STATEMENT OF

THE MILITARY COALITION (TMC)

before the

SUBCOMMITTEE ON MILITARY PERSONNEL,
HOUSE ARMED SERVICES COMMITTEE

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Presented by

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MADAM 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 Military Family Association
- National Order of Battlefield Commissions
- Naval Enlisted Reserve Association
- Naval Reserve Association
- Non Commissioned Officers Association
- Reserve Enlisted Association
- Reserve Officers Association*
- Society of Medical Consultants to the Armed Forces
- The Retired Enlisted Association
- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- Veterans of Foreign Wars of the United States
- Veterans' Widows International Network

*The Reserve Officers Association supports the non-health care portion of the testimony.

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

EXECUTIVE SUMMARY

Wounded Warrior Issues

Joint Transition Office – The Coalition is encouraged with the creation of a joint DoD-VA office to oversee development of a bi-directional electronic medical record. However, we strongly recommend that the Subcommittee upgrade the scope of responsibilities and span of authority for the new DoD-VA Interagency Program Office to include top-down planning and execution of all "seamless transition" functions, including the joint electronic health record; joint DoD/VA physical; implementation of best practices for TBI, PTSD, and special needs care; care access/coordination issues; and joint research.

The Coalition believes authorizing three years of their active-duty-level health care benefit for service-disabled members and their families after separation or retirement is essential to align stated "seamless transition" intentions with the realities faced by disabled members and families.

Disability Retirement Reform – The Coalition urges the Subcommittee to ensure any legislative changes to the military disability evaluation and retirement systems do not reduce compensation and benefit levels for disabled service members.

The Coalition does not support proposals to do away with the military disability retirement system and shift disability compensation responsibility to the VA.

The Coalition urges an expanded review of all administrative and disciplinary separations since Oct 7, 2001 for members with recent combat experience to assess whether the behavior that led to separation may have been due to service-caused exposure.

Active Force Issues

End Strength and Associated Funding – The Coalition strongly urges the Subcommittee to sustain projected increases in ground forces and provide additional recruiting, retention, and support resources as necessary to attain/sustain them.

The Coalition urges the Subcommittee to reconsider the consistency of projected reductions of Navy and Air Force forces with long-term readiness needs.

Compensation and Special Incentive Pay – The Coalition urges the Subcommittee to propose a military pay raise of at least 3.9% for FY2009 (one-half percentage point above private sector pay growth) and to continue such half-percent annual increases over the ECI until the current 3.4% pay comparability gap is eliminated.

The Coalition also urges the Subcommittee to continue periodic targeted pay raises as appropriate to recognize the growing education and technical qualifications of enlisted members and warrant officers and sustain each individual grade/longevity pay cell at the minimum 70th percentile standard.

Access to Quality Housing – The Military Coalition urges reform of military housing standards that inequitably depress BAH rates for mid-to-senior enlisted members by relegating their occupancy to inappropriately small quarters.

Family Readiness and Support – The Coalition urges the Subcommittee to support increased family support funding and expanded education and other programs to meet growing needs associated with increased ops tempo, extended deployments and the more complex insurance, retirement, and savings choices faced by over-extended military families.

Spouse Employment – The Coalition urges the Subcommittee to support H.R. 2682, a bill which would expand the Workforce Opportunity Tax Credit for employers who hire spouses of Regular and Reserve component service members.

Additionally, the Coalition supports providing tax credits to offset military spouses' expenses in obtaining career-related licenses or certifications when service members are relocated to a different state.

Flexible Spending Accounts – TMC urges the Subcommittee to continue pressing the Defense Department until service members are provided the same eligibility to participate in Flexible Spending Accounts that all other federal employees and corporate employees enjoy. Additionally, we support H.R. 1110.

Permanent Change of Station (PCS) Allowances – The Military Coalition urges the Subcommittee to upgrade permanent change-of-station allowances to better reflect the expenses members are forced to incur in complying with government-directed relocations, with priority on adjusting flat-rate amounts that have been eroded by years – or decades – of inflation, and shipment of a second vehicle at government expense to overseas accompanied assignments.

BRAC/Rebasing/Military Construction/Commissaries – The Coalition urges the Subcommittee to closely monitor rebasing/BRAC plans and schedules to ensure sustainment and timely development of adequate family support/quality of life programs. And at closing and gaining installations, respectively – to include housing, education, child care, exchanges and commissaries, health care, family centers, unit family readiness, and other support services.

Morale, Welfare, and Recreation Programs – TMC urges the Subcommittee to ensure that DoD funds MWR programs at least to the 85 percent level for Category A programs and 65 percent for Category B requirements.

Education Enhancements – TMC urges the Subcommittee to work with the House Veterans Affairs Committee to establish the benchmark level of Montgomery GI Bill (MGIB) education benefits at the average cost of attending a four-year public college, and support continuous in-state tuition eligibility for service members and their families in the state in which the member is assigned and the member's home state of record once enrolled as a student.

National Guard & Reserve Issues

Reserve Retirement and 'Operational Reserve' Policy – TMC strongly urges further progress in revamping the reserve retirement system in recognition of increased service and sacrifice of National Guard and Reserve Component members, including at a minimum, extending the new authority for a 90 day=3 month reduction to all guard and Reserve members who have served since 9/11. TMC urges the Subcommittee to favorably report H.R. 4930 as the minimum next step on this issue.

A Total Force Approach to the Montgomery GI Bill – TMC urges Congress to integrate Guard and Reserve and active duty MGIB laws into Title 38. In addition, TMC recommends restoring basic reserve MGIB rates to approximately 50% of active duty rates and authorizing upfront reimbursement of tuition or training coursework for Guard and Reserve members. Accordingly, we support H.R. 4889.

Family Support Programs and Benefits – TMC urges Congress to continue and expand its emphasis on providing consistent funding and increased outreach to connect Guard and Reserve families with relevant support programs.

Tangible Support for Employers – The Coalition urges Congress to support needed tax relief for employers of Selected Reserve personnel and reinforce the Employer Support for Guard and Reserve Program. TMC strongly supports final passage of H.R. 3997.

Seamless Transition for Guard and Reserve Members – The Coalition urges the Subcommittee to continue and expand its efforts to ensure Guard and Reserve members and their families receive needed transition services to make a successful readjustment to civilian status.

Retirement Issues

Concurrent Receipt – The Coalition urges the Subcommittee to act expeditiously on the recommendations of the Veterans' Disability Benefits Commission and implement a plan to eliminate the deduction of VA disability compensation from military retired pay for all disabled military retirees.

Uniformed Services Retiree Entitlements and Benefits – TMC urges the Subcommittee to resist initiatives to "civilianize" the military retirement system in ways that reduce the compensation value of the current retirement system and undermine long-term retention.

Permanent ID Card Reform – The Coalition urges the Subcommittee to direct the Secretary of Defense to authorize issuance of permanent military identification cards to uniformed services family members and survivors who are age 65 and older.

Survivor Issues

SBP-DIC Offset – The Coalition strongly urges the Subcommittee to take further action to expand eligibility for the special survivor indemnity allowance to include all SBP-DIC survivors and continue progress toward completely repealing the SBP-DIC offset for this most-aggrieved group of military widows.

Final Retired Pay Check – TMC urges the Subcommittee to end the insensitive practice of recouping the final month's retired pay from the survivor of a deceased retired member.

Health Care Issues

Full Funding for the Defense Health Program – The Military Coalition strongly urges the Subcommittee to take all possible steps to restore the reduction in TRICARE-related budget authority and ensure continued full funding for Defense Health Program needs.

Protecting Beneficiaries Against Cost-Shifting – 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.

TMC Healthcare Cost Principles – The Coalition most strongly recommends Rep. Chet Edwards' and Rep. Walter Jones' H.R. 579 and Sen. Frank Lautenberg's and Sen. Chuck Hagel's S. 604 as models to establish statutory findings, a sense of Congress on the purpose and principles of military health care benefits, and explicit guidelines for and limitations on adjustments.

- Active duty members and families should be charged no fees except retail pharmacy co-payments, except to the extent they make the choice to participate in TRICARE Standard or use out-of-network providers under TRICARE Prime.
- For retired and survivor beneficiaries, the percentage increase in fees, deductibles, and co-payments that may be considered in any year should not exceed the percentage increase beneficiaries experience in their compensation.
- The TRICARE Standard inpatient copay should not be increased further for the foreseeable future. At $535 per day, it already far exceeds inpatient copays for virtually any private sector health plan.
- There should be no enrollment fee for TRICARE Standard or TRICARE For Life (TFL), since neither offers assured access to TRICARE-participating providers. An enrollment fee implies enrollees will receive additional services, as Prime enrollees are guaranteed access to participating providers in return for their fee. Congress already has required TFL beneficiaries to pay substantial Medicare Part B fees to gain TFL coverage.
- There should be one TRICARE fee schedule for all retired beneficiaries, just as all legislators, Defense leaders and other federal civilian grades have the same health fee schedule. The TRICARE schedule should be significantly lower than the lowest tier recommended by the Defense Department, recognizing that all retired members paid large up-front premiums for their coverage through decades of arduous service and sacrifice.

TRICARE Standard Enrollment – The Coalition strongly recommends against establishment of any TRICARE Standard enrollment system; to the extent enrollment may be required, any beneficiary filing a claim should be enrolled automatically, without denying the claim. No enrollment fee should be charged for TRICARE Standard until and unless the program offers guaranteed access to a participating provider.

Private Employer Incentive Restrictions – The Coalition recommends Congress modify the law restricting private employer TRICARE incentives to explicitly exempt employers who offer only cafeteria plans (i.e., cash payments to all employees to purchase care as they wish) and employers who extend specific cash payments to any employee who uses health coverage other than the employer plan (e.g., FEHBP, TRICARE, or commercial insurance available through a spouse or previous employer).

Provider Participation Adequacy – The Coalition urges the Subcommittee to continue monitoring DoD and GAO reporting on provider participation to ensure proper follow-on action.

Administrative Deterrents to Provider Participation – The Coalition urges the Subcommittee to continue its efforts to reduce administrative impediments that deter providers from accepting TRICARE patients.

TRICARE Reimbursement Rates – 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.

