisions such as the Urgent Care Pilot, provisions to improve access to care and TRICARE portability, and the enhanced MHS reporting requirements that will address some of the current TRICARE problems until systemic reforms occur.

Reliable, safe, high quality care across both the Direct and Purchased Care systems is non-negotiable. Quality and safety must be measured and monitored to ensure military families are receiving the best possible medical care.

Policies Designed to Address the Unique Challenges of Military Service

The MHS must be designed to facilitate the transition of care for a mobile population. TRICARE Reform must identify and fix areas where the current system exacerbates disruptions in care necessitated by Permanent Change of Station (PCS) moves. With TRICARE Reform, families should be able to seamlessly transfer prescriptions and existing specialty care, including OB services, to new pharmacies and providers without delay.

TRICARE Reform must also consider issues associated with deployments and family separations. The benefit must work for families who are geographically separated. It must also provide enhanced coverage for mental health and other conditions caused or exacerbated by the extraordinary stress families experience during deployment.

Costs that Acknowledge the Value of Service

We reject the notion that health care is "free" for military families. While military families may not pay monthly premiums, deductibles, or co-pays under TRICARE Prime, service members earn the benefit by way of the extraordinary demands, risks, and sacrifices associated with military

[1] TRICARE Policy for Access to Care/HA Policy: 11-005

service. Comparisons with civilians' out-of- pocket costs, while helpful in assessing the military health benefit's value, are largely irrelevant when determining fair out-of-pocket costs for military families.

We appreciate DoD has not proposed any changes to TRICARE costs for active duty and their family members. We also appreciate DoD's assurance that any proposed TRICARE enrollment fee changes will not apply to medically retired service members and survivors. TRICARE Reform must continue to adhere to these principles.

Our Association has always been open to introducing a mechanism for modest cost increases for retirees and is willing to engage in conversations about appropriate fee levels and additional MHS efficiencies. However, we believe out-of-pocket expenses for retirees must be contained to avoid diminishing the value of the earned retirement benefit.

Areas to Consider with TRICARE Reform – What's Working?

TRICARE Reform should maintain or expand upon areas that are currently working for beneficiaries, including:

- **Access to Care in Certain Areas**: Health care is local, so access problems vary by location. There are some MTFs and TRICARE network areas where families are satisfied with their access to care.
- **Pockets of Excellence Within the Direct Care System**: Beneficiaries in some areas tell us they receive exceptional care at their MTFs. MHS leaders must ensure best practices within the system are identified and widely disseminated.
- **Mental Health and Applied Behavior Analysis (ABA) Coverage**: TRICARE has tailored coverage in these areas in recognition of military families' unique needs. Mental health care is available without referral and at zero out-of-pocket cost. As some military families struggle to cope after 14 years of war, it is vital these policies continue. DoD has also enhanced ABA coverage to meet the needs of family members with autism. Current ABA coverage is the result of years of deliberation, research investigation, and pilot program evaluation. The resulting coverage levels DoD has deemed appropriate for military families must remain linked to high-quality, evidenced-based practices in the future.
- **Current Beneficiary Costs:** Current low out-of-pocket costs reflect the value of service while catastrophic caps protect military families from potential financial hardship related to medical expenses. Given the extraordinary risks service members assume during the course of military service, we believe it is appropriate to protect them from financial risk wherever possible.
- **U.S. Family Health Plan (USFHP)**: USFHP beneficiaries express high satisfaction with the program. They appreciate assistance from Care Managers so they do not have to navigate the system on their own. They have access to robust provider networks. Military families using USFHP benefit from wellness, prevention and disease management programs as well

as provider outreach to enhance communication. All of these programs result in better health care outcomes. Compared to TRICARE Prime enrollees, USFHP participants have 33 percent fewer inpatient days and 28 percent fewer emergency room visits.[2]

What's not working? Access to Care Issues

Access to care is the broadest area of concern and takes many forms, including:

Direct Care Acute Appointment Shortages

For years, our Association has advocated for better access to urgent care. When military families call the MTF to make an appointment for a sick or injured family member, too many are told there are no appointments available. Too many are told they cannot get a referral to an urgent care in the community. Too many are left with the Emergency Room as their only option for treatment of acute medical problems such as ear infections and strep throat – conditions that aren't emergencies, but must be treated promptly.

Military families lead complicated lives rife with uncertainty. Obtaining health care for sick or injured family members should not be complicated or uncertain.

In April 2015, NMFA conducted an Acute Care Campaign via social media. Our goal was to demonstrate that acute care barriers are a widespread problem. With minimal effort, we engaged thousands of beneficiaries in a dialog and collected 131 stories about acute care access problems. With a worldwide network of Volunteers, frequent engagement with the military community, and our own experiences as military family members, we are able to differentiate common themes versus unique situations. Stories collected during our outreach campaign highlight how difficult it is for many families to access the right care, at the right time, in the most appropriate setting. Specific findings include:

- **Military families recognize their Primary Care Manager (PCM) is the best source for care when they are sick or injured.** As a recent DoD Health.mil article (*Pediatricians Serve as Important Resources for Parents*) points out, pediatricians have specialized training and skills versus general practitioners and parents understand this. Continuity of care is also important to military families.

  "Military families would vastly prefer not to be sent to the ER or urgent care. Not only is it more expensive for the military when this happens, but it interrupts patient care and continuity and does not provide the best care for our families." (Military Spouse)

- However, **military families face a variety of challenges in obtaining timely acute appointments with their direct care PCMs/pediatricians**. When families call for acute appointments, they are often told:

[2] Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

  - The next appointment is days or weeks away, so no appointment is made and families are left to determine appropriate next steps
  - To call back the next day
  - To go to the ER

- When a PCM/pediatrician appointment is unavailable, **military families often face confusing, inconsistent policies for obtaining network urgent care referrals**.
- **Most military families would prefer to avoid the ER, but often find it is their only option for care.** They are frustrated by the inconvenience and delay in care resulting from ER use.
- **Military families experience delays in follow up specialty care when they can't be seen by their PCM/pediatrician.** TRICARE doesn't accept referrals from ER or Urgent Care providers necessitating an additional visit with a PCM just to get the recommended referral.

Other MTF Appointment Issues

- **Routine Care Scheduling Challenges:** Families report delays in scheduling preventative, routine, and follow up care. Not only are some families unable to schedule routine appointments within a reasonable timeframe, but the process for scheduling is cumbersome. Families are often required to call the appointment line multiple times in the hopes of finding an opening within the currently available appointment book. We appreciate DoD has started to take steps to remedy this problem, but we believe routine appointment availability should still be examined during TRICARE Reform discussions.
- **Impact of Recapture Efforts on Appointment Scheduling:** While we support DoD's efforts to recapture care back into the direct system to better utilize existing capacity and fixed assets, we fear some MTFs may be overreaching leading to access problems. We have also seen questionable referral decisions that seem to be driven by specialty care recapture. For instance, families stationed at MCB Quantico have been told they must receive physical therapy at Walter Reed National Military Medical Center. Travel time from Quantico to Walter Reed only meets the one hour drive time access standard under the most optimal conditions. Restricting appointments to Walter Reed effectively creates a barrier to accessing necessary physical therapy for Quantico families.

Please note MTF access problems are not exclusive to family members. We regularly hear about service members who are unable to get timely appointments. We recently talked to a service member with a foot injury. When he called to schedule an appointment, the next available opening was five weeks away. **Failure to provide timely care to service members is a readiness issue.**

Cumbersome Referral and Authorization Process:
The referral and authorization needed to obtain network specialty care can result in delays and disruptions to care. Many families report problems with referral processing. These issues become more pronounced during PCS moves. Military families recognize continuity of medical care is one of the sacrifices they must make as a result of the highly mobile military lifestyle. Unfortunately, many

TRICARE and MTF policies hinder rather than facilitate the smooth transition of care during PCS moves. For instance, specialty care requires a new referral and authorization in the new location while patients are often required to reconfirm an existing diagnosis before seeking treatment.

