T H E M I L I T A R Y C O A L I T I O N

201 North Washington Street
Alexandria, Virginia 22314
(703) 838-8113

STATEMENT OF

THE MILITARY COALITION

to the

SUBCOMMITTEE ON MILITARY PERSONNEL, HOUSE ARMED SERVICES COMMITTEE

March 29, 2006

Presented by

VADM Norb Ryan, Jr. (USN-Ret)
President, Military Officers Association of America

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE. On behalf of The Military Coalition, a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning issues affecting the uniformed services community. This testimony provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

- Air Force Association
- Air Force Sergeants Association
- Air Force Women Officers Associated
- American Logistics Association
- AMVETS (American Veterans)
- Army Aviation Association of America
- Association of Military Surgeons of the United States
- Association of the United States Army
- Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
- Commissioned Officers Association of the U.S. Public Health Service, Inc.
- Enlisted Association of the National Guard of the United States
- Fleet Reserve Association
- Gold Star Wives of America, Inc.
- Jewish War Veterans of the United States of America
- Marine Corps League
- Marine Corps Reserve Association
- Military Chaplains Association of the United States of America
- Military Officers Association of America
- Military Order of the Purple Heart
- National Association for Uniformed Services
- National Guard Association of the United States
- National Military Family Association
- National Order of Battlefield Commissions
- Naval Enlisted Reserve Association
- Naval Reserve Association
- Non Commissioned Officers Association
- Reserve Enlisted Association
- Society of Medical Consultants to the Armed Forces
- The Retired Enlisted Association
- United Armed Forces Association
- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- Veterans of Foreign Wars of the United States
- Veterans' Widows International Network

Neither the Military Officers Association of America nor The Military Coalition, Inc., receives any grants or contracts from the federal government.

EXECUTIVE SUMMARY
RECOMMENDATIONS OF THE MILITARY COALITION

Defense Health Program Funding - The Military Coalition urges the Subcommittee to ensure continued full funding for Defense Health Program needs.

Protecting Beneficiaries Against Cost-Shifting - The Coalition recommends against implementing any increases in health fees for uniformed services beneficiaries this year. TMC supports H.R. 4949, offered by Rep. Edwards and Jones. We believe strongly that the principles espoused in this bill should be established in law, and urge the Subcommittee to include its provisions in the FY2007 Defense Authorization Act. The Coalition believes strongly that America can afford to and must pay for both weapons and military health care. The Coalition recommends strongly against establishment of any TRICARE Standard enrollment fee. The Coalition urges the Subcommittee to require DoD to pursue greater efforts to improve TRICARE and find more effective and appropriate ways to make TRICARE more cost-efficient without seeking to "tax" beneficiaries and make unrealistic budget assumptions. (See separate NMFA testimony concerning TRICARE Prime premiums and Standard deductibles.)

TRICARE Standard Improvements - The Coalition urges the Subcommittee to establish requirements for TRICARE Standard beneficiary surveys and a definition of what level of provider participation shall be deemed to require positive action to increase it. The Coalition urges the Subcommittee to direct DoD to eliminate TRICARE-unique administrative requirements that deter provider participation and thus contribute to denying beneficiaries access to care. The Coalition recommends requiring DoD to work with the State Medical Associations and the Centers for Medicare and Medicaid Services to initiate an appropriate information program for providers who will not see TRICARE patients, highlighting specific improvements in claims/payment processing timeliness.

TRICARE Reimbursement Rates - The Coalition urges the Subcommittee to exert what influence it can to persuade the Ways and Means/Finance Committees to reform the Medicare/TRICARE statutory payment formula. To the extent the Medicare rate freeze continues, we urge the Subcommittee to encourage the Defense Department to use its reimbursement rate adjustment authority as needed to sustain provider acceptance. The Coalition urges the Subcommittee to require a Comptroller General report on the relative propensity of physicians to participate in Medicare vs. TRICARE, and the likely effect on such relative participation of a further freeze in Medicare/TRICARE physician payments.

TRICARE vs. Medicare Coverage - The Coalition urges the Subcommittee to align TRICARE coverage to at least match that offered by Medicare in every area.

TRICARE Reserve Select - The Coalition strongly recommends increasing subsidy levels for TRICARE coverage for drilling Guard/Reserve members not yet mobilized and having one set rate for members of the Guard and Reserve who continue to be drilling members. At the very least, subsidies should be increased for members who do not have access to employer-sponsored health coverage. The Coalition recommends developing a cost-effective option to have DoD subsidize premiums for member's private insurance as an alternative to TRICARE Reserve Select coverage. We recommend a GAO report to identify the level of payment that would represent a cost-effective option for the government.

USERRA protections. The Coalition recommends further strengthening rights under USERRA to permit Reserve Component members to retain employer-sponsored insurance if coverage is terminated due to TRICARE benefits provided 90 days prior to mobilization.

Reserve Dental Coverage. The Coalition supports extending military dental coverage to Reservists for 180 days post mobilization (during TAMP), unless the individual's dental readiness is restored to T-2 condition before demobilization.

Restoration of TRICARE For Widows - The Coalition recommends restoration of TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

TRICARE Prime Remote - The Coalition recommends removal of the requirement for the family members to reside with the active duty member to qualify for the TRICARE Prime Remote Program.

BRAC, Re-Basing and Relocation - The Coalition urges Congress to codify the requirement to provide TRICARE Prime in BRAC-affected areas and ensure, via a report from DoD, that adequate health resources are available to provide care within access standards for those affected by Re-Basing.

Mental Health - The Coalition strongly urges Congress to closely monitor DoD and VA implementation of much-needed Post Traumatic Stress Disorder awareness and treatment programs.

Pharmacy Copayments - The Coalition recommends no changes to the copayment rates until all medications are available in the mail order program and limiting any future pharmacy copayment increases to the lesser of the percentage increase in basic pay or retired pay, rounded down to the next lower dollar. The Coalition recommends eliminating beneficiary copayments in the mail-order pharmacy system for generic and brand name medications to incentivize use of this lowest-cost venue and generate substantial cost savings.

Expansion of "Third Tier" Formulary - The Coalition urges the Subcommittee to monitor DoD's consideration of Beneficiary Advisory Panel input in future uniform formulary decisions and reassert its intent that the Panel should have a substantive role in the process, including access to meaningful data on relative cost of drugs in each affected class. The Coalition recommends a GAO review of the Uniform Formulary process to determine whether actions taken thus far have realized the projected savings.

TRICARE Prime Referral and Authorization System - The Coalition recommends that Congress require a cost analysis report concerning the referral process within DoD and reliance on Civilian Network Providers within an MTF's Prime Service Area.