Additionally, 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 along with the affect of an absence of bonus payments.

Minimize Medicare/TRICARE Coverage Differences – The Coalition urges the Subcommittee to align TRICARE coverage to at least match that offered by Medicare in every area and provide preventive services at no cost.

TRICARE Reserve Select (TRS) Premium – The Coalition recommends reducing TRS premiums to $48/month (single) and $175/month (family), as envisioned by the GAO, with retroactive refunds as appropriate. For the future, the percentage increase in premiums in any year should not exceed the percentage increase in basic pay.

The Coalition further recommends that the Subcommittee request a report from the Department of Defense on options to assure TRS enrollees' access to TRICARE-participating providers.

Private Insurance Premium Option – The Coalition recommends developing a cost-effective option to have DoD subsidize premiums for continuation of a Reserve employer's private family health insurance during periods of deployment as an alternative to permanent TRICARE Reserve Select coverage.

Involuntary Separatees – The Coalition recommends authorizing one year of post-Transitional Assistance Management Program (TAMP) TRS coverage for every 90 days deployed in the case of returning members of the IRR or members who are involuntarily separated from the Selected Reserve. The Coalition further recommends that voluntarily separating Reservists subject to disenrollment from TRS should be eligible for participation in the Continued Health Care Benefits Program (CHCBP).

Gray Area Reservists – The Coalition urges the Subcommittee to authorize an additional premium-based option under which members entering "gray area" retiree status would be able to avoid losing health coverage.

Reserve Dental Coverage – The Coalition supports providing dental coverage to Reservists for 90 days pre- and 180 days post-mobilization (during TAMP), unless the individual's dental readiness is restored to T-2 condition before demobilization.

Restoration of Survivors' TRICARE Coverage – 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 – 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, when the family separation is due to a military-directed move or deployment.

BRAC, Re-Basing, and Relocation – The Coalition recommends codifying the requirement to provide a TRICARE Prime network at all areas impacted by BRAC or rebasing. Additionally, we recommend that DoD be required to provide an annual report to Congress on the adequacy of health resources, services, quality and access of care for those beneficiary populations affected by transformation plans.

Pharmacy Co-payment Changes – The Coalition recommends deferral of any pharmacy copay increases pending assessment of the effects of the new federal pricing law on usage and cost patterns for the different venues, and that the Subcommittee instead urge DoD to pursue copay reductions and ease prior authorization requirements for medications for chronic diseases, based on private sector experience that such initiatives reduce long-term costs associated with such diseases.

Rapid Expansion of "Third Tier" Formulary – The Coalition urges the Subcommittee to reassert its intent that the Beneficiary Advisory Panel should have a substantive role in the formulary-setting process, including access to meaningful data on relative drug costs in each affected class, consideration of all BAP comments in the decision-making process, and formal feedback concerning rationale for rejection of BAP recommendations.

Referral and Authorization System – The Coalition recommends that Congress require a cost analysis report, including input from each Managed Care Support Contractor, concerning the referral process within DoD and reliance on Civilian Network Providers within an MTF's Prime Service Area.

Deductibility of Health and Dental Premiums – The Coalition urges all Armed Services Committee members to seek the support of the Ways and Means and Finance Committees to approve legislation to allow all military beneficiaries to pay TRICARE-related insurance premiums in pre-tax dollars, to include TRICARE dental premiums, TRICARE Reserve Select premiums, TRICARE Prime enrollment fees, premiums for TRICARE Standard supplements, and long-term care insurance premiums.

OVERVIEW

Madam Chairman, The Military Coalition (TMC) thanks you and the entire Subcommittee for your continued, steadfast support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors. The Subcommittee's work last year generated ground-breaking, innovative improvements in military end strength, currently serving pay, survivor benefits, disabled retiree programs, and of most significance, improvements in wounded warrior benefits, care, and treatment. These enhancements will definitely make a positive difference in the lives of active, Guard and Reserve personnel, retirees, survivors, and families.

As our men and women in uniform continue to prosecute the Global War on Terror, the Coalition believes it is critical that the Nation support our troops with the appropriate resources. The services have reported that they are wearing out equipment at a record pace; however, the Coalition is concerned that we are wearing out our people in uniform at even a faster pace. The current rate of deployments and the accompanied stress to our troops and their families put at risk the readiness of our service members.

The men and women in uniform, active duty, Guard, and Reserve, are answering the call – but not without ever-greater sacrifice. Currently, over 615,000 National Guard and Reserve members have been called to active Federal service for the War on Terrorism. Over 150,000 have had two or more deployments, putting particular stress on these members' civilian careers and employers. The "total force", with the support of their families, continues to endure mounting stress brought about by repeated deployments and ever-increasing workloads. Therefore, now is not the time to scrimp on the needs for our troops and their families.

Over the past several years, the Pentagon has repeatedly sought to curb spending on military personnel and facilities to fund operational requirements. In the process, the Defense Department has imposed dramatic force reductions in the Air Force and the Navy, tried to deter military retirees from using their earned health coverage by proposing large TRICARE fee increases, and cut back on installation quality of life programs.

The Coalition believes these efforts to rob personnel to fund operations will only make the uniformed services more vulnerable to future readiness problems. We agree with the Chairman of the Joint Chiefs of Staff, who has stated that four percent of GDP should be the "absolute floor" for the overall military budget. If we want a strong national defense, we have to pay for a strong military force as well as replace and upgrade aging, war-worn weapons and equipment.

The Coalition is encouraged by Congress' strong support for continued increases to Army and Marine Corps end strength, in recognition that our troops and families are dangerously overburdened. We believe the country must follow through on future planned increases, regardless of troop withdrawals from Iraq, and that these should be funded through permanent increases in the defense budget, not supplemental appropriations that undermine essential, long-term commitments. It's been proven that our military didn't have sufficient forces to meet the requirements of the current war. It would be inexcusable not to be better prepared for future contingencies.

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

WOUNDED WARRIOR ISSUES

Last February, a series of articles in the Washington Post titled "The Other Walter Reed" profiled shocking cases of wounded service members who became lost in military health care and administrative systems upon being transferred to outpatient rehabilitative care.

Subsequently, the national media ran many stories of seriously wounded troops warehoused in substandard quarters, waiting weeks and months for medical appointments and evaluation board results, left pretty much on their own to try and navigate the confusing maze of medical system and benefit and disability rules, and low-balled into disability separations rather than being awarded the higher benefits of military disability retirement.

Interviews with family members – spouses, children, and parents – revealed heartbreaking real life dramas of those who quit their jobs and virtually lived at military hospitals to become caregivers to seriously wounded troops. Left with diminishing resources and unfamiliar with military benefit and disability rules, they were severely disadvantaged in trying to represent the interests of their wounded spouses and children who couldn't stand up for themselves.

These issues drew the attention of the President and Congress, leading to the immediate appointment of multiple special commissions and task forces charged with investigating the problems and identifying needed solutions. The Coalition is very grateful for the work of the Dole-Shalala Commission, the Marsh-West Independent Review Group, the VA Interagency Task Force on Returning Veterans, the Mental Health Task Force, and the previously authorized Veterans' Disability Benefits Commission. The Coalition endorses the vast majority of these groups' recommendations, and we're pleased that the Subcommittee made a conscientious effort to address many of them in the Wounded Warrior Act provisions of the FY2008 NDAA.

Congress and TMC agree that our Nation's service men and women have earned first class care and assistance, both during recuperation and following separation or retirement from the military.

We are gratified at the sincere and unprecedented leadership efforts in the Departments of Defense and Veterans' Affairs and the Armed Services and Veterans' Affairs Committees to transform the system to make this long overdue goal a reality.

But years of bureaucratic and parochial barriers can't be swept away as easily as we all would wish. The good work done in 2007 was only a modest first step on the path to transforming military and veterans programs to meet the pressing needs of wounded and disabled members and their families. We're still a long, long way from achieving the "seamless transition" goal.

Joint Transition Office – The Coalition believes one critical problem is bureaucratic stove-piping in each department. While both DoD and VA are making great efforts to cooperate, there is no permanent joint activity or office whose primary mission is to jointly plan and execute the seamless transition strategy and then exercise productive oversight over the longer-term process. There's no doubt about the good intentions of leadership, but to sustain the effort for the long

term requires a change in organizational structure. Periodic meetings, after which the DoD and VA participants return to their separate offices on opposite sides of the Potomac, won't sustain the effort after the horror stories fade from the headlines.

This simply can't be someone's part-time job. It requires a full-time joint federal transition office, staffed by full-time DoD, service and VA personnel working in the same office with a common joint mission: developing, implementing and overseeing the Joint Executive Council's strategic plan. This office's responsibilities should include:

- **Joint In-Patient Electronic Health Record** – The FY2008 NDAA took the first step in authorizing a DoD/VA Interagency Program Office to oversee this specific initiative, which TMC has been seeking for years. But we believe the 2012 objective for implementing this system is too long to wait. Congress must press DoD and VA to speed delivery as soon as humanly possible, with concrete timelines and milestones for action. TMC also believes that the same logic that necessitates a joint office's oversight of this specific initiative is equally applicable in other areas, and that the interagency office's area of responsibility should be expanded accordingly.
- **Special Needs Health Care** – Polytrauma Rehabilitation Centers were established to meet the specialized clinical care needs of patients with multiple trauma conditions. They provide comprehensive inpatient rehabilitation services for individuals with complex cognitive, physical and mental health sequelae of severe disabling trauma. These centers require special oversight in order to ensure the required resources are available to include specialized staff, technical equipment and adequate bed space. This oversight must be a joint effort since it provides a significant piece of the health care continuum for severely injured personnel.
- **Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injuries (TBI), and Mental Health/Counseling** – The Coalition strongly supports the provisions in the FY2008 NDAA establishing Centers of Excellence for these programs. We simply must have some central monitoring, evaluation, and crossfeed to take best advantage of the wide variety of current and planned DoD, service, and VA programs and pilot projects aimed at destigmatizing, identifying, and treating TBI and PTSD. The Coalition believes it also is important to ensure that TBI and PTSD are identified and treated as combat injuries rather than mental health problems. The Coalition is doubtful whether these centers, by themselves, will be in a position to ensure coordination and implementation of best practices across all departments and services.
- **Caregiver Initiatives** – Several wounded warrior provisions in the recently enacted NDAA provide additional support for the caregiver of the wounded warrior, typically a family member. However, we believe more needs to be done to strengthen support for families, to include the authorization of compensation for family member caregivers of severely injured who must leave their employment to care for the service member.
- A**ccess to Care** – A significant impediment to the "seamless transition" goal is that there are significant differences between health coverage and some other entitlements when a member transitions from active military service to separated or retired status. TRICARE benefits for disability retirees and families are not the same as they were on active duty, and there are significant differences between coverage and availability of programs between TRICARE and the VA. When a member dies on active duty, Congress has deemed that the member's family should be eligible for three years of active-duty-level TRICARE coverage to assist in the family's transition. TMC believes strongly that members who are disabled significantly by military service deserve equal treatment. The FY2008 NDAA authorized continued active-duty level coverage, but only for the servicemember, and then only in cases where VA

coverage is not available. TMC believes this limitation significantly undermines the seamless transition goal for wounded/disabled members whose rehabilitation and recovery may continue long after the time they leave active duty. Their needs – and those of their families – should not be inhibited by higher copays, deductibles, and coverage decreases the moment they are separated or retired from active duty. Allowing disabled members and their families to retain their active duty military health care benefit for three years after separation or retirement is essential to align our stated intentions with the realities faced by disabled members and families.