> *"I can't tell you how many times that when we did get referrals they were for the wrong sort of service because that's just who came up first in the system with no regard to sub-specialty." (Military spouse)*

> *"PCMs should be able to transfer referrals across TRICARE regions. My example: My daughter was diagnosed with moderate scoliosis in May 2013. We PCS'd in June and had to start the process all over once we settled into our new location. By the time we had all the required referrals and seen all the appropriate specialists, we had wasted almost four months waiting for treatment. She finally got her back brace on October 1, and her curve had progressed significantly." (Military spouse)*

Difficulty Accessing Coverage While Traveling

It is imperative families have access to urgent care while traveling. It is unacceptable the Emergency Room is the only option for care for military families who are traveling or en route during a PCS.

> *"Traveling through states during a PCS move when your child needs to see a doctor is a nightmare. My daughter had an eye infection when we were traveling and stopped in the Midwest from NC to CA. The only option was the ER since we were not in our Tricare region. I spent hours on the phone with Tricare and my PCM from my previous state to get a referral so my daughter could be seen in a clinic. It was like pulling teeth from everyone right down to getting a prescription. Plus the time changes with offices made it difficult. It took 2 days and countless time on the phone between Tricare and the doctor's office. I felt helpless and angry having to fight for care for my 1 year old." (Military spouse)*

Purchased Care Access Issues

- **Areas with TRICARE Network Inadequacy:** In some areas, families complain there is a shortage of providers in the network and those listed often are no longer accepting new TRICARE patients. We fear this problem will become worse as the Affordable Care Act and Medicaid expansion increase the demand for medical providers.

- **Behavioral Health Provider Shortage**: Network issues are particularly pronounced with behavioral health providers. We recognize there is a national shortage of mental health providers. While TRICARE contractors have expanded their behavioral health provider networks to help meet demand, military families in some areas continue to report provider shortages, especially for psychiatric care for children and teens. We believe one of the consequences of 14 years of war is increased demand for mental health services which continues to outstrip supply. TRICARE Reform must explore innovative solutions, including

greater coordination between the military and the civilian provider base, to address this problem.

What's Not Working? Quality and Coverage Issues

Direct Care System

- **Variable Quality and Safety**:
  - We are concerned that DoD's 2014 MHS Review of quality measures showed mixed results with considerable variation across the system for both specific clinical measures and for individual MTFs. This is consistent with feedback we hear from military families. Some are very pleased with their MTF care while others relay stories that clearly demonstrate quality and safety issues. We appreciate DoD has launched a High Reliability Organization initiative. **TRICARE Reform must ensure continuous improvement efforts are consistently integrated across the entire Direct Care system**.
  - Another finding of particular concern involved follow up on sentinel events. The MHS Review found the execution and content of root cause analysis (RCA) to understand the possible causes of adverse health events related to care (sentinel events) remains highly variable across the Services and MTFs. In addition, there has been a failure to routinely follow up on reported RCAs to ensure systemic issues identified were corrected. **Failure to follow up on sentinel events is unacceptable**.[3] We have asked how this is being addressed and have not received any information.

- **Beneficiary Quality Perceptions:** Military family members feel care is compromised by provider turnover/lack of continuity of care, inadequate appointment length, and direct care providers who don't listen or review patient medical history.

  "We left the Prime system and switched to standard because there was high doctor turnover in our military clinic leading to poor patient care." (Military spouse)

  "I went to see my doctor for back pain and he asked me if I wanted to discuss the upper back or lower back. We couldn't talk about both. I had to make a second appointment." (Military spouse)

- **Inconsistent Policy Implementation at the MTF Level**: MTF Commanding Officers have a great deal of authority when it comes to setting policies at their facilities. While this is understandable given the complexity of the MHS and the unique conditions of each location, the existence of policies that vary from one MTF to another can make it even harder for military families to effectively navigate the system. Inconsistent policies for referring patients to TRICARE network urgent care is one of the most common examples. Another recent example we've heard relates to TRICARE's new Lactation Supplies and Support Policy. To its credit, DoD introduced the policy with an integrated communications plan including a Facebook Town Hall

[3] Military Health System Review Final Report to the Secretary of Defense – August, 2014

to answer beneficiary questions. The policy very clearly stated there were no restrictions on when an expectant or new mom could purchase a TRICARE covered breast pump. We've subsequently learned Landstuhl Regional Medical Center implemented the policy with a restriction. LRMC OBGYN will only provide the necessary breast pump prescription/order at 38 weeks. It is discouraging that DoD's strategic communications plan to educate military families about the new policy is being undermined by inconsistent implementation at the MTF level.

- **Poor Communication:** Families complain about difficulties in obtaining lab results, errors in medical records, and providers' failure to return phone calls. Similar to access, communication quality varies across MTFs. For instance, when the Direct Care recapture rolled out, affected families from Madigan Army Medical Center at Joint Base Lewis-McChord received a letter welcoming them back to the MTF together with a pamphlet highlighting the advantages of being seen at Madigan. Madigan also had a Patient Advocate specifically designated to field beneficiary questions about the recapture. Contrast this with the way the recapture was handled at Womack Army Medical Center at Fort Bragg. Affected patients received a post card alerting them to a Primary Care Manager (PCM) change with no further explanation. When we called Womack, the Patient Advocate could not answer our questions about the recapture waiver process, but made it clear we should not send families to her.

- **Lagging Customer Service Innovations:** DoD is slow to adopt Customer Service innovations, such as the Nurse Advice Line (NAL) and Secure Messaging. New program rollouts often lack patient focus. While DoD has analyzed the NAL's business impact, it has not to our knowledge surveyed users to ensure the service meets beneficiary needs. Although Secure Messaging aligns with young military families' preferred communication methods, adoption rates have lagged. We suspect this is linked to implementation issues such as the wide variety of names for the system (Relay Health, MiConnect, Medical Homeport Online, Army Medicine Secure Messaging and simply Secure Messaging) and inconsistent MTF, clinic and provider adoption.

Purchased Care

- **TRICARE Slow to Cover Emerging Technologies and Treatment Protocols:** Health care is in a period of rapid change and innovation. Since TRICARE coverage policies are governed by statute, they are difficult to update to cover new technologies. As a result, TRICARE beneficiary care lags that of civilians. Military families who receive care at MTFs have better access to health care innovations, since the rules governing MTFs are less stringent than TRICARE's regulations. We appreciate Congress gave DoD the authority to cover emerging technologies in the FY15 NDAA. However, DoD seems reluctant to exert that authority. In the case of Lab Developed Tests (LDTs,) TRICARE still covers only a fraction of tests available via commercial plans, Medicare and Medicaid.

  Earlier this year, the family of an Active Guard Reserve (AGR) soldier in Indiana contacted us for help in obtaining a diagnostic genetic test (an LDT) for their son. His doctors believe he may suffer from a rare genetic syndrome and recommended the test to inform their treatment decisions and better understand the child's prognosis. TRICARE denied coverage. After many months, we were eventually able to help the Indiana family obtain the test at Walter Reed. The

family traveled from Indiana to Maryland for a blood draw. The baby's blood sample was then sent to a commercial laboratory in Wisconsin for testing. Since the testing was done as a "courtesy," the family doesn't have access to the genetic counseling and possible future genetic testing necessary to determine next steps. TRICARE Reform must address this issue to ensure military family medical treatment evolves to include new technologies and treatment protocols.

- **Customer Service Issues:** The contracting process leads to regular Managed Care Support Contractor (MCSC) turnover. These changes rarely go smoothly and the result is customer service disruptions for military families. In some cases, where referral/authorization processing was disrupted, it has even affected access to care. TRICARE's T17 contracts will move to two TRICARE Regions resulting in an inevitable MCSC transition for many TRICARE beneficiaries.