DoD-VA Transition – The Coalition urges the Committee to direct and oversee a concerted "Manhattan Project" effort to ensure full and timely implementation of seamless transition activities, a bi-directional electronic medical record (EMR), enhanced post-deployment health assessments, and one-stop physical at time of discharge.

Tax Law Changes - The Coalition urges all Armed Services Committee members to press the Ways and Means and Finance Committees to approve legislation to allow all beneficiaries to pay TRICARE-related insurance premiums in pre-tax dollars, to include TRICARE Prime enrollment fees and premiums for TRICARE Standard supplements, long-term care insurance, and TRICARE dental premiums.

Dental Issues - The Coalition recommends allowing TRICARE-eligible former spouses to participate in the TRICARE Retiree Dental Plan. The Coalition recommends a GAO study of the viability of subsidizing the retiree dental program, including the likely long-term impact of different subsidy levels on retiree participation and dental health.

Guard/Reserve Health Care – The Coalition strongly recommends increasing subsidy levels for TRICARE coverage for drilling Guard/Reserve members not yet mobilized and having one set rate for members of the Guard and Reserve who continue to be drilling members. The Coalition supports further strengthening rights under USERRA to permit Reserve Component members to retain employer-sponsored insurance if coverage is terminated due to TRICARE benefits provided 90 days prior to mobilization. The Coalition supports extending military dental coverage to Reservists for 180 days post mobilization (during TAMP), unless the individual's dental readiness is restored to T-2 condition before demobilization.

OVERVIEW

Mr. Chairman, The Military Coalition (TMC) thanks you and the entire Subcommittee for your continued, unwavering support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services, to include their families and survivors. The Subcommittee's work has generated significant improvements in military end strength, pay, health care, survivor benefits, and disabled retiree programs.

Six years ago, the Joint Chiefs of Staff advised Congress of the need to repeal REDUX, fix pay raises, and correct inequities in retiree health care, all of which were having a negative retention impact on serving members. You heard the call, and made those fixes and others.

Now, unfortunately, we hear increasing complaints about the cost of some of those improvements from leaders who seem to have forgotten why they were enacted.

Some in the Administration argue for a return to past practices of capping military pay raises below private sector wage growth. Service leaders are planning force reductions even as Congress has authorized end strength increases to meet frenetic rotation requirements that have no end in sight. Defense officials decry the cost of retiree health care and seek to impose four-figure increases in health care fees charged to those who spent a career thinking they were paying their premiums in specie of personal and family sacrifice.

Some contend that support for military personnel programs inevitably faces a periodic cycle of ebb and flow, and that the benefit improvements of the last 6 years must now yield to several years of cutbacks.

The Military Coalition continues to look to this Subcommittee for leadership to ensure the country doesn't return to the penny-wise and pound-foolish benefit cutbacks that caused the retention problems of the 1970s and the 1990s.

Today's reality is that servicemembers and their families are being asked to endure ever-greater workloads and ever-greater sacrifices. Repeated deployments, often near back-to-back, have stressed the force to the point where recruiting is a real concern, and anyone who talks to frustrated military families has to question the credibility of any alleged rosy retention outlook.

In testimony today, The Military Coalition offers its collective recommendations on what needs to be done to address these important issues and sustain long-term personnel readiness.

Full Funding for the Defense Health Program

We particularly appreciate the key role played by the Subcommittee in ending the chronic under funding experienced in past years. But recent events raise our concern that this condition is likely to arise again unless the Subcommittee continues its aggressive oversight.

The Defense Department, Congress and The Military Coalition all have reason to be concerned about the rising cost of military health care. But it is important to recognize that the bulk of the problem is a national one, not a military-specific one. It's also important, in these times of focus on deficits, to keep in perspective the government's unique responsibility as the recruiter, retainer,

employer, and custodian of a career military force that serves multiple decades under extraordinarily arduous conditions to protect and preserve our national welfare.

In this regard, the government's responsibility and obligations to its servicemembers go well beyond those of corporate employers. The Constitution itself puts the responsibility on the government to provide for the common defense, and on Congress to raise and maintain military forces. No corporate employer shares any such awesome responsibility and obligation, and there is no other employee population upon whom the entire Nation depends for its very freedom.

Congress has pursued its responsibilities with vigor on behalf of those who are sacrificing, have sacrificed, and will continue to sacrifice so much for the rest of America. Continuing those vigorous efforts will be essential in addressing the budget challenges of the years ahead.

The Military Coalition urges the Subcommittee to ensure continued full funding for Defense Health Program needs.

Protecting Beneficiaries Against Cost-Shifting

The Administration is proposing a significant increase in fees paid by retired uniformed services beneficiaries, including doubling or tripling enrollment fees for TRICARE Prime and tripling or quadrupling fees for TRICARE Standard. In addition, the President's budget recommends a 67% increase in retail pharmacy fees for all active duty, Guard, Reserve, retired, and survivor beneficiaries.

The Coalition believes strongly that these proposed increases are disproportional, inequitable, inappropriate, and unwise. (See separate NMFA testimony concerning TRICARE Prime premiums and Standard deductibles.)

The Coalition recommends against implementing any increases in health fees for uniformed services beneficiaries this year. TMC supports H.R. 4949, offered by Rep. Edwards and Jones. We believe strongly that the principles espoused in this bill should be established in law, and urge the Subcommittee to include its provisions in the FY2007 Defense Authorization Act.

People vs. Weapons. Dr. William Winkenwerder, Assistant Secretary of Defense (Health Affairs), briefed the Coalition that rising military health care costs are "impinging on other service programs." Other reports indicate that DoD leadership is seeking more funding for weapons programs by reducing the amount it spends on military health care and other personnel needs.

The Military Coalition asserts that such budget-driven trade-offs are misguided and inappropriate. Cutting people programs to fund weapons ignores the much larger funding problem, and only makes it worse.

The Coalition believes strongly that the proposed defense budget is too small to meet national defense needs. Today's defense budget (in wartime) is less than 4% of GDP, well short of the average for the *peacetime years* since WWII.

The Coalition believes strongly that America can afford to and must pay for <u>both</u> weapons and military health care.

Comparison With Civilian Plans Is Inappropriate. Defense leaders assert that substantial military fee increases are needed to bring military beneficiary costs more in line with civilian practices. But comparison with corporate practices is inappropriate.

Military medical and retirement benefits must be markedly better than civilian benefits, since they are the primary offsets for enduring decades of extraordinarily arduous military service conditions that constitute military members' unique contributions toward their unique retirement and health benefits.

The Nation has a far greater obligation to military retirees than corporations have to theirs. In demanding such extraordinary commitments from career service member, the government assumes a reciprocal obligation to provide benefits commensurate with their extraordinary sacrifices.