- **Joint Research** – Combined Research Initiatives would further enhance the partnership between VA and DoD. Since many of the concerns and issues of care are shared, joint collaboration of effort in the area of research should enable dollars to go much further and provide a more standardized system of health care in the military and veteran communities. Furthermore, research must also be performed jointly and across all Military Departments and with other practicing healthcare agencies to ensure timely integration of these findings in the diagnosis and treatment of wounded and disabled patients.

The Coalition is encouraged with the creation of a joint DoD-VA office to oversee development of a bi-directional electronic medical record. However, we strongly recommend that the Subcommittee upgrade the scope of responsibilities and span of authority for the new DoD-VA Interagency Program Office to include top-down planning and execution of all "seamless transition" functions, including the joint electronic health record; joint DoD/VA physical; implementation of best practices for TBI, PTSD, and special needs care; care access/coordination issues; and joint research.

The Coalition believes authorizing three years of their active-duty-level health care benefit for service-disabled members and their families after separation or retirement is essential to align stated "seamless transition" intentions with the realities faced by disabled members and families.

Disability Retirement Reform – Several of the Walter Reed task forces and commissions recommended significant changes to the DoD Disability Evaluation System (DES), and the FY2008 NDAA includes several initiatives requiring joint DoD/VA DES pilot programs; use of the VA Schedule for Rating Disabilities; review of medical separations with disability ratings of 20 percent or less; and enhanced disability severance pay. These changes will hopefully improve the overall DES and help correct the reported "low-ball" ratings awarded some wounded warriors.

The Coalition is very supportive of the current DoD/VA disability rating pilot, which has the potential to help streamline transition from active duty into veteran/retired status. However, we believe further legislative efforts are required to curb service differences in determining whether a condition existed prior to service. To this end, language in the FY2008 NDAA aimed at addressing this problem may actually have exacerbated it by amending only a part of the relevant provisions of law.

The Coalition does not support proposals to simply do away with the military disability retirement system and shift disability compensation responsibility to the VA. While this proposal seems administratively simple, and supports our long-standing "concurrent receipt" goal of ensuring proper vesting of service-based retirement for members who suffer from service-caused disabilities, it poses two significant risks that TMC deems unacceptable. First, it

would cause significant compensation reductions for some severely disabled personnel – up to $1,000 a month or more in some cases, and even more for some Guard and Reserve members who suffer severe disabilities. Second, it would eliminate the 30%-disability retirement threshold that now establishes eligibility for retiree TRICARE coverage for disabled members and their families. TMC believes there must continue to be a statutory military disability threshold above which the member is considered a military retiree (not simply a separatee and veteran) and eligible for all the privileges of military retirement, including TRICARE coverage. The Coalition objects strongly to establishing disability ratings, compensation, or health care eligibility based whether the disability was incurred in combat vice non-combat.

The Coalition strongly supports the recent NDAA requirement for a case review of members separated with 20% or lower ratings since Oct. 7, 2001. There is evidence that many received "low-ball" ratings that did not adequately reflect the degree of their disabilities and unfairly denied them eligibility for military disability retired pay and health coverage.

But we believe the Subcommittee did not go far enough to correct past inequities. The Coalition is aware of many cases of "model troops" who fell into depression, drug use, and disciplinary situations after one or more combat tours, and who subsequently received administrative or disciplinary discharges.

The Coalition urges the Subcommittee to ensure any legislative changes to the military disability evaluation and retirement systems do not reduce compensation and benefit levels for disabled service members.

The Coalition does not support proposals to do away with the military disability retirement system and shift disability compensation responsibility to the VA.

The Coalition urges an expanded review of all administrative and disciplinary separations since Oct 7, 2001 for members with recent combat experience to assess whether the behavior that led to separation may have been due to service-caused exposure.

ACTIVE FORCE ISSUES

The Subcommittee's key challenges will be to fend off those who wish to cut needed personnel and quality of life programs while working with DoD and the Administration to reduce the stress on the force and their families already subjected to repeated, long-term deployments. Rising day-to-day workloads for non-deployed members and repeated extensions of combat tours creates a breeding ground for retention problems. Meeting these challenges will require a commitment of personnel and resources on several fronts.

End Strength and Associated Funding – The Coalition was encouraged when the Subcommittee ensured that the Army and Marine Corps authorized end strengths continued to grow in FY2008, and we are further encouraged that the DoD has asked for additional manpower increases for the Army and Marine Corps over the next four years.

Congress must ensure these increases are sufficient to ease force rotation burdens and the services are fully funded in order to achieve the new end strength. Increasing end strength is not a quick fix that will ease the stressors on service members who are currently serving and their families.

Some already speculate that the planned increases may not be needed if we can reduce the number of troops deployed to Iraq. The Coalition believes strongly that the increases are essential to future readiness, regardless of force levels in Iraq. We know we didn't have enough troops to fight the current war without imposing terrible penalties on military members and families, and we must build our force management plans to avoid having to do so when the nation is faced with another major unexpected contingency requirement.

For too long, we have planned only for the best-case scenario, which ignores our responsibility to the Nation to be prepared for unexpected and less-favorable scenarios, which could well arise anywhere around the globe, including the Far East.

A full range of funding is required to support this necessary end strength, including housing, health care, family programs, and child care. Having the services absorb these costs out of pocket is self-defeating.

Furthermore, as the Army and Marine Corps increase over the next four years, the Coalition remains concerned that ongoing Navy and Air Force active and Reserve personnel cuts are driven by budget considerations rather than operational requirements. We believe it is increasingly likely that future experience will prove these cutbacks ill-advised, and urge the Subcommittee to reconsider their consistency with long-term readiness needs.

The Coalition strongly urges the Subcommittee to sustain projected increases in ground forces and provide additional recruiting, retention, and support resources as necessary to attain/sustain them.

The Coalition urges the Subcommittee to reconsider the consistency of projected reductions of Navy and Air Force forces with long-term readiness needs.

Compensation and Special Incentive Pays – The Coalition is committed to ensuring that pay and allowance programs are equitably applied to the seven uniformed services. In that regard, the Coalition urges the Subcommittee to be mindful that personnel and compensation program adjustments for Department of Defense forces should also apply to uniformed members of the Coast Guard, NOAA Corps and Public Health Service.

Since the turn of the century, Congress and DoD have made significant progress to improve the lives of men and women in uniform and their families. Since 1999, when military pay raises had lagged a cumulative 13.5% behind the private sector pay comparability standard, the Subcommittee has narrowed that gap to 3.4%. Each year during that span, the Subcommittee has ensured at least some progress in shrinking that disparity further. TMC is grateful for that progress, and believes strongly that it should continue until full pay comparability is restored.

DoD uses the 70th percentile of earnings of private workers of comparable age, experience and education as a standard to help rebalance the military pay table through special targeted pay increases depending on grade and longevity status. The Coalition believes this measure is useful as one tool in the process of establishing the proper progression of the pay table, and needs to be monitored and applied as necessary in the future. But it does not, by itself, supplant overall growth in the Employment Cost Index (ECI) as the measure of pay comparability, nor does it erase the remaining 3.4% gap between military pay raises and private sector pay growth.

The Coalition believes Congress will never find a better opportunity to phase out the remaining gap than today's conditions when private sector pay growth is relatively low. In assessing the proper amount to reduce the pay gap, Congress also should consider that today's troops are working much harder – and their families sacrificing much more – for their modest raises.

This year, we expect the Defense budget will propose a 3.4% raise for military personnel in 2009 – a percentage equal to the growth in private sector pay two years earlier in 2007. The Coalition believes strongly that this is not the time to end Congress' steady path of progress in reducing the military pay comparability gap.

The Coalition urges the Subcommittee to propose a military pay raise of at least 3.9% for FY2009 (one-half percentage point above private sector pay growth) and to continue such half-percent annual increases over the ECI until the current 3.4% pay comparability gap is eliminated.

The Coalition also urges the Subcommittee to continue periodic targeted pay raises as appropriate to recognize the growing education and technical qualifications of enlisted members and warrant officers and sustain each individual grade/longevity pay cell at the minimum 70th percentile standard.

Access to Quality Housing – Today's housing allowances come much closer to meeting military members' and families' housing needs than in the past, thanks to the conscientious efforts of the Subcommittee in recent years.

But the Coalition believes it's important to understand that some fundamental flaws in the standards used to set those allowances remain to be corrected, especially for enlisted members.

The Coalition supports revised housing standards that are more realistic and appropriate for each pay grade. Many enlisted personnel are unaware of the standards for their respective pay grade and assume that their BAH level is determined by a higher standard or by the type of housing for which they would qualify if they live on a military installation. For example, only 1.25% of the enlisted force (E-9) is eligible for BAH sufficient to pay for a 3-bedroom single-family detached house, even though thousands of more junior enlisted members do, in fact, reside in detached homes. The Coalition believes that as a minimum, this BAH standard (single-family detached house) should be extended gradually to qualifying service members beginning in grade E-8 and subsequently to grade E-7 and below over several years as resources allow.