What's Not Working? Lack of Metrics, Benchmarks, Accountability and Oversight

- DoD and GAO reports consistently highlight the lack of high quality metrics leading to an inability to evaluate military health system performance. Without proper metrics, it will be impossible to monitor progress against TRICARE Reform goals.
  - The 2014 MHS Review identified a major gap in the ability of the MHS to analyze system-wide health care information. It also observed there is no mechanism to recognize patient input making it difficult to act on feedback from patients regarding their needs. We noted MHS metrics utilized in the report are sometimes incomplete or misleading. For instance, DoD's access measure indicates the average wait time for an acute appointment is 0.97 days, outperforming access standards. However, that metric only measures the timing of actual appointments scheduled. It does not capture suppressed demand or those patients told to call back or go to the Emergency Room because no appointments were available.
  - DoD's *Study on Health Care and Related Support for Children of Members of the Armed Forces* acknowledges a lack of common data evaluation systems or metrics within DoD or the Military Departments to evaluate the programs that support the physical and behavioral health care needs of children. Throughout the report, conclusions are drawn on limited and largely irrelevant data. Although the report "concludes that the MHS is meeting the needs of the children in its care, including those with special needs," we believe a more accurate conclusion is MHS has inadequate data to evaluate access to pediatric care in appropriate settings.
  - Most recently, the GAO released a report on the TRICARE Pharmacy Pilot. GAO concluded DoD has not fully monitored the pilot's performance and thus does not know whether it is working as intended. We agree with the GAO that this information would be beneficial given the expansion of the pilot requirements to all beneficiaries.
- Our Association finds it discouraging that even legislative fixes are not guarantees of MHS improvement. DoD frequently cites Section 704 from the FY15 NDAA granting them authority for provisional TRICARE coverage for emerging health care services and supplies. Yet they have

failed to exert that authority to make coverage improvements. Section 735 of the FY13 NDAA required not only a study on pediatric care for military-connected children, but also a plan to improve and continuously monitor military kids' access to care. Since the study's release in July 2014, DoD has released minimal information regarding next steps. DoD's seeming inability to move forward in a timely manner and engage in transparent communication lowers stakeholder and beneficiary confidence that improvements are possible.

Special Populations to Address with TRICARE Reform

- **Reserve Component Families:** National Guard and Reserve families are poorly served with their current TRICARE options. When activated, their families become eligible for TRICARE, but coverage and network providers may not align with their civilian plans. This leads to confusion and disruptions in care as families switch to providers in the TRICARE network. We have long advocated for more flexibility in allowing Reserve Component families to retain their employer sponsored plan when activated, perhaps by paying them a stipend to help cover premiums. We believe that TRICARE Reform does not have to be a "one size fits all" solution. TRICARE coverage should be tailored to meet the unique needs of Reserve Component families.

- **Maternity/OB:** The military has a large population of young families, so it is not surprising that inpatient procedures at military hospitals are predominantly related to pregnancy, childbirth and newborn care.[4] TRICARE Reform must not only ensure safe, high quality care for our expectant moms, it must also address the unique challenges associated with the military lifestyle.

  - **Quality**: The MHS Review noted inconsistent performance on maternal and neonatal birth outcome measures with higher rates of maternal hemorrhage and undefined neonatal trauma than the national average.

  - **Beneficiary Perceptions**: Our informal military maternity care survey revealed moms are largely satisfied with the care they receive. The most frequently cited complaint about military maternity care is the lack of provider consistency. Respondents were uncomfortable with seeing a new provider at each appointment. They feared the lack of continuity compromised the quality of their care. These concerns were even more prevalent among moms who had a previous birth experience in a civilian facility with greater provider consistency.

    > *"I would say of the three birth experiences I had, the two in civilian hospitals were my best. Not that the military facility was bad but it really does make a huge difference when you get to see the same doctor throughout the entire pregnancy. With my first at Tripler Army Medical I think I saw 9 different doctors and had never seen the one who delivered me. Just felt very impersonal*

[4] Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

and a bit frustrating having to retell situations or issues since they were not with me from the beginning." (Military spouse)

- **PCS**: The MHS must facilitate the transition of maternity care following a PCS to allow the expectant mom to follow the recommended prenatal care schedule.
  - √ Unfortunately, Direct Care policies and appointment shortages can slow the process . Our Association just talked with a young mother who PCS'd during the 28th week of her pregnancy. She had been identified as high risk by the OB at the losing duty station. Before being assigned to an OB at the new duty station, she had to see her new PCM and take a pregnancy test, despite the fact she hand carried her records to verify not only the pregnancy, but also her high risk status. Even after verifying the pregnancy, she could not get an appointment until she was 36 weeks.
  - √ Transitioning prenatal care to a TRICARE Network provider can present another set of problems. Many civilian OBs are reluctant to accept a new patient after a certain point in the pregnancy. One mom told us she PCS'd toward the end of her pregnancy. She called every OB in the TRICARE directory and nobody would take her as a patient. Finally, one office told her to just show up at the hospital when she went into labor and they would have to deliver her. This is not an acceptable level of care for military families. Expectant moms should have a resource to help them navigate obstacles in re-establishing network prenatal care.
- **Deployment**: The extraordinary stress associated with deployment must also be considered when shaping MHS maternity care.
  - √ A Fort Bragg doctor recently published a study showing women with a spouse deployed during their pregnancy are at increased risk for preterm birth and postpartum depression.[5] TRICARE Reform should consider the option of group prenatal care as it seems to have a positive effect on adverse perinatal outcomes among women with deployed spouses.
  - √ New moms we surveyed noted the importance of a wireless connection during labor and delivery when their partner is deployed. Most said their MTF lacked wireless. This technology allows the service member to experience the child's birth and support mom even though he or she is not physically present.

- **Special Needs:** Caring for a special needs family member can be difficult and draining for any family. However, the impact for military families is magnified by the unique challenges associated with military service and TRICARE policy. TRICARE Reform must ensure military special needs families are appropriately supported as they navigate multiple systems of care for their family members.

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[5] Christopher M. Tarney, et al., "Association of Spouse Deployment on Pregnancy Outcomes in a U.S. Military Population", Obstetrics & Gynecology, 2015

- **PCS**: Frequent geographic relocations are a fact of life for military families. A PCS will, by definition, disrupt the continuity of care that is so important in managing complex medical conditions. After every move, special needs families must begin a lengthy cycle of referrals, authorizations and waitlists resulting in repeated gaps in care. Military families fear these repeated treatment delays have a cumulative and permanent negative effect on their special needs family members.

- **Case Management**: Families often run into roadblocks when establishing or re-establishing care for special needs family members. When this happens, they need effective case management services to help them navigate obstacles to obtain the needed care and services. Families who contact our Association have no idea where to turn when their existing case managers fail to resolve their problems. TRICARE Reform should include an evaluation of current case management services to determine if they are meeting military families' needs.

- **ECHO**: For special needs military families, frequent relocation presents another obstacle: the inability to qualify for services through Medicaid waivers. State Medicaid programs provide assistance not covered by TRICARE: respite care, employment supports, housing, and more flexible medical coverage. Because the demand for these services far outstrips the supply, there is a lengthy waiting list to receive assistance in most states rendering them inaccessible to many military families who PCS before reaching the top of the list. TRICARE's Extended Health Care Option (ECHO) program was designed to address this imbalance by allowing families to access non-medical services not covered under TRICARE. However, the MCRMC found ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs.[6] DoD has assured our Association they are working on ECHO improvements. However, other than a policy update to cover incontinence supplies, we have heard none of the specifics. Given the importance of ECHO to special needs families, TRICARE Reform must examine how to improve ECHO benefits.

- **Transition**: The transition out of the military and into civilian life is difficult for many families, but especially so for special needs families, who immediately lose access to ECHO benefits. Families may still face long waits before being eligible for Medicaid, which leads either to gaps in treatment or financial hardship for a family trying to pay for needed care. As more service members and families transition out of the military, this problem will become more widespread. To ease the hardship for families in this situation, we recommend ECHO eligibility be extended for one year following separation to provide more time for families to obtain services in their communities.

- **Pediatric Care:** The MHS provides care for 2.4 million military kids, but because TRICARE policy is based on Medicare, a program for senior adults, its policies are not always optimal for pediatric care.