TRICARE Standard Enrollment Fee is Inappropriate. TRICARE Standard has long been the basic military insurance coverage. Only 50% of providers in America have ever submitted a TRICARE claim, and many providers are reluctant to accept Standard beneficiaries. Many who do so refuse to accept any new TRICARE patients. To date, little effort has been expended by the Department of Defense or its contractors to assist Standard beneficiaries in finding providers.

When TRICARE Prime was authorized in 1995, Congress authorized an enrollment fee for this program in recognition that beneficiaries who signed up for Prime could expect a higher level of service. They were to be guaranteed access to a participating provider within established timeliness standards.

The Department is now attempting to establish an enrollment for TRICARE Standard without any such commitment for a higher level of service. With TRICARE provider payments expected to decline in the future under current law, provider participation is actually likely to decline in the future.

Establishing an enrollment fee without any commitment to provide improved service for that fee is inappropriate.

The Coalition recommends strongly against establishment of any TRICARE Standard enrollment fee.

Large Retiree Fee Increases Can Only Hurt Retention. The reciprocal obligation of the government to maintain an extraordinary benefit package to offset the extraordinary sacrifices of career military members is a practical as well as moral obligation. Mid-career military losses can't be replaced like civilians can.

Eroding benefits for career service can only undermine long-term retention/readiness. Today's troops are very conscious of Congress' actions toward those who preceded them in service. One reason Congress enacted TRICARE For Life is that the Joint Chiefs of Staff at that time said that inadequate retiree health care was affecting attitudes among active duty troops.

The current Joint Chiefs have endorsed increasing TRICARE fees only because their political leaders have convinced them that this is the only way they can secure funding for weapons and other needs. The Military Coalition believes it is inappropriate to put the Joint Chiefs in the untenable position of being denied sufficient funding for current readiness needs if they don't agree to beneficiary benefit cuts.

Reducing military retirement benefits would be penny-wise and pound-foolish when recruiting is already a problem and an overstressed force is at increasing retention risk.

TFL Trust Fund Accrual Deposit Is Dubious Excuse. An analysis by the Congressional Budget Office showed that most of the growth in defense health spending (56%) is attributable to overall growth in national health care spending. The next largest contributor is beneficiary population growth (23%). Establishment of the accrual accounting methodology for the TFL trust fund (which doesn't affect current outlays) accounts for 18% of the DoD cost growth.

When the Defense Department argued two years ago that the trust fund deposit was impinging on other defense programs, the Coalition and the subcommittee agreed that that should not be allowed to happen. When the Administration refused to increase the budget topline to accommodate the statutorily mandated trust fund deposit, Congress changed the law to specify that the entire responsibility for TFL trust fund deposits should be transferred to the Treasury. Subsequently, Administration budget officials chose to find a way to continue charging that deposit against the defense budget anyway.

In the Coalition's view, this represents a conscious and inappropriate Administration decision to cap defense spending below the level needed to meet national security needs. If the Administration chooses to claim to Congress that its defense budget can't meet those other needs, then Congress (which directed implementation of TFL and the trust fund deposit) has an obligation to increase the budget as necessary to meet them.

Proposed Increases Far Exceed Inflation Increases. The Administration's proposed increases are grossly out of line with TRICARE benefit levels originally enacted by Congress, even allowing for interim inflation since current fees were established.

If the $460 family Prime enrollment fee were increased by interim CPI changes (those used to increase retired pay), assuming the same 2.5% future CPI change assumed in the President's budget, it would be $635 for FY2008 – far less than $1400 proposed by DoD.

If the $300 deductible for TRICARE Standard were CPI-adjusted for the same period, it would be $414 by 2008 –one-third the $1200 in annual deductible and new fees proposed by DoD.

Further, the Administration proposes to make annual fee adjustments thereafter, based on FEHBP medical inflation, which has been two to three times the inflation-based increases in members' retired pay. This would ensure that members' medical costs would consume a larger share of their income with each passing year. The Coalition realizes that this has been happening to many private sector employees, but believes strongly that the government has a greater obligation to protect the interests of its military beneficiaries than private corporations feel for their employees.

Proposed Increases Disproportional to VA Fee Changes. Congress acted wisely in each of the last two years by squelching Administration proposals to institute an annual enrollment fee of $250 and significantly raise pharmacy co-payments for non-disabled veterans who had served as few as two years. This year, the VA has increased pharmacy copayments by $1. Tripling and quadrupling TRICARE fees for retirees who served 20-30 years in uniform and raising retail pharmacy copays by 67% for all military beneficiaries would be grossly disproportionate in comparison.

Unrealistic Budget Assumptions Will Leave TRICARE Underfunded. The DoD budget proposal assumes the proposed fee increases and co-payment changes will save money by shifting 14% of pharmacy users away from retail outlets and causing hundreds of thousands of current beneficiaries to exit TRICARE by 2011. Thus, DoD has reduced the amount budgeted for health care on the assumption that it will be treating fewer beneficiaries.

Many Defense and Service analysts believe it is unrealistic to assume that this number of beneficiaries will leave TRICARE if such fees are introduced, largely because switching to civilian coverage usually would entail even larger fees for beneficiaries.

Because the assumed level of beneficiary flight is extremely unlikely to occur, the Department almost certainly will experience a substantial budget shortfall before the end of the year. This would then require supplemental funding, further benefit cutbacks, and even greater efforts to shift more costs to beneficiaries in future years.

Thus, the most likely result of this misguided cost-shifting proposal would be to disproportionately penalize retirees, undermine military health benefits, and further threaten future retention and readiness.

Alternative Options to Make TRICARE More Cost-Efficient. The Coalition believes strongly that the Defense Department has not sufficiently investigated other options to make TRICARE more cost-efficient without shifting costs to beneficiaries. The Coalition offers the list of alternatives below as initial cost saving possibilities.

- Promote retaining other health insurance by making TRICARE a true second-payer to other insurance (far cheaper to pay another insurance's copay than have the beneficiary migrate to TRICARE)
- Eliminate DoD-unique administrative requirements that make DoD pay higher overhead fees
- Size and staff military treatment facilities (least costly care option) to reduce reliance on non-MTF civilian providers
- Change electronic claim system to kick back errors in real time to help providers submit "clean" claims, reduce delays/multiple submissions
- Change law to limit incentives private firms can offer employees to shift to TRICARE, or require such matching payments to TRICARE
- Increase efficiency via a single contract for all claims processing
- Implement effective disease management programs and ensure coordination across the entire system
- Test voluntary participation in Medicare Advantage Regional PPO to foster chronic care improvement and disease management

- Negotiate with drug manufacturers for retail pharmacy discounts (the most costly venue), which DoD has failed to do, or change the law to mandate federal pricing for retail pharmacy network (rather than charging beneficiaries more if drug companies don't agree to federal pricing)
- Reduce/eliminate all mail-order copays to boost use of lowest-cost venue
- Do more to educate beneficiaries and providers on advantages of mail-order pharmacy
- Establish one central DoD facility to order/fill all prescriptions for exceptionally high-cost drugs (AF model has been successful)
- Centralize military treatment facility pharmacy budget/funding process, with emphasis on accountability and cost-shifting

TRICARE Still Has Significant Shortcomings. While DoD chooses to focus its attention on the cost of the TRICARE program to the government, the Coalition believes those making that case too often fail to acknowledge that TRICARE continues to have significant problems that deter many providers from accepting it and affect delivery of care to beneficiaries.