The Military Coalition urges reform of military housing standards that inequitably depress BAH rates for mid to senior enlisted members by relegating their occupancy to inappropriately small quarters.

Family Readiness and Support – A fully funded, robust family readiness program continues to be crucial to overall readiness of our military, especially with the demands of frequent and extended deployments.

Resource issues continue to plague basic installation support programs. At a time when families are dealing with increased deployments, they are being asked to do without. Often family centers are not staffed for outreach. Library and sports facilities hours are being abbreviated or

cut altogether. Manpower for installation security is being reduced. These are additional sacrifices that we are imposing on our families left behind while their service members are deployed.

In a similar vein, the Coalition believes additional authority and funding is needed to offer respite and extended child care for military families. These initiatives should be accompanied by a more aggressive outreach and education effort to improve members' and families' financial literacy. We should ensure members are aware of and encouraged to use child care, mental health support, spousal employment, and other quality-of-life programs that have seen recent growth. However, this education effort should also include expanded financial education initiatives to inform and counsel members and families on life insurance options, Thrift Savings Plan, IRAs, flexible spending accounts, savings options for children's education, and other quality of life needs.

In particular service members must be educated on the long-term financial consequences of electing to accept the much lower-value $30,000 REDUX retention bonus after 15 years of service vice sustaining their full High-3 retirement benefit.

The Coalition urges the Subcommittee to support increased family support funding and expanded education and other programs to meet growing needs associated with increased ops tempo, extended deployments and the more complex insurance, retirement, and savings choices faced by over-extended military families.

Spouse Employment – The Coalition is pleased that movement is being made to enhance the total force spouse employment opportunities through a test program and strong partnerships between DoD, Department of Labor, service organizations, employers, and others; however, more needs to be done.

More and more military spouses are in the workforce than in the past, but challenges in finding jobs after relocation adversely impact the military families' financial stability and satisfaction with military life. Spouse employment helps contribute to a strong military and helps in retention of our high quality, all-volunteer force. Defense leaders repeatedly acknowledge, "We recruit service members, but we retain families."

One of the greatest frustrations for working spouses is the career and financial disruption associated with military-directed relocations. If we're serious about retaining more military families, we must get serious about easing this significant career and military life dissatisfier.

The Coalition urges the Subcommittee to support H.R. 2682, which would expand the Workforce Opportunity Tax Credit for employers who hire spouses of Regular and Reserve component service members.

Additionally, the Coalition supports providing tax credits to offset military spouses' expenses in obtaining career-related licenses or certifications when service members are relocated to a different state.

Flexible Spending Accounts – The Coalition cannot comprehend the Defense Department's continuing failure to implement existing statutory authority for active duty and Selected Reserve

members to participate in Flexible Spending Accounts (FSAs), despite both Armed Services Committees' prodding on this subject.

All other federal employees and corporate civilian employees are able to use this authority to save thousands of dollars a year by paying out-of-pocket health care and dependent care expenses with pre-tax dollars. It is unconscionable that the Department has failed to implement this money-saving program for the military members who are bearing the entire burden of national sacrifice in the Global War on Terrorism.

TMC urges the Subcommittee to continue pressing the Defense Department until service members are provided the same eligibility to participate in Flexible Spending Accounts that all other federal employees and corporate employees enjoy. Additionally, we support H.R. 1110.

Permanent Change of Station (PCS) Allowances – PCS allowances have continually failed to keep pace with the significant out-of-pocket expenses service members and their families incur in complying with government-directed moves.

For example, PCS mileage rates still have not been adjusted since 1985. The current rates range from 15 to 20 cents per mile – an ever-shrinking fraction of the 50.5 cents per mile rate authorized for temporary duty travel. Also, military members must make any advance house-hunting trips at personal expense, without any government reimbursements such as federal civilians receive.

Additionally, the overwhelming majority of service families consist of two working spouses, making two privately owned vehicles a necessity. Yet the military pays for shipment of only one vehicle on overseas moves, including moves to Hawaii and Alaska. This forces relocating families into large out-of-pocket expenses, either by shipping a second vehicle at their own expense or selling one car before leaving the states and buying another upon arrival. The Coalition is greatly disappointed that, for two consecutive years, a Subcommittee proposal to authorize shipping two vehicles to non-foreign duty locations outside of CONUS has been dropped in conference.

The Coalition is grateful that the senior enlisted PCS weight allowance tables were increased slightly in the FY2006 NDAA; however, we believe that these modification need to go further for personnel in pay grades E-7, E-8, and E-9 to coincide with allowances for officers in grades O-4, O-5, and O-6 respectively. The personnel property weight for a senior E-9 leader without dependents remains the same as for a single O-3 despite the normal accumulation of household goods over the course of a career.

Four years ago, the Subcommittee authorized the Families First initiative. Among its provisions was full replacement value (FRV) reimbursement for household goods damaged during PCS moves. We are grateful that this first FRV phase has begun but will continue to monitor its implementation. The next phase, focusing on survey results and real time access to the progress of household goods in the moving process has yet to be fully implemented. We will continue to monitor the progress and hope that Congress will be doing the same.

Aside from that long-delayed initiative the last real adjustment in PCS expenses was seven years ago in 2001, when this Subcommittee upgraded PCS per diem (but not mileage) rates and raised the maximum daily Temporary Lodging Expense (TLE) allowance from $110 to $180 a day for

a PCSing family, among certain other adjustments, including the increase in the junior enlisted weight allowances. That TLE amount is supposed to cover a family's food and lodging expenses while in temporary quarters at the gaining or losing installation. Today, after seven years of inflation, it's hardly adequate to cover the daily expenses of a family of four or five anywhere in America, let alone a family ordered to relocate to San Diego or Washington, DC.

The Coalition also supports authorization of a dislocation allowance for service members making their final "change of station" upon retirement from the uniformed services and a 500-pound professional goods weight allowance for military spouses.

We cannot avoid requiring members to make regular relocations, with all the attendant disruptions in their children's education and their spouses' careers. The Coalition believes strongly that the Nation that requires military families to incur these disruptions should not be making them bear the attendant high expenses out of their own pockets.

The Military Coalition urges the Subcommittee to upgrade permanent change-of-station allowances to better reflect the expenses members are forced to incur in complying with government-directed relocations, with priority on adjusting flat-rate amounts that have been eroded by years – or decades – of inflation, and shipment of a second vehicle at government expense to overseas accompanied assignments.

BRAC/Rebasing/Military Construction/Commissaries – TMC remains concerned about inadequacy of service implementation plans for DoD transformation, global repositioning, Army modularity, and BRAC initiatives. Given the current wartime fiscal environment, TMC is greatly worried about sustaining support services and quality of life programs for members and families. These programs are clearly at risk – not a week goes by that the Coalition doesn't hear reports of cutbacks in base operation accounts and base services because of funding shortfalls.

Feedback from the installation level is that local military and community officials often are not brought "into the loop" or provided sufficient details on changing program timetables to plan, seek, and fund support programs (housing, schools, child care, roads, and other infrastructure) for the numbers of personnel and families expected to relocate to the installation area by a specific date.

We believe it is important to note that the commissary is a key element of the total compensation package for service members and retirees. In addition to providing average savings of thirty percent over local supermarkets, commissaries provide an important tie to the military community. Shoppers get more than groceries at the commissary. It is also an opportunity to connect with other military family members and to get information on installation programs and activities through bulletin boards and installation publications. Finally, shoppers receive nutrition information and education through commissary promotions and educational campaigns contributing to the overall health of the entire beneficiary population.

The Coalition urges the Subcommittee to closely monitor rebasing/BRAC plans and schedules to ensure sustainment and timely development of adequate family support/quality of life programs. And at closing and gaining installations, respectively – to include housing, education, child care, exchanges and commissaries, health care, family centers, unit family readiness, and other support services.

Morale, Welfare, and Recreation Programs – The availability of appropriated funds to support MWR activities is an area of continuing concern. TMC strongly opposes any DOD initiative that withholds or reduces MWR appropriated support for Category A and Category B programs or that reduces the MWR dividend derived from military base exchange programs.

Service members and their families are reaching the breaking point as a result of the war and the constant changes going on in the force. It is unacceptable to have troops and families continue to take on more responsibilities and sacrifices and not give them the support and resources to do the job and to take care of the needs of their families.

TMC urges the Subcommittee to ensure that DoD funds MWR programs at least to the 85 percent level for Category A programs and 65 percent for Category B requirements.

Education Enhancements – Providing quality education for all military children is a key recruiting and retention standard that has been historically supported by the Subcommittee.

The Coalition is concerned that there was no increase in the amount of the DoD Supplement to Impact Aid. The need for supplemental funding as school districts receive more military children as rebasing is implemented is increasing. We believe that the funding should reflect this greater impact.

Service members have seen the value of their Montgomery GI Bill (MGIB) dramatically diminish due to double digit education inflation. The Coalition recommends tying the MGIB education benefit level to the average cost of a four-year public college.

Furthermore, service families facing several duty location changes during a career often encounter problems establishing state residency for the purpose of obtaining in-state tuition rates for military children and spouses. The Coalition supports authorizing in-state college tuition rates for service members and their families in the state in which the member is assigned and the member's home state of record. The in-state tuition should remain continuous once the military member or family member is established as a student.

TMC urges the Subcommittee to work with the House Veterans Affairs Committee to establish the benchmark level of Montgomery GI Bill (MGIB) education benefits at the average cost of attending a four-year public college, and support continuous in-state tuition eligibility for service members and their families in the state in which the member is assigned and the member's home state of record once enrolled as a student.

NATIONAL GUARD AND RESERVE FORCE ISSUES

Every day somewhere in the world, our National Guard and Reserves are answering the call to service. Although there is no end in sight to their participation in homeland security, overseas deployment and future contingency operations, Guard and Reserve members have volunteered for these duties and accept them as a way of life in the 21st Century.