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[6] Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

- **Medical Necessity**: TRICARE's adult-based definition of medical necessity prevents some kids from getting the care they need – care that is widely accepted and practiced in the civilian health care system and MTFs. TRICARE is authorized to approve purchased care only when it is "medically or psychologically necessary and appropriate care based on reliable evidence." DoD's hierarchy of reliable evidence includes only "published research based on well controlled clinical studies, formal technology assessments, and/or published national medical organization policies/positions/reports." While beneficiaries certainly want safe and effective treatment, such tightly prescribed data for children is not always available. TRICARE's strict adherence to this adult-based standard of reliable evidence results in coverage denials for widely accepted pediatric treatments.

- **Well-Child Care**: DoD's *Study on Health Care and Related Support for Children of Members of the Armed Forces* acknowledges that TRICARE's pediatric preventative program does not conform to American Academy of Pediatrics (AAP) periodicity guidelines. TRICARE's well-child benefit ends at age 5 (at age 6 beneficiaries are covered under generally authorized clinical preventative services) whereas AAP recommends screening for physical, emotional, and developmental needs to age 21. We believe TRICARE's well-child benefit should align with AAP and Affordable Care Act guidelines, as well as Medicaid's Early and Periodic Screening Diagnostic and Treatment (EPSDT) services.

- **Habilitative Care**: Habilitation services are available only for active duty family members through the ECHO program and are subject to an annual dollar limit of $36,000. This differs from the ACA which recognizes habilitative services and devices as an essential health benefit without lifetime or annual dollar caps on care. Habilitative services, provided for a person to attain or maintain a skill for daily living, are uniquely necessary for children due to their stages of growth and development. Habilitative services should be covered as a basic health benefit as medically necessary just as rehabilitation services are covered.

- **Medical Nutrition**: TRICARE's definition of medical nutrition is too narrow and counseling and management are only covered as part of diabetic care. TRICARE is not keeping pace with current best practices nationally for specialized pediatric care.

- **Behavioral Health:** More than 14 years of war have left families with behavioral health problems and reintegration challenges that may last for many years. During a recent visit to Fort Bragg, our Association learned Womack's Child and Adolescent Behavioral Health Service refers multiple military children to residential treatment each month. It is a moral imperative to provide service members and their families with the help they need after years of enduring repeated combat deployments. We appreciate the efforts Congress and DoD have undertaken to streamline access to behavioral health care. Unfortunately, issues remain with TRICARE's current mental health coverage, including:

  - **Outdated Regulations:** Regulations for Residential Treatment Centers (RTCs) were last updated in 1995. Certification standards date to 1989 - far exceeding requirements of state licensing agencies and the three national accrediting organizations. The TRICARE standards do not result in higher quality or safer care, but do keep licensed, accredited, willing

providers out of the network by their imposition of overly burdensome standards, an institutional treatment environment, a lengthy and expensive application process, and the requirement that all children and adolescents in the same residential unit as a TRICARE beneficiary receive the same level of care, regardless of who is paying for their care or what their treatment standards may be.

– **Failure to cover current best practices:** In the private sector, there has been a shift away from TRICARE covered services (such as RTCs) to more community-based care models. Intensive outpatient treatment programs have been adopted as a standard practice in the private sector and the Veterans Health Administration. TRICARE, however, does not reimburse for this care. Instead, it requires patients to be referred to more expensive residential or inpatient care, which is often located farther from where they live.

Barriers to Improving TRICARE

Our Association is open to discussing a variety of ideas for improving how the health benefit is delivered to military families. We believe now is the time for Congress and DoD to consider a fundamental overhaul of military health care given the barriers to improving the existing TRICARE program, which include:

- The **current budgetary environment**, with an emphasis on cost-cutting and increased beneficiary contributions, is unlikely to yield TRICARE benefit enhancements. Given the pressure to reduce DoD health care spending, we find ourselves repeatedly fighting just to maintain the current benefit. For example, this year we argued against DoD's Consolidated TRICARE proposal that would increase beneficiary costs while doing nothing to enhance the benefit for military families. It is unlikely we will realize TRICARE program improvements during a period of fiscal constraint.

- **TRICARE reimbursement policies, governed by statute, are difficult to modernize.** It literally takes an Act of Congress to make substantive changes to TRICARE coverage policy. This means TRICARE is slow to cover new technologies and treatment protocols. As health care continues to evolve, military families will be left with coverage that lags their civilian counterparts.

- **The Military Health System's dual readiness and benefit provision missions make it difficult to focus on improving the beneficiary health care benefit**: The critical need to achieve readiness (i.e., a medically ready fighting force and a ready medical provider force capable of delivering health and combat-casualty care in operational environments) leads to a lack of focus on the earned health care benefit for family members, retirees, and survivors. When readiness resources are tight, sick kids lose.

- The **Military Health System's lack of a unified medical command** leads to inconsistent policy compliance by the Services. There is no measure of MTF compliance and no accountability from the MTF to the Service to DoD in regard to policy adherence. Without a

unified medical command, we are skeptical policy improvements would be consistently implemented at the local level.

- **DoD's demonstrated unwillingness to address known TRICARE problems** leads us to believe they will continue to resist program changes in the future. For instance, despite being given the authority to cover emerging technologies, TRICARE still covers only a fraction of Lab Developed Tests. This means military families are denied coverage for procedures such as noninvasive prenatal tests. DoD has also failed to address pediatric care problems identified in their own *Study on Health Care and Related Support for Children of Members of the Armed Forces.* We fear the cumulative impact of years of unresolved issues will continue to degrade the TRICARE benefit value over time.

- **Fee for service contracts prevent adoption of innovative reimbursement models**. As commercial health insurance and other government payers move toward a greater emphasis on preventative services and outcomes, TRICARE contracts are locked in to the fee for service model. DoD's most recent proposals to "simplify" TRICARE would only expand the fee for service model to the MTFs. This would continue to prevent military families from benefitting from innovations in medical care delivery.

Closing Remarks

We recognize many of the issues we have presented, viewed in isolation, may seem insignificant. However, we urge you to review this feedback with two facts in mind. First, when a military family seeks care in the MHS, their stressors only begin with the immediacy of the medical issue and stretch far beyond to the many extraordinary challenges of military life. Military families deserve a health care system that facilitates, rather than impedes, their access to care. Second, the cumulative impact of these obstacles, delays, and inconveniences magnifies the effect of each one and, in some cases, creates an insurmountable barrier to accessing necessary care.

After the past few years of pay raises below the ECI, BAH cuts, and multiple proposals to eliminate the Commissary benefit, military families are skeptical and likely to view TRICARE Reform as cuts in disguise. We stand ready to work with Congress and DoD, on behalf of military families, to achieve the stated objective of a Military Health System that works better for all beneficiaries.

DISCLOSURE FORM FOR WITNESSES
COMMITTEE ON ARMED SERVICES
U.S. HOUSE OF REPRESENTATIVES

INSTRUCTION TO WITNESSES: Rule 11, clause 2(g)(5), of the Rules of the U.S. House of Representatives for the 114th Congress requires nongovernmental witnesses appearing before House committees to include in their written statements a curriculum vitae and a disclosure of the amount and source of any federal contracts or grants (including subcontracts and subgrants), or contracts or payments originating with a foreign government, received during the current and two previous calendar years either by the witness or by an entity represented by the witness and related to the subject matter of the hearing. This form is intended to assist witnesses appearing before the House Committee on Armed Services in complying with the House rule. Please note that a copy of these statements, with appropriate redactions to protect the witness's personal privacy (including home address and phone number) will be made publicly available in electronic form not later than one day after the witness's appearance before the committee. Witnesses may list additional grants, contracts, or payments on additional sheets, if necessary.