The Coalition urges the Subcommittee to require DoD to pursue greater efforts to improve TRICARE and find more effective and appropriate ways to make TRICARE more cost-efficient without seeking to "tax" beneficiaries and make unrealistic budget assumptions.

TRICARE Standard Improvements

The Coalition very much appreciates the Subcommittee's continuing interest in the specific problems unique to TRICARE Standard beneficiaries. In particular, we applaud your efforts in the FY2006 Defense Authorization Act to expand TRICARE Standard provider surveys and establish Standard support responsibilities for TRICARE Regional Offices. These are needed initiatives that should help make it a more effective program. We remain concerned, however, that more remains to be done. TRICARE Standard beneficiaries need assistance in finding a provider that can provide healthcare services within a reasonable time and distance from their home. This will become increasingly important with the expansion of TRICARE Reserve Select as these individuals are most likely not living within a Prime Service Area.

Provider Participation Adequacy. The provider surveys are a first step and should provide a wealth of additional information. The question is what use will be made of the information.

The Coalition is concerned that DoD has not established any standard for the adequacy of provider participation. Participation by half of the providers in a locality may suffice if there is not a large Standard beneficiary population. The Coalition would prefer to see an objective participation standard (perhaps number of beneficiaries per provider) that would help shed more light on which locations have participation shortfalls of Primary Care Managers and Specialists that require positive action. The Coalition is not asking DoD to build a TRICARE Standard network. However, once shortfalls are identified then further action by DoD should be undertaken to entice providers to accept TRICARE Standard patients.

We are also concerned about whether the Standard surveys actually measure what they purport to measure. In particular, we are perplexed that DoD survey results for some locations do not conform to (admittedly anecdotal) inputs that beneficiary associations have received from some of the same

localities. Coalition discussions with those who processed the surveys yielded acknowledgements that health care providers may give different answers to the surveyors than they give to beneficiaries – if only because the beneficiaries may ask different questions of them than the survey-takers do. The Coalition believes it would be useful and appropriate to conduct independent surveys of TRICARE Standard beneficiaries, so that beneficiary inputs could be correlated with provider inputs for a given area.

The Coalition urges the Subcommittee to establish requirements for TRICARE Standard beneficiary surveys and a definition of what level of provider participation shall be deemed to require positive action to increase it.

Administrative Deterrents to Provider Participation. Feedback from providers indicates TRICARE imposes additional administrative requirements on providers that are not required by Medicare or other insurance plans. On the average, about 50 percent of a provider's panel is Medicare patients, whereas only 2 percent are TRICARE beneficiaries. Providers are unwilling to incur additional administrative expenses that affect only a small number of patients. Thus, providers are far more prone to non-participation in TRICARE than in Medicare.

One problem is that TRICARE requires that each provider be identified by each physical location where he or she performs services. If a clinic has 50 providers that have privileges at 10 different addresses in a clinic group, TRICARE requires 500 unique provider numbers. Medicare and most commercial insurers are moving to embrace a National Provider Indicator. TRICARE has been reluctant to change because of concerns for identifying fraud, but Medicare has been successful in fraud identification using one unique provider identification number.

Another problem is that, TRICARE still requires submission of a paper claim to determine medical necessity on a wide variety of claims for Standard beneficiaries. This thwarts efforts to encourage electronic claim submission and increases provider administrative expenses and delays receipt of payments. Examples include speech therapy, occupational/physical therapy, land or air ambulance service, use of an assistant surgeon, nutritional therapy, transplants, durable medical equipment, and pastoral counseling.

Another source of claims hassles and payment delays involve cases of third party liability (e.g., auto insurance health coverage for injuries incurred in auto accidents). Currently, TRICARE requires claims to be delayed pending receipt of a third-party-liability form from the beneficiary. This often delays payments for weeks and can result in denial of the claim (and non-payment to the provider) if the beneficiary doesn't get the form in on time. Recently, a major TRICARE claims processing contractor recommended that these claims should be processed regardless of diagnosis and that the third-party-liability questionnaire should be sent out after the claim is processed to eliminate protracted inconvenience to the provider of service.

The Coalition urges the Subcommittee to direct DoD to eliminate TRICARE-unique administrative requirements that deter provider participation and thus contribute to denying beneficiaries access to care.

Provider Education Needs Improvement. While these and other administrative impediments remain to be corrected, the Coalition does believe that overall claims processing timeliness has improved considerably from previous years.

We believe one reason for provider non-participation in TRICARE is lack of information, outdated information, or previous bad experiences with TRICARE in areas that have subsequently seen substantial improvement. DoD is currently developing an annual newsletter for TRICARE Standard beneficiaries and could generate an informative newsletter to providers who have submitted claims. This will be all well and good but the target group of providers that will not get a newsletter or information are those who do not see TRICARE beneficiaries. We look forward to working with DoD to improve efforts to educate providers with respect to the differences between TRICARE Standard and TRICARE Prime. A solid education and communication program will go a long way to attract providers.

The Coalition recommends requiring DoD to work with the State Medical Associations and the Centers for Medicare and Medicaid Services to initiate an appropriate information program for providers who will not see TRICARE patients, highlighting specific improvements in claims/payment processing timeliness.

Tricare Reimbursement Rates

Physicians consistently report that TRICARE is virtually the lowest-paying insurance plan in America. Other national plans typically pay one-quarter to one-third higher rates. In some cases the difference is even higher.

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

This is exacerbated by annual threats of further reductions in TRICARE rates due to the statutory Medicare rate-setting formula. Doctors are unhappy enough about reductions in Medicare rates, and many already are reducing the number of Medicare patients they see.

But the problem is far more severe with TRICARE, because TRICARE patients typically comprise a small minority of their beneficiary caseload. Physicians may not be able to afford turning away large numbers of Medicare patients, but they're more than willing to turn away a small number of patients who have low-paying, high-administrative-hassle TRICARE coverage.

Congress has acted to avoid Medicare physician reimbursement cuts for the last three years, but the failure to provide a payment increase for 2006 is another step in the wrong direction according to physicians. Further, Congress still has a long way to go in order to fix the underlying reimbursement determination formula.