Since Sept. 11, 2001, more than 615,000 National Guard and Reserve service men and women have been called to active Federal service for the War on Terrorism and more than 150,000 have served multiple deployments. They are experiencing similar sacrifices as the active duty forces. However, readjusting to home life, returning to work and the communities and families they left

behind puts added stress on Guard and Reserve members. Unlike active duty members, whose combat experience enhances their careers, many Guard Reserve members return to employers who are unhappy about their active duty service and find that their civilian careers have been inhibited by their prolonged absences. Further, despite the continuing efforts of the Subcommittee, most Guard and Reserve families do not have the same level of counseling and support services that the active duty members have.

All Guard and Reserve components are facing increasing challenges involving major equipment shortages, end-strength requirements, wounded-warrior health care, assistance and counseling for Guard and Reserve members for pre-deployment and post-deployment contingency operations.

Congress and the Department of Defense must provide adequate benefits and personnel policy changes to support our troops who go in harm's way.

Reserve Retirement and 'Operational Reserve' Policy – The assumption behind the 1948-vintage G-R retirement system – retired pay eligibility at age 60 – was that these service members would be called up only infrequently for short tours of duty, allowing the member to pursue a full-time civilian career with a full civilian retirement. Under the "Operational Reserve" policy, Reservists will be required to serve one-year active duty tours every five or six years.

Repeated, extended activations devalue full civilian careers and impede Reservists' ability to build a full civilian retirement, 401(k), etc. Regardless of statutory reemployment protections, periodic long-term absences from the civilian workplace can only limit Guard and Reserve members' upward mobility, employability and financial security. Further, strengthening the Reserve retirement system is needed as an incentive to retain critical mid-career officers and NCOs for a full Reserve career to meet long-term readiness needs.

The Coalition is grateful for the FY 2008 NDAA provision that would lower the Reserve retirement age by three months for each cumulative 90 days of active duty on contingency operation orders. TMC appreciates the importance of this small first step, but is very concerned that the new authority authorizes such credit only for service in 2008 and beyond – ignoring the extreme sacrifices of those who have borne the greatest burden of sacrifice in the war on terror for one, two, three or more combat tours in the past six years.

TMC strongly urges further progress in revamping the reserve retirement system in recognition of increased service and sacrifice of National Guard and Reserve Component members, including at a minimum, extending the new authority for a 90 day=3 month reduction to all guard and Reserve members who have served since 9/11. TMC urges the Subcommittee to favorably report H.R. 4930 as the minimum next step on this issue.

A Total Force Approach to the MGIB – The Nation's active duty, National Guard and Reserve forces are operationally integrated under the Total Force policy. But educational benefits under the MGIB do not reflect the policy nor match benefits to service commitment.

TMC is grateful that the FY2008 NDAA addressed a major inequity for operational Reservists by authorizing 10 years of post-service use for benefits earned under Chapter 1607, 10 USC.

But this change will require the DoD, not the VA to pay the costs of readjustments for Reservists. At a hearing on January 17, 2008, a senior DoD official acknowledged that the DoD no longer should control Chapter 1607.

In addition, basic reserve MGIB benefits for initial service entry have lost proportional parity with active duty rates since 9/11. These relative benefits have spiraled down from a historic ratio of 47-50% of active duty MGIB levels to less than 29% – at a time when Guard and Reserve recruitment continues to be very challenging.

TMC urges Congress to integrate Guard and Reserve and active duty MGIB laws into Title 38. In addition, TMC recommends restoring basic reserve MGIB rates to approximately 50% of active duty rates and authorizing upfront reimbursement of tuition or training coursework for Guard and Reserve members. Accordingly, we support H.R. 4889.

Family Support Programs and Benefits – The Coalition supports providing adequate funding for a core set of family support programs and benefits that meet the unique needs of Guard and Reserve families with uniform access for all service members and families. These programs would promote better communication with service members, specialized support for geographically separated Guard and Reserve families and training and back up for family readiness volunteers. This access would include:

- Web-based programs and employee assistance programs such as Military One Source and Guard Family.org.
- Enforcement of command responsibility for ensuring that programs are in place to meet the special needs of families of individual augmentees or the geographically dispersed.
- Expanded programs between military and community religious leaders to support service members and families during all phases of deployments.
- Availability of robust preventive counseling services for service members and families and training so they know when to seek professional help related to their circumstances.
- Enhanced education for Guard and Reserve family members about their rights and benefits.
- Innovative and effective ways to meet the Guard and Reserve community's needs for occasional child care, particularly for preventive respite care, volunteering, and family readiness group meetings and drill time.
- A joint family readiness program to facilitate understanding and sharing of information between all family members, no matter what the service.

The Coalition recognizes the Subcommittee's longstanding interest and efforts on this topic, including several provisions in the FY2008 NDAA. The Coalition will monitor the results of the surveys and increased oversight called for in the provisions and looks forward to working closely with the Family Readiness Council.

TMC urges Congress to continue and expand its emphasis on providing consistent funding and increased outreach to connect Guard and Reserve families with relevant support programs.

Tangible Support for Employers – Employers of Guard and Reserve service members shoulder an extra burden in support of the national defense. The new "Operational Reserve" policy places even greater strain on employers. For their sacrifice, they get plaques to hang on the wall.

For Guard and Reserve members, employer 'pushback' is listed as one of the top reasons for Reservists to discontinue Guard and Reserve service. If we are to sustain a viable Guard and Reserve force for the long term, the Nation must do more to tangibly support employers of the Guard and Reserve and address their substantive concerns, including initiatives such as:

- Tax credits for employers who make up any pay differential for activated employees.
- Tax credits to help small business owners hire temporary workers to fill in for activated employees.
- Tax credits for small manufacturers to hire temporary workers.

The Coalition urges Congress to support needed tax relief for employers of Selected Reserve personnel and reinforce the Employer Support for Guard and Reserve Program. TMC strongly supports final passage of HR 3997.

Seamless Transition for Guard and Reserve Members – Over 615,000 members of the Guard and Reserve have been activated since 9/11. Congressional hearings and media reports have documented the fact that at separation, many of these service members do not receive the transition services they and their families need to make a successful readjustment to civilian status. Needed improvements include but are not limited to:

- Funding to develop tailored Transition Assistance Program (TAP) services in the hometown area following release from active duty.
- Expansion of VA outreach to provide "benefits delivery at discharge" services in the hometown setting.
- Authority for mobilized Guard and Reserve members to file "Flexible Spending Account" claims for a prior reporting year after return from active duty.
- Authority for employers and employees to contribute to 401k and 403b accounts during mobilization.
- Enactment of academic protections for mobilized Guard and Reserve students including: academic standing and refund guarantees; and, exemption of Federal student loan payments during activation.
- Automatic waivers on scheduled licensing / certification / promotion exams scheduled during a mobilization.
- Authority for reemployment rights for Guard and Reserve spouses who must suspend employment to care for children during mobilization.

The Coalition appreciates the work of this Subcommittee in seeking to address some of these needs in the FY2008 NDAA, but more remains to be done.

The Coalition urges the Subcommittee to continue and expand its efforts to ensure Guard and Reserve members and their families receive needed transition services to make a successful readjustment to civilian status.

RETIREMENT ISSUES

The Military Coalition is extremely grateful to the Subcommittee for its support of maintaining a strong military retirement system to help offset the extraordinary demands and sacrifices inherent in a career of uniformed service.

Concurrent Receipt – In the FY2004 NDAA, Congress acknowledged the inequity of the disability offset to earned retired pay and established a process to end or phase out the offset for all members with at least 20 years of service and at least a 50% disability rating. That legislation also established the Veterans' Disability Benefits Commission and tasked the Commission to review the disability system and recommend any further adjustments to the disability offset law.

Now the Commission has provided its report to Congress, in which it recommended an end to the VA compensation offset for all disabled military retirees, regardless of years of service, percentage of disability, or source of the service-connected disability (combat vs. non-combat).

In the interim, Congressional thinking has evolved along similar lines. The Coalition is thankful for the Subcommittee's efforts in the FY2008 NDAA to extend Combat-Related Special Compensation to disabled retirees who had their careers forced into retirement before attaining 20 years of service, as well as ending the offset for retirees rated unemployable by the VA.

Despite this important progress, major inequities still remain that require the Subcommittee's immediate attention. Many retirees are still excluded from the same principle that eliminates the disability offset for those with 50 percent or higher disabilities. The Coalition agrees strongly with the Veterans' Disability Benefits Commission that principle is the same for all disabled retirees, including those not covered by concurrent receipt relief enacted so far.

The one key question is, "Did the retired member fully earn his or her service-based retired pay, or not, independent of any disability caused by military service in the process?" The Coalition and the Disability Commission agree that the answer has to be "Yes." Any disability compensation award should be over and above service-earned retired pay.

If a service-caused disability is severe enough to bar the member's continuation on active duty, and the member is forced into medical retirement short of 20 years of service, the member should be "vested" in service-earned retired pay at 2.5% times pay times years of service.

To the extent that a member's military disability retired pay exceeds the amount of retired pay earned purely by service, that additional amount is for disability and therefore is appropriately subject to offset by VA disability compensation.

The principle behind eliminating the disability offset for Chapter 61 retirees with less than 20 years of service with combat-related disabilities is no less applicable to those who had their careers cut short by other service-caused conditions. It is simply inappropriate to make such members fund their own VA disability compensation from their service-earned military retired pay, and it is unconscionable that current law forces thousands of severely injured members with as much as 19 years and 11 months of service to forfeit most or all of their earned retired pay.

The Coalition urges the Subcommittee to act expeditiously on the recommendations of the Veterans' Disability Benefits Commission and implement a plan to eliminate the deduction of VA disability compensation from military retired pay for all disabled military retirees.

Uniformed Services Retiree Entitlements and Benefits – The Coalition awaits the results of the 10th Quadrennial Review of Military Compensation, which was tasked with reviewing the recommendations of the Defense Advisory Committee on Military Compensation (DACMC). The Coalition does not support the DACMC recommendations to modify the military retirement

system to more closely reflect civilian practices, including vesting for members who leave service short of a career and delaying retired pay eligibility until age 60 for those who serve a career.