Witness name: Joyce Wessel

Capacity in which appearing: (check one)

○ Individual

◉ Representative

If appearing in a representative capacity, name of the company, association or other entity being represented: National Military Family Association

Federal Contract or Grant Information: If you or the entity you represent before the Committee on Armed Services has contracts (including subcontracts) or grants (including subgrants) with the federal government, please provide the following information:

2015

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant

2014

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant

2013

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant

Foreign Government Contract or Payment Information: If you or the entity you represent before the Committee on Armed Services has contracts or payments originating from a foreign government, please provide the following information:

2015

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment

2014

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment

2013

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract or payment

DOCUMENTS SUBMITTED FOR THE RECORD

DECEMBER 3, 2015

Statement

Of

The National Association of Chain Drug Stores

For

United States House of Representatives
Armed Services Committee
Subcommittee on Military Personnel

Hearing on:

Stakeholder Views on Military Health Care

December 3, 2015
10:30 a.m.
2212 Rayburn House Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209

Introduction

The National Association of Chain Drug Stores (NACDS) thanks the Subcommittee for the opportunity to submit a statement for the hearing on "Stakeholder Views on Military Health Care." NACDS and the chain pharmacy industry are committed to partnering with Congress, the Department of Defense (DoD), and other stakeholders to improve the quality and affordability of healthcare services for our nation's military heroes, retirees, and their families.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 850 supplier partners and over 60 international members representing 22 countries. For more information, visit www.NACDS.org.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Through personal interactions with patients, face-to-face consultations and convenient access to preventive

care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow—in partnership with doctors, nurses, and others. As policies to control spending in the TRICARE program are considered, NACDS urges Congress to protect patient health and preserve access to local pharmacies. Attempting to reduce TRICARE costs by increasing prescription drug copay amounts and severely limiting the number of pharmacy options available to a patient comes at the expense of TRICARE beneficiary health and only serves to shift costs to other federal healthcare programs such as Medicare.

Preserving Patient Access and Choice in the TRICARE Program

Significant changes in prescription drug cost sharing for TRICARE beneficiaries have already been implemented in recent years. Most recently, the FY2015 National Defense Authorization Act (NDAA) contained additional changes to drive TRICARE beneficiaries out of local pharmacies and into the TRICARE Mail Order Program (TMOP), including requiring the use of mail order for non-formulary medications and requiring refills of non-generic prescription maintenance medications through military treatment facility pharmacies (MTFs) or TMOP. The FY2015 NDAA also implemented copay increases for prescriptions obtained at both retail and through mail order. These provisions unfairly penalize TRICARE beneficiaries who prefer to use local pharmacies. Moreover, while these provisions may appear to save money in the short run, they actually are more costly over the long term. Failure to take medications as prescribed costs the U.S. health system $290 billion annually, or 13% of total health expenditures.

Restricting beneficiary access and raising copay amounts can have the unintended effect of reducing medication adherence, resulting in decreased health outcomes and increased use of more costly medical interventions, such as physician and emergency room visits, and hospitalizations.

Policymakers have begun to recognize the vital role that local pharmacists can play in maintaining and improving medication adherence. In 2012, the Congressional Budget Office (CBO) issued a report which revised its methodology for scoring proposals related to prescription drug use and found that for each one percent increase in the number of prescriptions filled by beneficiaries there is a corresponding decrease in overall medical spending. In reviewing the original Senate version of the FY2016 NDAA, which proposed increases in prescription copays for TRICARE beneficiaries, the CBO applied this methodology and stated:

> *Thus, while the higher copayments may deter some beneficiaries from filling prescriptions they no longer need or use, those higher copayments also could cause some chronically ill beneficiaries to stop taking their medications, resulting in more doctor visits and hospitalizations. As a result, CBO estimates that the $4.9 billion in direct pharmacy savings would be offset by a $1.1 billion increase in other federal spending for medical services (mostly from Medicare).*

Congress has also recognized the importance of pharmacist-provided medication adherence by including medication therapy management (MTM) as a required offering in the Medicare Part D program. The experiences of Part D beneficiaries, as well as public and private studies, have confirmed the effectiveness of this pharmacist-provided service. A 2013 Centers for Medicare and Medicaid Services (CMS) report found that Part D MTM programs consistently and substantially improved medication adherence and quality of prescribing for evidence-based medications for beneficiaries with congestive heart failure, COPD, and diabetes. The study also found significant reductions in hospital costs, particularly when a comprehensive medication review was utilized. This included savings of nearly $400 to $525 in lower overall hospitalization costs for beneficiaries with diabetes and congestive heart failure.

A study of published research on medication adherence conducted by Avalere in 2013 concluded that the evidence largely shows that patients who are adherent to their medications have more favorable health outcomes such as reduced mortality and use fewer healthcare services (especially hospital readmissions and ER visits). Such patients are thus cheaper to treat overall, relative to non-adherent patients. The study found that there was an even wider range of cost offsets for patients demonstrating adherence to medications across particular chronic conditions. Thus, we urge Congress to protect the health of TRICARE beneficiaries by refusing to impose additional prescription drug copay increases in the FY2016 NDAA.

In addition to refusing to impose additional copay increases on TRICARE beneficiairies, NACDS urges Congress to take steps to preserve access to the services beneficiaries need by establishing long-term solutions that will not harm patient care, such as creating acquisition cost parity across all treatment locations, including retail, MTFs, and mail order. Presently, retail pharmacies that serve TRICARE beneficiaries have to pay much more for prescription drugs than mail order and military pharmacies. Creating acquisition cost parity will lead to greater savings for the DoD while at the same time ensure beneficiaries have access to the care and services they need. We believe that a provision for a pilot program (such as that included in the original House verion of the FY2016 NDAA (H.R. 1735)) could potentially lead to long-term solutions for the TRICARE pharmacy program. Such a pilot would help ensure that retail pharmacy can continue to provide access to quality care and the important medication counseling services that only retail pharmacy can provide.

Conclusion

The recent changes in TRICARE prescription drug policies are placing even greater financial burdens on TRICARE beneficiaries, potentially increasing medical-related program costs, and jeopardizing beneficiary health through decreased medication adherence. We support sensible cost savings initiatives, and support TRICARE beneficiaries in maintaining access to their prescription medications at their local pharmacies. Doing so would decrease overall program costs while also preserving beneficiaries' health and wellness.

Thank you for the opportunity to share our views. We look forward to working with you on policies that control costs and preserve access to local pharmacies.

DoD Health Costs Are NOT Growing, Let Alone "Out of Control" ($B)

	FY10	FY11	FY12	FY13	FY14	FY15*	FY16*
TFL Deposit	10.8	11.0	10.9	8.5	7.4	7.0	6.6
Purchased Care	14.3	14.8	15.4	14.7	14.8	14.8	
Total Unified Med. Pgm.	49.9	51.6	52.9	48.4	49.3	48.5	

Source: Department of Defense Reports to Congress/ FY16 PB

* FY15 data projected in Jan 15 DoD report; FY16 from FY16 budget submit

MOAA™ Military Officers Association of America

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

DECEMBER 3, 2015

RESPONSES TO QUESTIONS SUBMITTED BY MR. MacARTHUR

Mr. BOUSUM. Consolidation of the military health system. In my opinion, a medic is a medic, no matter what color the uniform. Consolidating the military health system into one command makes sense, might provide budgetary efficiencies, and would probably be applauded by military members and families alike. And I agree with your conclusion about the responsibilities of the surgeons general, although I am not convinced that it takes a three star general officer to oversee training, equipping, or supporting. Broad authority. In my opinion, flexibility in TRICARE contracts allows for dynamic changes and not having to wait five to eight contract years to react. Military centers. In my opinion, consolidating facilities to provide regional coverage for larger concentrations of military troops and families, while extending the reach into the private sector for dispersed beneficiariesreservists, or specialty care is prudent. Inclusion of VA and other federal medical facilities also makes sense—a whole of government approach instead of a parochial Defense Department paradigm. Military health reserve system. In my opinion, allowing providers to contractually affiliate with the Department without having a military obligation as an added pool of resources may provide an outlet for patriotic service to these providers, or in some cases, allow continued service for those providers with previous military or federal service. Modeled after the Individual Mobilization Augmentee (IMA) concept (without the military obligation), rotations of civilian providers will become a valuable manpower and educational resource for the military treatment facility. A concern may be in proper compensation for their service commitment based on their specialty (nurse, doctor, or specialist). [See page 13.]