Correcting the statutory formula for Medicare and TRICARE physician payments to more closely link adjustments to changes in actual practice costs and resist payment reductions is a primary and essential step. We fully understand that is not within the purview of this Subcommittee, but we urge your assistance in pressing the Ways and Means and Finance Committees for action.

In the meantime, the rate freeze for 2006 makes it even more urgent to consider some locality-based relief in TRICARE payment rates, given that doctors see TRICARE as even less attractive than Medicare.

The TRICARE Management Activity has the authority to increase the reimbursement rates when there is a provider shortage or extremely low reimbursement rate for a specialty in a certain area and providers are not willing to accept the low rates. In some cases a state Medicaid reimbursement for a similar service is higher than that of TRICARE. To date, this authority has been used only in Alaska. One concern, as mentioned previously, is that the Department has been reluctant to establish a standard for adequacy of participation.

There are specialties that do not fall cleanly within the Medicare reimbursement rates. Obstetrical and pediatric services have been a constant source of aggravation for military beneficiaries and the Managed Care Support Contractors. We applaud Congress' requirement for a Comptroller General report on obstetrical and pediatric reimbursement levels to ensure the adequacy of a quality network. We look forward to its findings and in the meantime encourage DoD to make full use of its authority to set higher rates for these specialties.

The Coalition urges the Subcommittee to exert what influence it can to persuade the Ways and Means/Finance Committees to reform Medicare/TRICARE statutory payment formula. To the extent the Medicare rate freeze continues, we urge the Subcommittee to encourage the Defense Department to use its reimbursement rate adjustment authority as needed to sustain provider acceptance.

The Coalition urges the Subcommittee to require a Comptroller General report on the relative propensity of physicians to participate in Medicare vs. TRICARE, and the likely effect on such relative participation of a further freeze in Medicare/TRICARE physician payments.

Minimize the differences between Medicare and TRICARE coverage. DoD submitted a report to Congress last year indicating the coverage differences between Medicare and TRICARE. The report showed that there are at least a few services covered by Medicare that are not covered by TRICARE. These include an initial physical at age 65, chiropractic coverage, respite care, and certain hearing tests. We believe that the TRICARE coverage should at least be the equal of Medicare's in every area. Our military retirees have made sacrifices far and above those who have not served and deserve no less coverage than is provided to other federal beneficiaries.

The Coalition urges the Subcommittee to align TRICARE coverage to at least match that offered by Medicare in every area.

Guard and Reserve Healthcare

The Coalition greatly appreciates Congress' efforts to address several Guard and Reserve priorities with the FY 2006 NDAA, including extending fee-based TRICARE eligibility to all drilling Guard and Reserve members. Still, we believe that more must be done to ensure that Guard and Reserve members' and their families' readiness remains a viable part of our National Security Strategy. Since DoD is relying upon the Guard and Reserve personnel more heavily and deployments are becoming longer and more frequent, we must continue to view these individuals as an indispensable part of our armed forces. We should treat them accordingly.

Setting the TRS Premium. We have concerns over the manner at which the premiums for this program are set. Currently, the Defense Department adjusts TRS premiums based on annual adjustments to the basic FEHBP insurance option. This adjustment mechanism has no relationship either to the Department's military health care costs or to increases in eligible members' compensation.

The Coalition believes we have a higher obligation to restrain health cost increases for currently serving military members who are periodically being asked to leave their families and lay their lives on the line for their country. These members deserve better than having their health premiums raised arbitrarily by a formula that has no real relationship to them.

The Coalition strongly recommends capping TRS premium increases at a percentage not to exceed the percentage of their basic pay raise.

Improve Premium Subsidies. Although we recognize that Congress took a huge step in expanding eligibility to all members of the Selected Reserve, we are also aware that the step finally taken fell well short of what both the House and Senate Armed Services Committees initially recommended last year. We are very concerned that the high premiums required for those who have not been mobilized in the recent past will deter many Guard and Reserve members from needed participation. Such fees are particularly unfair for members who do not have access to other health insurance coverage.

The Coalition strongly recommends increasing subsidy levels for TRICARE coverage for drilling Guard/Reserve members not yet mobilized and having one set rate for members of the Guard and Reserve who continue to be drilling members. At the very least, subsidies should be increased for members who do not have access to employer-sponsored health coverage.

Private Insurance Premium Option. The Coalition believes Congress is missing an opportunity to reduce its health care costs (for retired members as well as for Selected Reservists) by failing to authorize eligible members the option of electing a partial subsidy of their civilian insurance premiums in lieu of TRICARE coverage.

Many members would be motivated to elect this option, especially if their family's current health care provider is reluctant to participate in TRICARE. Rather than having to find a new provider who will accept TRICARE, many beneficiaries may prefer a partial subsidy (at lower cost to DoD) to preserve the convenience and continuity of their family's health care.

The Department could calculate a maximum monthly payment level that would represent a cost savings to the government, so that each member who elected that option would reduce TRICARE costs.

The Coalition recommends developing a cost-effective option to have DoD subsidize premiums for member's private insurance as an alternative to TRICARE Reserve Select coverage. We recommend a GAO report to identify the level of payment that would represent a cost-effective option for the government.

USERRA protections. We very much appreciate Congress' continuing efforts to ensure that USERRA provisions catch up to recent changes in members' service requirements. One continuing need is to further strengthen rights under USERRA to permit Reserve Component members to retain employer-sponsored insurance if coverage is terminated due to the existence of TRICARE coverage, and to protect their re-enrollment rights in employer-provided health coverage upon expiration of TAMP and 28-percent-subsidized TRS coverage.

The Coalition recommends further strengthening rights under USERRA to permit Reserve Component members to retain employer-sponsored insurance if coverage is terminated due to TRICARE benefits provided 90 days prior to mobilization.

Reserve Dental Coverage. The Coalition remains concerned about the dental readiness of the Reserve forces. Once these members leave active duty, the challenge increases substantially, so the Coalition believes the services should at least facilitate correction of dental readiness issues identified while on active duty.

The Coalition supports extending military dental coverage to Reservists for 180 days post mobilization (during TAMP), unless the individual's dental readiness is restored to T-2 condition before demobilization.

Consistent Benefit

As time progresses and external changes occur, we are made aware of pockets of individuals who for one reason or another are denied the benefits that they should be eligible for. DoD and all its health contractors were leaders in modifying policy and procedures to assist Katrina victims. Additionally, Congress' action to extend eligibility for TRICARE Prime coverage to children of deceased active duty members was truly the right thing to do.