Many such proposals have been offered in the past, and have been discarded for good reasons. The only initiative to substantially curtail/delay military retired pay that was enacted – the 1986 REDUX plan – had to be repealed 13 years later after it began inhibiting retention.

The Coalition believes such initiatives to "civilianize" the military retirement system in ways that reduce the value of the current retirement system and undermine long-term retention are based on a seriously flawed premise. The reality is that unique military service conditions demand a unique retirement system. Surveys consistently show that the military retirement system is the single most powerful incentive to serve a full career under conditions few civilians would be willing to endure for even one year, much less 20 or 30. A civilian-style retirement plan would be appropriate for the military only if military service conditions were similar to civilian working conditions – which they most decidedly are not. The Coalition believes strongly that, if such a system as recommended by the DACMC existed for today's force under today's service conditions, the military services would already be mired in a much deeper and more traumatic retention crisis than they have experience for many of the past several years.

TMC urges the Subcommittee to resist initiatives to "civilianize" the military retirement system in ways that reduce the compensation value of the current retirement system and undermine long-term retention.

Permanent ID Card Eligibility – The advent of TRICARE For Life (TFL), expiration of TFL-eligible spouses' and survivors' military identification cards – and the threatened denial of health care claims – have caused many frail and elderly members and their caregivers significant administrative and financial distress.

Previously, those who lived miles from a military installation or who resided in nursing homes and assisted living facilities simply did not bother to renew their ID cards upon the four year expiration date. Before enactment of TFL, they had little to lose by not doing so. But now, ID card expiration cuts off their new and all-important health care coverage.

Congress has agreed with the Coalition's concerns that a four-year expiration date is reasonable for younger family members and survivors who have a higher incidence of divorce and remarriage, but it imposes significant hardship and inequity upon elderly dependents and survivors.

In the FY2005 NDAA, Congress authorized permanent ID cards for spouses and survivors who have attained age 75 (vs. the Coalition-recommended age 65), recognizing that many elderly spouses and survivors with limited mobility or who live in residential care facilities find it difficult or impossible to renew their military ID cards. Subsequently, Congress expanded that eligibility to permanently disabled dependents of retired members, regardless of age.

Coalition associations continue to hear from a number of beneficiaries below the age of 75 who are disabled, living in residential facilities, are unable to drive, or do not live within a reasonable distance of a military facility. The threat of loss of coverage is forcing many others to try to

drive long distances – sometimes in adverse weather and at some risk to themselves and others – to get their cards renewed.

For administrative simplicity, the Coalition believes the age for the permanent ID card for spouses and survivors should coincide with the advent of TRICARE For Life. To the extent an interim step may be necessary, the eligibility age could be reduced to 70.

The Coalition urges the Subcommittee to direct the Secretary of Defense to authorize issuance of permanent military identification cards to uniformed services family members and survivors who are age 65 and older.

SURVIVOR ISSUES

The Coalition is grateful to the Subcommittee for its significant efforts in recent years to improve the Survivor Benefit Plan (SBP). We particularly note that, as of April 1, thanks to this Subcommittee's efforts, the minimum annuity for all SBP beneficiaries, regardless of age will be 55% of covered retired pay.

We also appreciate the Subcommittee's initiative in last year's defense bill that establishes a special survivor indemnity allowance that is the first step in a longer-term effort to phase out the Dependency and Indemnity Compensation (DIC) offset to SBP when the member died of a service-caused condition.

SBP-DIC Offset – The Coalition believes strongly that current law is unfair in reducing military Survivor Benefit Plan (SBP) annuities by the amount of any survivor benefits payable from the VA Dependency and Indemnity Compensation (DIC) program.

If the surviving spouse of a retiree who dies of a service-connected cause is entitled to DIC from the Department of Veterans Affairs and if the retiree was also enrolled in SBP, the surviving spouse's SBP benefits are reduced by the amount of DIC. A pro-rata share of SBP premiums is refunded to the widow upon the member's death in a lump sum, but with no interest. This offset also affects all survivors of members who are killed on active duty.

The Coalition believes SBP and DIC payments are paid for different reasons. SBP is purchased by the retiree and is intended to provide a portion of retired pay to the survivor. DIC is a special indemnity compensation paid to the survivor when a member's service causes his or her premature death. In such cases, the VA indemnity compensation should be added to the SBP the retiree paid for, not substituted for it. It should be noted as a matter of equity that surviving spouses of federal civilian retirees who are disabled veterans and die of military-service-connected causes can receive DIC without losing any of their federal civilian SBP benefits.

The Coalition is concerned that, in authorizing the special survivor indemnity allowance in last year's NDAA, the conferees did not use the precise language proposed by this Subcommittee, but adopted a technical language change that had the effect of limiting eligibility for the new allowance to survivors of members who were either retired or in the "gray area" reserve at the time of death. That is, it excluded survivors of members who died while serving on active duty.

The Coalition believes strongly that the latter group of survivors is equally deserving of the new allowance. Some have argued that relief should be allowed only for those who paid a cash

premium in retirement. The Coalition strongly disagrees, noting that a severely injured member who dies one month after his military disability retirement and who paid one month of SBP premiums is little different than the case of a member who is more severely injured and expires more rapidly. Further, the new law authorizes coverage for "gray area" retirees who have paid no premiums, since their retired pay and SBP premiums don't begin until age 60.

But the Coalition believes the issue goes beyond any such hair-splitting. The reality is that, in every SBP/DIC case, active duty or retired, the true premium extracted by the service from both the member and the survivor was the ultimate one – the very life of the member – and that the service was what caused his or her death.

The Coalition knows that the Subcommittee is aware that the military community (and especially the survivors concerned) view the amount of the new allowance – $50 per month initially, and growing to $100 over the course of several years – as grossly inadequate. We appreciate that the Subcommittee could have elected to do nothing rather than incur the expected negative feedback about the small amount. In that regard, we applaud you for having the courage to acknowledge the inequity and take this first step, however small, to begin trying to address it.

But we also urge the Subcommittee to work hard to accelerate increases in the amount of the allowance, to send the much-needed message to these survivors who have given so much to their country that Congress fully intends to find a way to address their loss more appropriately.

The Coalition strongly urges the Subcommittee to take further action to expand eligibility for the special survivor indemnity allowance to include all SBP-DIC survivors and continue progress toward completely repealing the SBP-DIC offset for this most-aggrieved group of military widows.

Final Retired Pay Check – The Military Coalition believes the policy requiring recovery of a deceased member's final retired pay check from his or her survivor should be changed to allow the survivor to keep the final month's retired pay.

Current regulations require the survivor to surrender the final month of retired pay, either by returning the outstanding paycheck or having a direct withdrawal recoupment from her or his bank account.

The Coalition believes this is an extremely insensitive policy imposed by the government at a most traumatic time for a deceased member's next of kin. Unlike his or her active duty counterpart, a retiree's survivor receives no death gratuity. Many older retirees do not have adequate insurance to provide even a moderate financial cushion for surviving spouses. Very often, the surviving spouse already has had to spend the final month's retired pay before being notified by the military finance center that it must be returned. Then, to receive the partial month's pay of the deceased retiree up to the date of death, the spouse must file a claim for settlement – an arduous and frustrating task, at best – and wait for the military's finance center to disburse the payment. Far too often, this strains the surviving spouse's ability to meet the immediate financial obligations commensurate with the death of the average family's "bread winner."

TMC urges the Subcommittee to end the insensitive practice of recouping the final month's retired pay from the survivor of a deceased retired member.

HEALTH CARE ISSUES

The Coalition very much appreciates the Subcommittee's strong and continuing interest in keeping health care commitments to military beneficiaries. We are particularly grateful for your support for the last two years in refusing to allow the Department of Defense to implement disproportional beneficiary health fee increases.

The Coalition is more than willing to engage substantively in TRICARE fee and copay discussions with DoD. In past years, the Coalition and the Defense Department have had regular and substantive dialogues that proved very productive in facilitating reasonably smooth implementation of such major program changes as TRICARE Prime and TRICARE for Life. The objective during those good-faith dialogues has been finding a balance between the needs of the Department and the needs of beneficiaries.

It is a great source of regret to the Coalition that there has been substantively less dialogue on the more recent fee increase initiatives. From its actions, it is hard to draw any other conclusion than the Department's sole concern is to extract a specified amount of budget savings from beneficiaries. The savings are intended to come from increased revenues from higher fees and less utilization by military retirees. The Coalition and Congressional Budget Office believe that DoD's approach will not achieve the projected savings.

The unique package of military retirement benefits – of which a key component is a top-of-the-line health benefit – is the primary offset afforded uniformed service members for enduring a career of unique and extraordinary sacrifices that few Americans are willing to accept for one year, let alone 20 or 30. It is an unusual – and essential – compensation package that a grateful Nation provides for the relatively few who agree to subordinate their personal and family lives to protecting our national interests for so many years.

Full Funding for the Defense Health Program – The Coalition very much appreciates the Subcommittee's support for maintaining – and expanding where needed – the healthcare benefit for all military beneficiaries, consistent with the demands imposed upon them.

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. To a large extent, military health cost growth is a direct reflection of health care trends in the private sector.

It is true that many private sector employers are choosing to shift an ever-greater share of health costs to their employees and retirees. In the bottom-line-oriented corporate world, many firms see their employees as another form of capital, from which maximum utility is to be extracted at minimum cost, and those who quit are replaceable by similarly experienced new hires. But that can't be the culture in the military's closed personnel, all volunteer model, whose long-term effectiveness is utterly dependent on establishing a sense of mutual, long-term commitment between the service member and his/her country.

Some assert active duty personnel costs have increased 60% since 2001, of which a significant element is for compensation and health costs. But much of that cost increase is due to conscious decisions by Congress to correct previous shortfalls – including easing the double-digit military

"pay gap" of that era and correcting the unconscionable situation before 2001 when military beneficiaries were summarily dropped from TRICARE coverage at age 65. Additionally, much of the increase is due to the cost of war and increased optempo.

Meanwhile, the cost of basic equipment soldiers carry into battle (helmets, rifles, body armor) has increased 257% (more than tripled) from $7K to $25K since 1999. The cost of a Humvee has increased seven-fold (600%) since 2001 (from $32K to $225K).