Admiral RYAN. MOAA has long supported a unified medical command, in the belief that there can be no system efficiency without a single point of responsibility for the health care budget, policy and execution. As for giving the command "broad authority to change plans and delivery within broad cost constraints", MOAA would be reluctant to agree to such a general concept without additional specifics and guidelines. One thing we believe would be essential would be to establish a joint working group, to include reasonable beneficiary organization participation, to develop, evaluate, and implement proposed changes. This is exactly what was done in the implementation of TRICARE For Life. The TRICARE Management Authority (predecessor to the Defense Health Agency) provided the working group head and a wide variety of agency participants who met weekly with a select group of beneficiary association representatives to exchange perspectives, identify problems, and propose and evaluate potential solutions. That process worked exceptionally well, with positive outcomes (indeed, better than expected outcomes) for both the Defense Department and the beneficiaries. The military health reserve system could pose the greatest challenges, simply because of the general shortage of providers. Without more specificity concerning this proposal, it's difficult to provide substantive comments. [See page 13.]

Ms. RAEZER. Our Association supports a unified medical command in the hope it would lead to greater policy consistency across the MHS. Currently, policy adherence varies across the Services and individual MTFs. This makes it hard for military families to navigate the system as they encounter new rules, policies and procedures at each new duty station.

We are open to the idea of concentrating military medical assets in areas with significant military populations. However, we would want to be assured that:

- Military medical facilities outside of the major medical centers (e.g., outpatient clinics on remote installations) would provide high quality care on par with that received by families at the major military medical centers
- There are adequate civilian medical resources in the surrounding community to meet military family needs—e.g., are there enough civilian providers in Junction City, Kansas (population 25,388) to provide for the medical needs of Fort Riley families (family member population 24,678)?
- Families living near military medical centers would continue to have options for civilian care (e.g., TRICARE Standard)—we would not want military families to be "trapped" in an underperforming direct care system should they encounter problems with the MTF Ensuring a vibrant military health reserve system uti-

lizing health care professionals in the private sector who agree to be on reserve status and go wherever whenever seems like a win from the military perspective. However, we wonder what would happen to civilian medical facility staffing and civilian health care should a large and/or sudden mobilization of health care reservists occur. [See page 13.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

DECEMBER 3, 2015

QUESTIONS SUBMITTED BY MR. WALZ

Mr. WALZ. One of the reasons the commission recommended changing the military health care system is because military families and retirees told them they wanted choices. Is this the message you hear from your organization members? If your members do want more choice, is the Commission's recommendation what the members of your organization want? Do they believe choice will improve medical care? What are your concerns with the recommended change? Are there ways to improve the TRICARE program instead? If so how?

Mr. BOUSUM. The majority of the members of the Enlisted Association of the National Guard of the United States (EANGUS) do not believe that TRICARE is broken. When surveyed, EANGUS members are satisfied with the care they receive when the system works. Many members of the National Guard struggle with continuity of care when activated to Title 10 and receive health care coverage under TRICARE Prime. EANGUS members are interested in the findings of the congressionally mandated Department of Defense assessment to review recommendations made by the Military Compensation and Retirement Modernization Commission to consolidate duty statuses, section 515 of The National Defense Authorizations Act for Fiscal Year 2016 (Public Law 114–92). As a general principle, EANGUS members believe that health care coverage should not be linked to duty status and that all members of the National Guard should be able to stay on the same health care plan regardless of orders.

Mr. WALZ. What are the specific challenges regarding Reserve Component forces accessing care?

Mr. BOUSUM. Members of the Enlisted Association of the National Guard of the United States (EANGUS) recognize that some military service organizations are apprehensive about any Congressional or Department of Defense action to make changes to TRICARE. However, members of the National Guard are often located in rural areas. Access to quality health care is limited. Access to specialized care can be even harder to find, and where it is found, the quality or knowledge base of the providers are limited—it's not the best care; it's only the best of the available care, and this can make a difference in treatment of certain conditions, like autism and down syndrome. Since most members of the National Guard do not live on, or near, major military installations, EANGUS members believe that the contract requirement for a pre-authorization (i.e. referral) to use urgent care clinics should be eliminated. Unlike hospital emergency rooms, urgent care clinics have faster response times and less cost. In rural areas that don't have urgent care clinics, a simpler process is needed to eliminate the need for Reservists to pay upfront costs of emergency room visits and have to seek reimbursement from TRICARE. TRICARE should effect payment directly to the hospital before exacting co-payments from the member.

Mr. WALZ. What aspect of health care matters most to your members (ie. Continuity of provider, low cost, flexible appointment scheduling, etc.)?

Mr. BOUSUM. Members of the Enlisted Association of the National Guard of the United States (EANGUS) care most about continuity of provider. Members of the National Guard and their family members often lose access to their primary care physicians when activated to Title 10 and receive health care coverage under TRICARE Prime. Too few primary care physicians accept TRICARE which is why members and their families are forced to change doctors. EANGUS staff recognize that the Department of Defense has increased use of 12304b orders to activate members of the Guard. 12340b orders provide health care coverage only during deployment, not 90 days before and after deployment as with all other duty status orders. The overuse of 12304b orders makes it so that the family members of the members of the National Guard are left to navigate finding a health care provider without the servicemember to assist. As a result, forward deployed members of the National Guard are concerned for their family members' stressful situation, particularly in the cases were family members are injured or ill, and focus less on the mission. Readiness suffers as a result.

Mr. WALZ. One of the reasons the commission recommended changing the military health care system is because military families and retirees told them they wanted choices. Is this the message you hear from your organization members?

Admiral RYAN. The message we hear from our members is that those who are dissatisfied with their access to care want another choice that will get them access. It's not that they necessarily want multiple options to pick from, but that they need to know they and their families can get access to quality care on a timely basis. The issue here is mostly with TRICARE Prime enrollees. And among that group, the most dissatisfied are the ones who are enrolled in military treatment facilities. That's where most of the excessive waiting times occur. They want DOD to adhere to its own access standards, and if they can't be seen in the military facilities within those standards, they want and need to be referred to a civilian network provider within DOD's timeliness standards.

Mr. WALZ. If your members do want more choice, is the Commission's recommendation what the members of your organization want?

Admiral RYAN. Many members of the Guard and Reserve community would see the Commission's recommendation as an improvement over the widely varying TRICARE benefits now offered to them at various stages of their lives. It would also provide better continuity of care than TRICARE now provides when transitioning to and from active-duty callups, transitioning from Selected Reserve to gray area reserve status and from gray area to retired pay status.

That said, military technicians—who now are enrolled in FEHBP—have been frustrated for years that they are compelled to pay high-cost FEHBP premiums and are not authorized to enroll in the much lower-cost TRICARE Reserve Select (TRS) available to other Reserve component members. So any new option involving an FEHBP-style plan should include a significantly more favorable federal subsidy.

Our survey results did not show any particular indication of interest in the Commission's plan from the active-duty or retired-pay-eligible population. They simply want DOD to meet its own stated standards of timely access, and a strong majority expressed the believe that they shouldn't have to be charged more money to get that access.

Mr. WALZ. Do they believe choice will improve medical care?

Admiral RYAN. Our survey of 30,000 beneficiaries showed the significant majority are satisfied with the quality of their medical care, once they get access to it. Where they are currently having access problems (i.e., mainly in TRICARE Prime and mainly in military treatment facilities), they believe they should have an alternative option to receive that care in the civilian community, and that improved access would effectively mean improved care.

Mr. WALZ. What are your concerns with the recommended change?

Admiral RYAN. MOAA believes the MCRMC-recommended change to scrap TRICARE and implement an FEHBP-style insurance system through the Office of Personnel Management is unnecessary to achieve improved care access, and almost certainly would carry its own unintended consequences.

First, it would turn over DOD's employer responsibility for this unique population over to a civilian personnel agency where the military population would, for all intents and purposes, be treated as civilians. DOD imposes extraordinary hardships on this population through frequent relocations, combat deployments, family separations, and more that require unique consideration from the military employer.

Second, MOAA feels strongly that the military health care benefit is earned by arduous military service, and that the same benefit and coverage should apply to all, as it does under TRICARE. MOAA believes it would be inappropriate to implement an FEHBP-style system where getting better coverage depends on one's income level. If choice means having tiered healthcare options where higher-ranking people can buy better coverage than lower-ranking people can afford, that's not the kind of choice we think is appropriate for the military healthcare system.