Restoration of TRICARE for Widows. One group of individuals that has earned the TRICARE benefit is now being closed out and needs to be brought back into the fold. When a TRICARE-eligible widow/widower remarries, he/she loses TRICARE benefits -- and rightly so. When that individual's second marriage ends in death or divorce, the individual has eligibility restored for military ID card benefits, including SBP coverage, commissary/exchange privileges, etc. – with the sole exception that TRICARE eligibility is not restored.

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

Military survivors deserve equal treatment.

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

TRICARE Prime Remote exceptions. We thank Congress for the FY2006 Defense Authorization Act provision allowing the Secretaries to waive the requirement for the spouse to reside with the servicemember for purposes of TRICARE Prime Remote eligibility if the service determines special

circumstances warrant such coverage. We remain concerned about the potential for inconsistent application of eligibility, however.

With longer deployments and sea shore and overseas assignment patterns families are faced with some tough decisions. A spouse and children may find it easier and more supportive to reside with or around relatives during extended separations from their Active Duty spouse. The special authority is a step in the right direction, but there is a wide variety of circumstances that could dictate a family separation of some duration, and the Coalition believes each family is in the best situation to make its own best decision.

The Coalition recommends removal of the requirement for the family members to reside with the active duty member to qualify for the TRICARE Prime Remote Program.

BRAC, Re-Basing, and Relocation. Relocation from one geographic region to another brings multiple problems. A smooth health care transition is crucial to a successful relocation. And that means ensuring a robust provider network and capacity is available as long as members and families remain in either losing or gaining locations affected by BRAC and Global Re-basing. A major effort is essential by the Department and its Managed Care Support Contractors to ensure smooth beneficiary transition from one geographic area to another.

It also is important to sustain Prime networks at closing locations to protect health care access for Guard/Reserve and retired members and families remaining in the area. We stress the importance of coordination of construction and funding in order to maintain access and operations while the process takes place.

We urge Congress to codify the requirement to provide TRICARE Prime in BRAC-affected areas and ensure, via a report from DoD, that adequate health resources are available to provide care within access standards for those affected by Re-Basing.

Mental Health

We are most appreciative of the extra effort the Subcommittee made in the FY2006 Defense Authorization Act to assist members and families who may be affected by Post Traumatic Stress Disorder (PTSD) or other psychological conditions. The pilot projects on PTSD and creation of a Task Force on Mental Health are major steps to establish outreach and ensure returning members and their families get timely access to the care they need.

We support the establishment of a meaningful pre- and post-deployment mental health screening process to ensure members and their families are referred to and receive appropriate interventional services. We will be very interested in the results of the studies Congress has required of DoD on this topic and look forward to working with DoD and Congress as the results are completed.

The Coalition strongly urges Congress to closely monitor DoD and VA implementation of much-needed Post Traumatic Stress Disorder awareness and treatment programs.

Pharmacy

The TRICARE Pharmacy benefit must remain strong and affordable and meet the pharmaceutical needs of millions of eligible beneficiaries. While we are pleased at the overall operation of the program, the Coalition does have concerns about certain apparent trends.

In particular, we are concerned about ongoing efforts to shift disproportional cost increases onto military beneficiaries.

Pharmacy Copayment Changes. The Coalition is concerned that, five years after pharmacy copayment levels were established, the Department is proposing a 67% increase in retail copayments. The rationale for the proposed increase is the rapid growth in retail pharmacy use since enactment of TRICARE For Life.

The Coalition believes strongly that uniformed services beneficiaries deserve more stability in their benefit levels, and that DoD has not performed due diligence in exploring other ways to reduce pharmacy costs without shifting such increased expense burdens to beneficiaries. Thus far, the Department has refused to negotiate with drug companies for discounts in the retail arena. Not enough has been done to educate beneficiaries and providers on the advantages of the mail-order program. The Department has failed to centralize purchasing and filling of prescriptions for high-cost drugs, as the Air Force has done successfully.

Last year, Congress rightfully rejected the Administration's proposal to double VA pharmacy copayments for certain categories of nondisabled veterans. This year, the VA increased copayments by $1 for those categories, a much more reasonable adjustment that would not have happened without Congress' intervention. Military beneficiaries deserve no less protection.

A formula that limits pharmacy copayment increases to the lesser of the percentage increase in basic pay or retired pay, rounded down to the next lower dollar, would provide for modest periodic adjustments consistent with beneficiary income increases. DoD should not modify copayment rates until all medications that are available in the retail system are also available in the mail order program.

The Coalition recommends no changes to the copayment rates until all medications are available in the mail order program and limiting any future pharmacy copayment increases to the lesser of the percentage increase in basic pay or retired pay, rounded down to the next lower dollar.

Most of all, the Department has ignored what the Coalition believes would create the most powerful incentive for beneficiaries to shift from the more costly retail program to the mail order program – eliminating mail-order copays. While modest already, mail-order copayments entail considerable processing expense for the contractor and DoD. In many cases, the processing expense is greater than the value of the copayment. Marketers know that offering something for free is a powerful economic incentive. The Coalition believes that eliminating mail-order copayments altogether would send a strong economic and educational message to beneficiaries on the advantages of the mail-order system, and that the government would realize very large savings from this change.

The average drug purchased in the mail-order system saves the government $49 relative to providing the drug through the retail system. If all mail-order copayments would be eliminated, the savings would still be at least $43 per prescription (in fact, savings would be larger, since the government would no longer pay contractors to process copayments). Elimination of mail-order

copays would save the government $20 million for each 1% of prescriptions that migrate from the retail to the mail-order pharmacy system.

The Coalition recommends eliminating beneficiary copayments in the mail-order pharmacy system for generic and brand name medications to incentivize use of this lowest-cost venue and generate substantial cost savings.

Rapid Expansion of "Third Tier" Formulary. The Coalition very much appreciated the efforts of the Subcommittee to protect beneficiary interests by establishing a statutory requirement for a Beneficiary Advisory panel (BAP) to give beneficiary representatives an opportunity in a public forum to voice our concerns about any medications DoD proposes moving to the third tier ($22 co-pay). We were further reassured when, during implementation planning, Defense officials advised the BAP that they did not plan on moving many medications to the third tier.

Unfortunately, this has not been the case. To date, DoD has moved 41 medications to the third tier. While the BAP did not object to most of these, the BAP input has been universally ignored in the small number of cases when it recommended against a proposed reclassification. In at least one case, the medications moved to the third tier affected 98% of the beneficiaries with prescriptions in that particular class of drug. The Coalition is also concerned that the BAP has been denied access to information on relative costs of the drugs proposed for reclassification and the Defense Department has established no mechanism to provide feedback to the BAP on why its recommendations are being ignored.

The Coalition believes the Subcommittee envisioned that the Beneficiary Advisory Panel would be allowed a substantive input in the Uniform Formulary decision process, but that has not happened. We hope to address this matter substantively with the ASD(HA).