While we have an obligation to do our best to intelligently allocate these funds, the bottom line is that maintaining the most powerful military force in the world is expensive – and doubly so in wartime.

The Coalition assumes that DoD will again propose a reduction to the defense health budget based on the assumption that Congress will approve beneficiary fee increases for FY2009 at least as large as those as outlined last year. The Coalition objects strongly to the Administration's arbitrary reduction of the TRICARE budget submission. DoD has typically overestimated its healthcare costs as evidenced by a recent GAO report on the TRICARE Reserve Select premiums. The Coalition deplores this inappropriate budget "brinksmanship", which risks leaving TRICARE significantly underfunded, especially in view of statements made for the last two years by leaders of both Armed Services Committees that the Department's proposed fee increases were excessive.

The Coalition understands only too well the very significant challenge such a large and arbitrary budget reduction would pose for this Subcommittee if allowed to stand. If the reduction is not made up, the Department almost certainly will experience a substantial budget shortfall before the end of the year. This would then generate supplemental funding needs, further program cutbacks, and likely efforts to shift even more costs to beneficiaries in future years – all to the detriment of retention and readiness.

The Coalition particularly objects to DoD's past imposition of "efficiency wedges" in the health care budget, which have nothing to do with efficiency and everything to do with imposing arbitrary budget cuts that impede delivery of needed care. We are grateful at the Subcommittee's strong action on this topic, and trusts in your vigilance to ensure that such initiatives will not be part of this year's budget process.

The Military Coalition strongly urges the Subcommittee to take all possible steps to restore the reduction in TRICARE-related budget authority and ensure continued full funding for Defense Health Program needs.

Protecting Beneficiaries Against Cost-Shifting

The Task Force on the Future of Military Health Care had a great opportunity for objective evaluation of the larger health care issues. Unfortunately, the Coalition believes the Task Force missed that mark by a substantial margin.

The bulk of its report cites statistics provided by the Defense Department and focuses discussions of cost-sharing almost solely on government costs, while devoting hardly a sentence to what the Coalition views as an equally fundamental issue – the level of health coverage that members earn by their arduous career service, the value of that service as an in-kind, up-front

premium pre-payment, and the role of lifetime health coverage as an important offset to the unique conditions of military service. The Task Force focused on what was "fair to the taxpayer" and felt the benefit should be "generous but not free".

The Task Force gave short shrift to what the Coalition sees as a fundamental point – that generations of military people have been told by their leaders that their service earned them their health care benefit, and the Defense Department and Congress reinforced that perception by sustaining flat, modest TRICARE fees over long periods of time. But now the Department and the Task Force assert that the military retirement health benefit is no longer earned by service. They now say beneficiary costs should be "restored" to some fixed share of Defense Department costs, even though no such relationship was ever stated or intended in the past. The Task Force report acknowledges that DoD cost increases over the intervening years have been inflated by military/wartime requirements, inefficiency, lack of effective oversight, structural dysfunction, or conscious political decisions by the Administration and Congress. Yet they assert that the government should foist a fixed share of those costs on beneficiaries anyway.

The Coalition believes the Task Force's fee recommendations (see charts below) – which actually propose larger fee increases than DoD had – would be highly inequitable to beneficiaries and would pose a significant potential deterrent to long-term career retention.

Current vs. Proposed TRICARE Fees
(Recommended by DoD Task Force on Future of Military Health Care)

Retiree Under Age 65, Family of Three

TRICARE Prime*	**Current**	**Proposed**
Enrollment Fee	$460	$1,090 - $2,090***
Doctor Visit Copays	$60	$125
Rx Cost Shares**	$288	$960
Yearly Cost	***$808***	***$2,175 - $3,175***

TRICARE Standard*	**Current**	**Proposed**
Enrollment Fee	$0	$120
Deductible	$300	$600 - $1,150***
Rx Cost Shares**	$288	$960
Yearly Cost	***$588***	***$1680 - $2,230***

* Fully phased-in proposal; assumes 5 doctor visits per year.
**Assumes 2 generic and 2 brand name prescriptions per month in retail pharmacy
***Includes annual medical inflation adjustment recommended by the Task Force.

Retiree Over Age 65 and Spouse

TRICARE For Life*	**Current**	**Proposed**
Medicare Part B	$2,314	$2,314
Enrollment Fee	$0	$240
Rx Cost Shares**	$396	$1,260
Yearly Cost	***$2,710***	***$3,814***

*Assumes lowest tier Medicare Part B premium for 2008.
**2 generic and 3 brand name prescriptions per month purchased at a network retail pharmacy

Currently Serving Family of Four

TRICARE Standard*	Current	Proposed
Enrollment Fee	$0	$120 (??)
Deductible	$300	$600 - $1,150***
Rx Cost Shares**	$180	$660
Yearly Cost	***$480***	***$1,260 - $1,930***

*Fully phased in proposals. Spouse and 2 children use Standard.
(??) Task Force report unclear whether enrollment fee would apply to currently serving families who elect TRICARE Standard
**Assumes 2 generic and 1 brand name prescription per month purchased at retail pharmacy.
*** Includes annual military medical inflation adjustment as recommended by the Task Force.

The Task Force cited GAO and other government reports to the effect that DoD financial statements and cost accounting systems are not auditable because of system problems and inadequate business processes and internal controls. Despite those statements, the Task Force accepted DoD data as the basis for assessing and proposing beneficiary cost-sharing percentages. The Coalition has requested information concerning the 1996 calculation and has never received an adequate accounting as to what was included in the calculation.

The Task Force refers to its fee increases as "modest" and suggests the changes would be more generous than those offered by 75% to 80% of all organizations in the private sector that offer health care benefits. The Coalition finds it telling that the Task Force would be content that 20% to 25% of US firms offer their employees – most of whom never served one day for their country – a better benefit than the Defense Department provides in return for two or three decades of service and sacrifice in uniform.

The Coalition is very grateful that Congress has expressed a much greater recognition of beneficiary perspectives, and has sought a more comprehensive examination of military health care issues. In that regard, the Coalition testimony will outline several specific concerns and address some principles that the Coalition believes need to be addressed in statute, just as there are statutory standards and guidelines for other major compensation elements – pay raises, housing and subsistence allowances, retired pay COLAs, etc.

People vs. Weapons – Defense officials have provided briefs to Congress indicating that the 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 continues to assert 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 only about 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 both weapons and military health care.

Military vs. Civilian Cost-Sharing Measurement – Defense leaders assert that substantial military fee increases are needed to bring military beneficiary costs more in line with civilian practices. But merely contrasting military vs. civilian cash cost-shares is a grossly misleading, "apple-to-orange" comparison.

For all practical purposes, those who wear the uniform of their country are enrolled in a 20- to 30-year pre-payment plan that they must complete to earn lifetime health coverage. In this regard, military retirees and their families paid enormous "up-front" premiums for that coverage through their decades of service and sacrifice. Once that pre-payment is already rendered, the government cannot simply pretend it was never paid, and focus only on post-service cash payments.

The Department of Defense and the Nation – as good-faith employers of the trusting members from whom they demand such extraordinary commitment and sacrifice – have a reciprocal health care obligation to retired service members and their families and survivors that far exceeds any civilian employer's to its workers and retirees.

The Task Force on the Future of Military Health Care acknowledges that its recommendations for beneficiary fee increases, if enacted, would leave military beneficiaries with a lesser benefit than 20-25% of America's corporate employees. The pharmacy copayment schedule they propose for military beneficiaries is almost the same – and not quite as good in some cases – as the better civilian programs they reviewed.

The Coalition believes that military beneficiaries from whom America has demanded decades of extraordinary service and sacrifice have earned coverage that is the best America has to offer – not just coverage that is at the 75th percentile of corporate plans.

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.

Those who think retiree health care isn't a retention issue should recall a quote by then Chief of Naval Operations and now Chairman of Joint Chiefs of Staff, Admiral Mike Mullen, in a 2006 Navy Times:

> "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."

That's more than backed up by two independent Coalition surveys. A 2006 Military Officers Association of America survey drew 40,000 responses, including more than 6,500 from active duty members. Over 92% in all categories of respondents opposed the DoD-proposed plan. There was virtually no difference between the responses of active duty members (96% opposed) and retirees under 65 (97% opposed). A Fleet Reserve Association survey showed similar results.

Reducing military retirement benefits would be particularly ill-advised when recruiting is already a problem and an overstressed force is at increasing retention risk.

Proposed Increases Far Exceed Inflation Increases – The increases proposed by the Administration and the Task Force 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 had been increased by the same Consumer Price Index (CPI) percentage increase as retired pay, it would be $642 for FY2009 – far less than either the $1512 envisioned in the FY2008 budget request or the $900-$1,700 cited by the Task Force as its ultimate target fees.

If the $300 deductible for TRICARE Standard were CPI-adjusted for the same period, it would be $419 by 2009 – far short of the $1,210 in annual deductible and new fees proposed by DoD in 2007, or the $610-$1,080 Task Force target.

Further, both the Administration and the Task Force propose adjusting beneficiary fees by medical cost growth, which has been two to three times the inflation-based increase in members' retired pay. The Task Force estimates the annual increase would be 7.5%.

Both methodologies would ensure that medical costs would consume an ever-larger share of beneficiaries' 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.

Pharmacy copay increases proposed by the Task Force are even more disproportional. They would increase retail copays from $3 (generic), $9 (brand), and $22 (nonformulary) to $15, $25, and $45, respectively. Those represent increases of 400%, 178%, and 100%, respectively. Despite citing experience in civilian firms that beneficiary use of preferred drugs increased when their copays were reduced or eliminated, the Task Force actually proposes the highest percentage copay increases for the medications TRICARE most wants beneficiaries to use. That huge increase for retail generics flies in the face of recent commercial initiatives such as Wal-Mart's offering of many generics to the general public for a $4 copay. If the purpose is to push military beneficiaries to use Wal-Mart instead of TRICARE, it might indeed save the government some

money on those medications, but it won't make military beneficiaries feel very good about their military pharmacy benefit. And it shouldn't make Congress feel good about it, either.