Third, imposing significantly higher cost shares on uniformed service beneficiaries—nearly as high as those associated with FEHBP—is an inherent part of the MCRMC proposal. MOAA agrees with the 70+% of our survey recipients who said they should not have to be charged more to get access to quality care.

Mr. WALZ. Are there ways to improve the TRICARE program instead? If so how?

Admiral RYAN. There are many ways to improve TRICARE rather than throwing it out and imposing a civilian-style insurance system. MOAA's statement for the record lists more than a dozen specific recommendations, some of which include:

Provider Payments Should Reward Quality Care. MOAA concurs with the MCRMC belief that both Medicare and TRICARE need to move to payment systems and treatment bundles that reward providers for meeting standards of quality and healthy outcomes rather than simply paying them for the number of patient encounters they have.

Focus on the Causes of Problems, Not the Symptoms. If the real reason behind a cost increase is program inefficiency, DOD or service decision-making, the exigencies of national conflict, or arbitrary hiring freezes or other conditions caused by sequestration, that is not any fault of the beneficiary, and raising beneficiary fees is not the appropriate response. The solution should be to focus on addressing those problems rather than making beneficiaries pay more simply because it's budgetarily or programatically easier.

Consider Implementing a MCRMC-Style Insurance System for the Guard/Reserve (G/R). The current hodgepodge of makeshift healthcare programs for the under-60 G/R community makes it one program where it actually is possible to start over from scratch. The subsidy levels envisioned by the MCRMC would provide a better deal for many G/R beneficiaries than they have today—especially "gray area" retirees and those drawing retired pay before age 60 because of deployment credit, who now have no subsidized care. Selected Reservists who prefer to keep family coverage through an employer should be allowed to retain that coverage upon activation, with the premium paid or subsidized by DOD.

Consider Establishing a Joint HASC/HVAC Subcommittee on DOD/VA Transition. If the HASC and HVAC can cooperate in a joint subcommittee—even a temporary one—to devise joint policy, program, and budget solutions on such issues as a joint interoperable electronic healthcare record, there is a far greater chance this joint resolve can be reflected in DOD and VA programs.

Require DOD to Implement the MCRMC Recommendation to Expressly Allocate Readiness and Benefit Costs. A thoughtful and rational dialogue on beneficiary cost sharing absolutely requires an agreement on exactly which expenses are a cost of doing national defense business vs. a benefit value delivered primarily for the sake of the beneficiaries.

Seek Some Form of Agreement on the Premium Value of a Service Career. This issue is at the crux of every disagreement between DOD and its beneficiaries over how much the latter should be expected to pay for their healthcare benefits, and why. The legislative history of CHAMPUS, TRICARE Prime, and TRICARE For Life allows at least some starting inferences on this thorny topic. A primary reason for beneficiary outrage at proposals for steep fee increases are current-year assertions that military beneficiaries are somehow undeserving of current benefit levels or that their benefits should be more like civilians'. Such arguments fly directly in the face of what the military retirees were told in order to induce them to stay for a career in uniform and contradict the long history of military healthcare programs provided at modest cost in tacit, if not explicit, recognition of the extraordinary, in-kind premiums career service members and families pre-pay in terms of arduous service and sacrifice over multiple decades.

Test the Concept of Unified Budget and Oversight Authority in MSMs. The Defense Health Agency is in an excellent position to oversee establishment of pilot project to test the concept of a single budgetary/operations oversight authority in at least two of the multi-service market areas (MSMs). Such a test should offer some insight into the feasibility and potential savings associated with unified vs. multiple-service oversight of budget, appointing/referral, and other operational and support programs.

Increase Patient Visits Per Provider in MTFs. Assess and change support staffing and other factors that lead military providers to see significantly fewer patients per week than their civilian counterparts. If, as defense health officials often assert, it is more cost-effective to see beneficiaries in MTFs, it should be worthwhile investing in whatever is necessary to promote more comparable numbers of patient visits per military provider. This should also substantively ease the appointing and referral problems reported by Prime enrollees.

Require Leadership Oversight/Training on Appointment Timeliness. It is beyond understanding that the TRICARE Prime appointment process apparently ignores DOD access standards on a routine basis at many facilities. This is in substantial measure a leadership problem, in MOAA's view. It should be made clear to MTF commanders and others in leadership positions over appointing offices that it is their responsibility to monitor appointment timeliness and take necessary corrective action when standards are not being met.

Focus Managed-Care Outreach Efforts on High-Use/Cost Beneficiaries. Under current rules, priority is given in MTFs to active duty members and families, TRICARE Prime enrollees, other under-65 beneficiaries, and TFL-eligibles, in that order. MOAA believes much greater priority for managed care or case management should be given to beneficiaries with a history of high-cost care and those with chronic conditions that have the greatest potential for incurring high costs in the future. For example, a TRICARE Reserve Select family with multiple children requiring complex care would have a high incentive to be seen in a managed-care environment,

but is not eligible for Prime enrollment. Similarly, certain TFL-eligibles or other non-Prime enrollees may have chronic conditions posing long-term cost risks far higher than a majority of Prime enrollees. These high-cost care users are readily identifiable from existing cost records. Surely there are savings to be realized by shifting to include a care-cost factor and creating outreach programs to bring such families into a more active managed-care or case management system.

Pursue Public-Private Partnerships to Reduce TFL and Other Costs. Several innovative cost-saving programs around the country have potential application to military beneficiaries and facilities. MOAA would encourage DOD to investigate the potential for partnerships with civilian contractors to establish TFL-specific Medicare Advantage programs in locations where there are large retiree populations and significant military medical facilities. The partnership agreement would establish the military facility as the preferred provider for certain surgeries or other conditions to help sustain military providers' readiness skill levels. These programs should include outreach efforts to identify high-cost users and those with chronic conditions to bring them into a case management environment. This system would reduce the contractor's cost and allow addition of other program elements (e.g., vision or dental) to incentivize TFL-eligibles' participation. The military facility, in turn, could be reimbursed at some level through the TFL trust fund. This would seem to have a winning potential for the government, DOD, contractors, and beneficiaries alike. Anthem's Care More program is an exceptional and proven model, and Humana and United Healthcare offer similar programs. The MCRMC staff cited another successful model in the Las Vegas area.

Adopt pediatric-centered payment policies that let providers to make optimal care decisions for children. Because TRICARE payment systems are based on Medicare systems designed for older people, the systems often don't work for pediatric care and don't properly reimburse providers for needed and delivered care. Reimbursement should follow appropriate care, not form the basis for care decisions. In situations where emerging technology is clearly providing compelling options for patients and families, TRICARE should allow payment to follow the needs of the patient instead of driving the type of care the patient receives. When there is a known issue with translation of policy or payment from Medicare to pediatrics, there must be an efficient process for resolving the difference. Continued innovation and research will ensure this issue is at the forefront in the coming years, with genetic testing, gene therapy, and individualized medicine as examples of prevention, intervention, and treatments that will need to be covered and reimbursed appropriately.

Do More to Connect TRICARE Standard Beneficiaries with Providers. One way to improve TRICARE Standard beneficiaries' access to providers is to educate them that they are not limited to seeing network providers. It's preferable if they do, because that saves money for both DOD and the beneficiary. But if a beneficiary is having trouble getting an appointment with a network provider, there should be a method to put them in touch with a non-network provider who is willing to accept non-discounted rates payable under Standard.

Ease the Cost Burden on TRICARE Young Adult (TYA) Beneficiaries. Unlike civilian insurance programs, which spread the cost of adding children under 26 by raising family premiums slightly across the board, TYA requires each TYA-eligible (or the parents) to pay the full individual premium cost of his or her care. With the 26% (TRICARE Standard) and 47% (Prime) premium increase for 2016, the $2,500 to nearly $3,700 annual cost of this program is particularly onerous, especially for families with more than one qualifying child. MOAA encourages the Subcommittee to explore alternative ways to spread this cost across the entire population, in hopes that this could be done via a relatively inconsequential increase. As currently implemented, the high individual cost of the coverage deters many beneficiaries from using it, which defeats the purpose of the program.