The Coalition urges the Subcommittee to monitor DoD's consideration of Beneficiary Advisory Panel input in future uniform formulary decisions and reassert its intent that the Panel should have a substantive role in the process, including access to meaningful data on relative cost of drugs in each affected class.

The Coalition recommends a GAO review of the Uniform Formulary process to determine whether actions taken thus far have realized the projected savings.

TRICARE Prime and MCSC Issues

DoD and its health contractors are continually trying to improve the level of TRICARE Prime service. We appreciate their inclusion of our associations in their process improvement activities and will continue to work with them to ensure the program remains beneficiary-focused and services are enhanced, to include: Beneficiary education, network stability, service level quality, uniformity of benefit between regions (as contractors implement best business practices), and access to care.

Referral and Authorization System. There has been much discussion and consternation concerning the Enterprise Wide Referral and Authorization (EWRAS) system. Much time, effort and money have been invested in a program that has not come to fruition. Is adding to the administrative paperwork requirements and forcing the civilian network providers into a referral

system really accomplishing what DoD set out to do? Rather than forcing unique referral requirements on providers, perhaps DoD should look at expanding its Primary care base in the Prime Service Areas and capture the workload directly.

The Coalition recommends that Congress require a cost analysis report concerning the referral process within DoD and reliance on Civilian Network Providers within an MTF's Prime Service Area.

DoD/VA Transition

TMC is grateful that the FY2005 Defense Authorization Act required DoD to do a better job of collecting baseline health status data through a formal medical readiness tracking and health surveillance system.

Seamless Transition. Our nation's servicemen and women deserve first class treatment and services before, during and after separation from military service. DoD and VA have critical, complementary roles in the transition process. Unfortunately, bureaucratic inertia and intramural priorities in DoD and the VA have slowed the pace of collaborative efforts towards the goal of "seamless transition". Some of these efforts have been going on for decades with little or no substantive progress, in part because those responsible for action have come to have low expectations. Time and again, progress has been stymied by a combination of a lack of leadership priority and oversight, management turnover, bureaucratic inertia, and technological backwardness.

Single Separation Exam. We are particularly concerned about the significant gaps in implementing a single separation physical in the Washington, DC area. Key medical treatment facilities (MTFs) like Walter Reed Army Medical Center and National Naval Medical Center do not have a single, systematic process in place. This is particularly alarming considering the DoD and VA are headquartered here. It seems reasonable to expect the Washington, DC MTFs to serve as models for other DoD and VA medical delivery systems. The Coalition recommends the Committees to provide continued oversight to ensure that this important program is implemented promptly and effectively at all sites.

Electronic Medical Record. DoD has developed an electronic health record system (AHLTA) that will provide DoD providers with real-time, centrally based access to beneficiary health information regardless of current location. This is a wonderful advancement and we applaud DoD's efforts. However, the current system still does not allow direct transfer of this information to the VA upon separation of an active duty member. This poses a major problem which must be corrected as soon as possible. We look forward to seeing the results of the report on this topic as required by the FY2006 NDAA and hope that Congress will demand a highly ambitious implementation of two-way electronic data exchange between DoD and VA.

The Coalition urges the Committee to direct and oversee a concerted "Manhattan Project" effort to ensure full and timely implementation of seamless transition activities, a bi-directional electronic medical record (EMR), enhanced post-deployment health assessments, and one-stop physical at time of discharge.

Tax Law Changes

Many uniformed services beneficiaries pay annual enrollment fees for TRICARE Prime, and premiums for supplemental health insurance, such as a TRICARE supplement, the TRICARE Dental and Retiree Dental Plans, or for long-term care insurance. For most military beneficiaries, these premiums are not tax-deductible because their annual out-of-pocket costs for healthcare expenses do not exceed 7.5% of their adjusted gross taxable income. In 2000, a Presidential directive allowed Federal employees who participate in FEHBP to have premiums for that program deducted from their pay on a pre-tax basis. Similar legislation for all active and retired military and federal civilian beneficiaries would restore equity with private sector workers, many of whom already can pay their health premiums with pre-tax dollars. Tax incentives will help offset the cost of these important coverages, promote enrollment, and reduce members' liability for catastrophic expenses.

The Coalition urges all Armed Services Committee members to press the Ways and Means and Finance Committees to approve legislation to allow all beneficiaries to pay TRICARE-related insurance premiums in pre-tax dollars, to include TRICARE Prime enrollment fees and premiums for TRICARE Standard supplements, long-term care insurance, and TRICARE dental premiums.

Dental Issues

Former Spouse Dental Coverage. The TRICARE Retiree Dental plan offers retirees the option to purchase a dental insurance policy. There is only one category of TRICARE-eligible beneficiaries who are denied eligibility to participate in the TRICARE Retiree Dental Plan – otherwise qualifying former spouses. The Coalition believes this inconsistency is inappropriate.

The Coalition recommends allowing TRICARE-eligible former spouses to participate in the TRICARE Retiree Dental Plan.

Retiree Dental Plan. The TRICARE Retiree Dental Plan is contractor-operated and is not subsidized by the government. Retired beneficiary premiums must cover the total cost of the program. For retirees, this has become an increasing monthly expense, with some choosing to forego dental care. For the long term, the Coalition would like to see some level of government subsidy for the TRICARE Retiree Dental Plan.

The Coalition recommends a GAO study of the viability of subsidizing the retiree dental program, including the likely long-term impact of different subsidy levels on retiree participation and dental health.

Vice Admiral Norbert R. Ryan, Jr., United States Navy, Retired

Admiral Ryan became President of the Military Officers Association of America (MOAA) in September 2002. He is MOAA's ninth President in the organization's 76 years.

A native of Mountainhome, Pennsylvania, Admiral Ryan graduated from the United States Naval Academy in June 1967. He is also a graduate of George Washington University, with a Master of Science Degree in Personnel Administration, and the Senior Officials in National Security Program at Harvard University's John F. Kennedy School of Government.

He was designated a Naval Aviator in 1968, and his numerous operational and sea duty assignments included command at the Squadron and Wing level culminating with command of Commander, Patrol Wings, U.S. Pacific Fleet/Commander, Task Force Twelve (CTF-12).

In addition to his operational assignments, Vice Adm. Ryan has also served as Company Officer/Midshipman Personnel Officer, U.S. Naval Academy; Deputy Executive Assistant/Aide to the Chief of Naval Operations; Executive Assistant to the Vice Chairman, Joint Chiefs of Staff; Assistant Chief of Naval Personnel for Total Force Programming and Manpower (Pers-5); Assistant Chief of Naval Personnel for Distribution (Pers-4); and Chief of Legislative Affairs.

In November 1999, Admiral Ryan assumed the duties of Chief of Naval Personnel/Deputy Chief of Naval Operations (Manpower & Personnel), a position he held until his retirement in August 2002.

Among his awards and decorations Admiral Ryan is authorized to wear the Navy Distinguished Service Medal (w/1 Gold Star), Defense Superior Service Medal, Legion of Merit (w/3 Gold Stars), and the Meritorious Service Medal (w/2 Gold Stars).

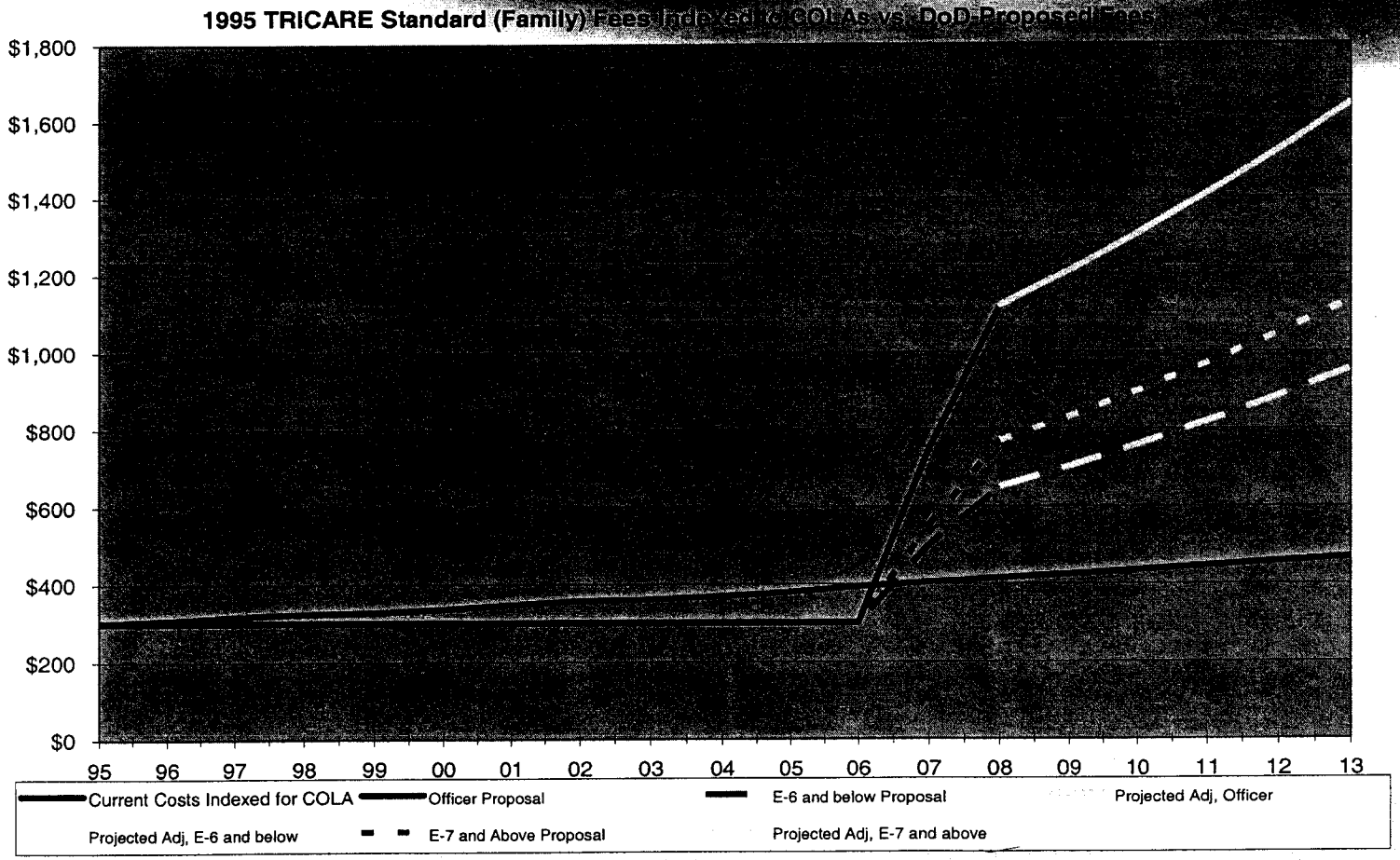
The Admiral and his wife Judy, have two adult children, and reside in Fairfax Station, Va.

Oral Presentation

VADM Norb Ryan, Jr (USN-Ret)
Military Officers Association of America

MOAA
Military Officers Association of America

Chart 1
Proposed TRICARE Standard Fees



MOAA
Military Officers Association of America

Chart 2
Troops Are Watching

Navy Times, 27 Feb. . .

CNO: ***"More and more sailors are coming in married. They talk to me more about medical benefits than I ever thought to when I was in my mid-20s. I believe we've got the gold standard. . . for medical care right now, and that's a recruiting issue, a recruiting strength, and it's a retention strength."***

MOAA
Military Officers Association of America

Chart 3
Beneficiary Views on Fee Hikes

MOAA Web Survey (40,000)

	DoD Plan	COLA-Based
Category	%Opp/Favor	% Opp/Favor
Act. Duty	96% / 2%	79% / 12%
Gd/Res	93% / 4%	71% / 17%
Ret <65	97% / 2%	74% / 16%
Ret >65	91% / 3%	78% / 11%
Survivors	92% / 3%	84% / 9%

MOAA
Military Officers Association of America

Chart 4 - Assumed Savings Won't Materialize

- **Won't Cause 150,000 TRICARE Exits**
- **Will Leave Health Budget Short, Leading to Further Cuts**
- **Outcome:**
  - **Disproportionately Penalize Retirees**
  - **Underfund Military Health Program**
  - **Undermine Retention/Readiness**

MOAA
Military Officers Association of America

Chart 5 - TRICARE Problems Needing Fixes

- Many Drs Refuse TRICARE Patients
  - Pays 25-33% Less Than Private Insurance
  - Excessive Admin. Burdens
- Rates Scheduled for Further Cuts
- Contractors Have No Incentive to Recruit Standard Providers
- Works Poorly w/ Other Ins.
- High Standard Inpatient Copays

MOAA
Military Officers Association of America

Chart 6
MOAA Recommendations

- **No Fee Hikes This Year**
  - **Consistent with Rejection of $250 VA Fee**
- **Direct DoD Implementation of Alternative Cost-Saving Methods**
- **Direct GAO Study of Cost-Control Efforts**
- **Establish Statutory Limits on DoD Authority for Future Fee Increases**
- **Keep Pushing TRICARE Standard Fixes**

MOAA
Military Officers Association of America