Mr. WALZ. During the height of the wars in Iraq and Afghanistan, many retirees were transferred from military treatment facility primary care providers to civilian treatment facilities. Are there still retirees who would prefer to come back to military treatment facilities, but cannot because of access issues?

Admiral RYAN. We believe there likely are some who fall in that category, but not as many as some would expect. Among the 3,000 TRICARE Prime beneficiaries (the significant majority of whom were retired) who responded to MOAA's survey, 17% considered being seen in the military facility as being "extremely important" and another 21% thought it was "fairly important". But even larger numbers reported that they were, in fact, being seen in the military facility. While there are some who would prefer to be seen there, but are not, it would appear from MOAA's survey sample that most who prefer to be seen in a military facility are being afforded that opportunity. We also hear from many retired members and family members that,

once they start being seen in the civilian community, they are content to remain there.

Mr. WALZ. What aspect of health care matters most to your members (ie. Continuity of provider, low cost, flexible appointment scheduling, etc.)?

Admiral RYAN. Our survey found a considerable amount of consistency that access (which we took to mean ease of making appointments and referrals) was important across all ages and categories (TRICARE For Life, TRICARE Prime, and TRICARE Standard. But all categories and ages also reported a distinct belief that it would not be reasonable to have to pay more in fees.

Some specific survey results are summarized in the chart below:

	TFL	Prime	Standard
How important is picking your provider? (% answering ''extremely'' or ''fairly'' important)	99%	93%	99%
How important is guaranteed access? (% answering ''extremely'' or ''fairly'' important)	88%	91%	81%
Are you willing to pay more for priority access?			
a. Definitely	3%	4%	3%
b. Probably	20%	22%	16%
c. Not sure	42%	37%	41%
d. Probably not	24%	23%	29%
e. Definitely not	11%	13%	11%
Do you think it's reasonable to ask TRICARE beneficiaries to pay more?			
f. Definitely	2%	4%	2%
g. Probably	12%	14%	12%
h. Not sure	10%	8%	8%
i. Probably not	20%	19%	22%
j. Definitely not	54%	54%	56%

Mr. WALZ. One of the reasons the commission recommended changing the military health care system is because military families and retirees told them they wanted choices. Is this the message you hear from your organization members? If your members do want more choice, is the Commission's recommendation what the members of your organization want? Do they believe choice will improve medical care? What are your concerns with the recommended change? Are there ways to improve the TRICARE program instead? If so how?

Ms. RAEZER. Choice is most important to military families who are dissatisfied with the quality of care they currently receive through TRICARE, as well as the patient experience and access to care. The top priority for military families is improved access to care. Greater choice, as one possible way to improve access, is therefore important to families. There are two main types of access challenges with the Military Health System (MHS) that must be addressed with MHS Reform:

- Direct Care System Appointment Challenges: Approximately 80% of military families are TRICARE Prime enrollees and rely on military hospitals and clinics for most of their health care. Too often, military families have problems getting appointments at military treatment facilities (MTFs) and can't access the right care, at the right time, with the right provider.
- TRICARE and MTF Policies: Numerous TRICARE referral and coverage policies limit or delay military family access to care recommended by their medical providers. TRICARE coverage policy, based on Medicare, isn't optimal for families with young children. It has also failed to keep up with technological innovations and evolving standards of care, leaving military families with substandard coverage relative to civilian plans and other government payers.

While military families don't currently report widespread access challenges within the TRICARE private-sector provider network, our Association fears attempts to reduce purchased care spending will result in erosion of network provider access and questionable coverage policies. Provider reimbursement rates will continue to decline, resulting in fewer providers participating in the TRICARE network. Alternatively, providers might further limit the number of TRICARE patients they will see due to low reimbursement rates. The result will be diminished access to care for military families. As dissatisfaction with access, quality, or the patient experience increases, so will the desire for more health care options increase.

From our Association's perspective, the top priority for MHS Reform is addressing the variety of access challenges military families currently face as well as future threats to health care access posed by continued fiscal constraints on the MHS.

Will the MCRMC proposal address military family issues with the MHS? Our Association believes the Commission's proposal has the potential to provide military families with a more robust and valuable health care benefit than they have today. Offering military families a selection of high quality commercial health plans could provide them with better access to high quality care, a more comprehensive set of benefits, and the ability to tailor coverage options based on individual family needs.

We also believe the Commission's proposal would address health care coverage problems the Reserve Component faces. Switching to TRICARE when the service member is activated can result in disruptions in care for the National Guard or reserve member's family, while maintaining the service member's employer sponsored health insurance in order to provide continuity of care can lead to significant out-of-pocket costs. We have long advocated giving National Guard and Reserve members more flexibility to maintain employer-sponsored coverage for their families during activation and believe the Commission's plan is one way to achieve this.

What are NMFA's concerns regarding the MCRMC proposal? While our Association supports, in principle, the concept of moving military families to high quality commercial health plans, the Commission's proposal raises several questions and areas of concern, including:

- Potential for increased out-of-pocket costs. Some segments of the military family community will incur significantly higher out-of-pocket costs versus the current system. TRICARE Choice's catastrophic cap is unspecified. Details are sparse on the Chronic/Catastrophic Program and we are not convinced it would sufficiently insulate special needs families from high health care costs. We are skeptical the Basic Allowance for Health Care (BAHC) formula would adequately cover costs for high quality plans for all types of families. Finally, working age retiree premiums and out-of-pocket expenses will be significantly higher versus current TRICARE retiree costs.
- Beneficiary education and financial planning guidance needed. TRICARE Choice would require an unprecedented level of beneficiary communication and education to help families choose the right plans. Medical bills are highly variable in amount and timing, requiring more sophisticated budgeting skills and additional financial planning training.
- Does not address access and quality issues within the MTFs. While we see merit to the Commission's proposal, it is important to note that it does nothing to address beneficiary complaints regarding the direct care system other than allowing dissatisfied beneficiaries to seek care somewhere else in the hope competition will incentivize the MTFs to improve.
- Potential impact on military medical readiness. Even though the MTFs will remain an integral component of military family health care delivery under the Commission's proposal, the report contains few details on the potential effect the plan might have on the direct care system. There is no analysis of potential impact on MTF caseload or consequences of loss of beneficiary caseload on military medical personnel readiness.

Are there ways to improve the TRICARE program instead? We are skeptical the existing MHS construct can be tweaked to simultaneously achieve cost savings and significant improvements to access, quality of care, and the patient experience particularly given the barriers to improving the MHS, including:

- The current budgetary environment. It is unlikely that we will realize TRICARE program improvements during a period of fiscal constraint.
- Entrenched TRICARE reimbursement policies, governed by statute, which are difficult to modernize. It literally takes an Act of Congress to make substantive changes to TRICARE coverage policy. While today's MHS Reform initiative might fix current gaps in coverage, new gaps would likely emerge as medicine evolves in the future.
- The Military Health System's dual readiness and benefit provision missions make it difficult to focus on improving the beneficiary health care benefit.
- Inconsistent policy compliance by the Services and MTFs. There is no measure of MTF compliance and no accountability from the MTF to the Service to DOD in regard to policy adherence. Without a unified medical command and a cultural change emphasizing policy adherence, we are skeptical that policy improvements would be consistently implemented at the local level.
- DOD's demonstrated unwillingness to address known TRICARE problems leads us to believe they will continue to resist program changes in the future.
- Fee for service contracts prevent adoption of innovative reimbursement models. As commercial health insurance and other government payers move toward a

greater emphasis on preventative services and outcomes, TRICARE contracts are locked in to the fee for service model. This prevents military families from benefitting from innovations in medical care delivery.

Given the barriers to improving TRICARE and the MHS, we believe now is the time for Congress and DOD to consider a fundamental overhaul of military health care.

Mr. WALZ. What aspect of health care matters most to your members (ie. Continuity of provider, low cost, flexible appointment scheduling, etc.)?

Ms. RAEZER. Given the current state of the Military Health System, military families' primary concern is access to care. If you can't get an appointment at the MTF, all other factors are largely irrelevant. Once basic access to care problems are addressed, military families will likely be more focused on improving other aspects of care. They recognize many aspects of the current system need improvement, but their main focus today is improving access.