The Coalition particularly questions the need for pharmacy copay increases now that Congress has approved federal pricing for the TRICARE retail pharmacy system.

Retirees Under 65 "Already Gave" 10% of Retired Pay – The large proposed health fee increases would impose a financial "double whammy" on retirees and survivors under age 65.

Any assertion that military retirees have been getting some kind of "free ride" because TRICARE fees have not been increased in recent years conveniently overlooks past government actions that have inflicted far larger financial penalties on every retiree and survivor under 65 – penalties that will grow every year for the rest of their lives.

That's because decades of past budget caps already depressed lifetime retired pay by an average of 10% for military members who retired between 1984 and 2006. For most of the 1980s and 1990s, military pay raises were capped below private sector pay growth, accumulating a 13.5% "pay gap" by 1998-99 – a gap which has been moderated since then but persists at 3.4% today.

Every member who has retired since 1984 – exactly the same under-65 retiree population targeted by the proposed TRICARE fee increases – has had his or her retired pay depressed by a percentage equal to the pay gap at the time of retirement. And that depressed pay will persist for the rest of their lives, with a proportional depression of Survivor Benefit Plan annuities for their survivors.

As a practical example, a member who retired in 1993 – when the pay gap was 11.5% – continues to suffer an 11.5% retired pay loss today. For an E-7 who retired in 1993 with 20 years of service, that means a loss of $2,000 this year and every year because the government chose to cap his military pay below the average American's. An O-5 with 20 years of service loses more than $4,300 a year.

The government has spent almost a decade making incremental reductions in the pay gap for currently serving members, but it still hasn't made up the whole gap – and it certainly hasn't offered to make up those huge losses for members already retired. Under such circumstances, it strikes the Coalition as ironic that defense officials now propose, in effect, billing those same retirees for "back TRICARE fee increases".

Fee-Tiering Scheme Is Inappropriate – Both the Administration and the Task Force have proposed multi-tiered schemes for proposed beneficiary fee increases, with the Administration's based on retired pay grade and the Task Force's based on retired pay amount. The intent of the plan is to ease opposition to the fee increases by introducing a means-testing initiative that penalizes some groups less than others.

The Coalition rejects such efforts to mask a fundamental inequity by trying to convince some groups that the inequity being imposed on them is somehow more acceptable because even greater penalties would be imposed on other groups.

Any such argument is fundamentally deceptive, since the Task Force plan envisions adjusting fee levels by medical inflation (7-8% a year), while retired pay thresholds would be adjusted by

retiree COLAs (2%-3% a year). That would guarantee "tier creep" – shifting ever greater numbers of beneficiaries into the top tier every year.

Surveys of public and private sector health coverage indicate that less than 1% of plans differentiate by salary. No other federal plan does so. The Secretary of Defense has the same coverage as any GS employee, and the Speaker of the House has the same coverage as any Representative's lowest-paid staff member.

The Coalition believes strongly that all military retirees earned equal health benefits by virtue of their career service, and that the lowest fee tier proposed by either the Administration or the Task Force would be an excessive increase for any military beneficiary (see chart at appendix A).

TRICARE for Life (TFL) Trust Fund Accrual Deposit Is Dubious Excuse – According to DoD, most of the growth in defense health spending (48%) was attributable to the establishment of the accrual accounting methodology for the TFL trust fund (which doesn't affect current outlays). The next largest contributor is medical care cost inflation (24%). Increase in usage by retirees and their dependents under age 65 accounted for 7% of the increase. Other benefit enhancements weigh in at 5% while GWOT and other factors account for the remaining 15%. However, the affect of shifting beneficiaries from military treatment facilities to the civilian network was not discussed.

When the Defense Department began arguing three 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 top line 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.

TRICARE For Life Enrollment Fee is Inappropriate – The Coalition disagrees strongly with the Task Force's recommendation to impose a new $120 annual enrollment fee for each TFL beneficiary. The Task Force report acknowledged that this would be little more than a "nuisance fee" and would be contrary to Congress' intent in authorizing TFL.

The Task Force report cites data highlighting that costs are higher for beneficiaries age 65 and older, as if neither the Administration nor Congress envisioned in 2001 that older beneficiaries might need more medications and more care.

Congress authorized TFL in 2001 in recognition that, prior to that date, most older beneficiaries had to pay for all of their care out of their own pockets after age 65, since most had been summarily ejected from any military health or pharmacy coverage. Congress also required that, to be eligible for TFL, beneficiaries must enroll in Medicare Part B, which already entails a

substantial and rapidly growing annual premium. Therefore, TRICARE only pays the portion of costs not covered by Medicare.

When the current Administration came to office in 2001, military and civilian Defense leaders praised TRICARE For Life, as enacted, as an appropriate benefit that retirees had earned and deserved for their career service. The Coalition asks, "What has changed in the six intervening years of war that has somehow made that service less meritorious?"

Alternative Options to Make TRICARE More Cost-Efficient – The Coalition continues to believe strongly that the Defense Department has not sufficiently investigated other options to make TRICARE more cost-efficient without shifting costs to beneficiaries. The Coalition has offered a long list of alternative cost-saving possibilities, including:

- 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).
- Reduce or eliminate all mail-order co-payments to boost use of this lowest-cost venue.
- Change electronic claim system to kick back errors in real time to help providers submit "clean" claims, reduce delays/multiple submissions.
- Size and staff military treatment facilities (least costly care option) in order to reduce reliance on non-MTF civilian providers.
- Promote programs to offer special care management services and zero copays or deductibles to incentivize beneficiaries to take medications and seek preventive care for chronic or unusually expensive conditions.
- Promote improved health by offering preventive and immunization services (e.g., shingles vaccine, flu shots) with no copay or deductible.
- Authorize TRICARE coverage for smoking cessation products and services (it's the height of irony that TRICARE currently doesn't cover these programs that have been long and widely acknowledged as highly effective in reducing long-term health costs).
- Reduce long-term TRICARE Reserve Select costs by allowing members the option of a government subsidy (at a cost capped below TRS cost) of civilian employer premiums during periods of mobilization.
- Promote use of mail-order pharmacy system via mailings to users of maintenance medications, highlighting the convenience and individual expected cost savings
- Encourage retirees to use lowest-cost-venue military pharmacies at no charge, rather than discouraging such use by limiting formularies, curtailing courier initiatives, etc.

The Coalition is pleased that the Defense Department has begun to implement at least some of our past suggestions, and stands ready to partner with DoD to investigate and jointly pursue these or other options that offer potential for reducing costs.

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 there is insufficient acknowledgement that thousands of providers and beneficiaries continue to experience significant problems with TRICARE. Beneficiaries at many locations, particularly those lacking large military populations, report difficulty in finding providers willing to participate in the program. Doctors complain about the program's low payments and administrative hassles. Withdrawal of providers from TRICARE networks at several locations has generated national publicity.

Of particular note is a 2007 GAO survey of Guard and Reserve personnel, also cited by the DoD Task Force on the Future of Military Health Care, in which almost one-third of respondents reported having difficulty obtaining assistance from TRICARE, and more than one-fourth reported difficulty in finding a TRICARE-participating provider.

And that problem is getting worse rather than better. The Task Force report stated that all military beneficiary categories report more difficulty than civilians in accessing care, and that military beneficiaries' reported satisfaction with access to care declined from 2004 to 2006. The problem is exacerbated in areas like Alaska where a combination of physician shortages and an unwillingness to take TRICARE make it very difficult to find a physician.

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.

TMC Healthcare Cost Principles – The Military Coalition believes strongly that the current fee controversy is caused in part by the lack of any statutory record of the purpose of military health benefits and the degree to which cost adjustments are or should be allowable. Under current law, the Secretary of Defense has broad latitude to make administrative adjustments to fees for TRICARE Prime and the pharmacy systems. As a practical matter, the Armed Services Committees can threaten to change the law if they disapprove of the Secretary's initiatives. But absent such intervention, the Secretary can choose not to increase fees for years at a time or can choose to quadruple fees in one year.

Until recently, this was not a particular matter of concern, as no Secretary had previously proposed dramatic fee increases. Given recent years' precedents, the Coalition believes strongly that the Subcommittee needs to establish more specific and permanent principles, guidelines, and prohibitions to protect against dramatic administrative fluctuations in this most vital element of service members' career compensation incentive package.

Other major elements of the military compensation package have much more specific standards in permanent law. There is a formula for the initial amount of retired pay and for subsequent annual adjustments. Basic pay raises are tied to the Employment Cost Index, and housing and food allowances are tied to specific standards as well.

A 2006 survey of military retirees indicates that 65% of retirees under 65 have access to private health insurance. What the Task Force report does not measure is the percent of retirees that do not embark on a second career and thus depend solely on their retirement income. If fees are allowed to be tiered, up to one third of retirees could see a large portion of their retirement eaten up by healthcare costs.

The Coalition most strongly recommends Rep. Chet Edwards' and Rep. Walter Jones' H.R. 579 and Sen. Frank Lautenberg's and Sen. Chuck Hagel's S. 604 as models to establish statutory findings, a sense of Congress on the purpose and principles of military health care benefits, and explicit guidelines for and limitations on adjustments.

- ***Active duty members and families should be charged no fees except retail pharmacy co-payments, except to the extent they make the choice to participate in TRICARE Standard or use out-of-network providers under TRICARE Prime.***
- ***For retired and survivor beneficiaries, the percentage increase in fees, deductibles, and co-payments that may be considered in any year should not exceed the percentage increase beneficiaries experience in their compensation.***
- ***The TRICARE Standard inpatient copay should not be increased further for the foreseeable future. At $535 per day, it already far exceeds inpatient copays for virtually any private sector health plan.***
- ***There should be no enrollment fee for TRICARE Standard or TIRCARE For Life (TFL), since neither offers assured access to TRICARE-participating providers. An enrollment fee implies enrollees will receive additional services, as Prime enrollees are guaranteed access to participating providers in return for their fee. Congress already has required TFL beneficiaries to pay substantial Medicare Part B fees to gain TFL coverage.***
- ***There should be one TRICARE fee schedule for all retired beneficiaries, just as all legislators, Defense leaders and other federal civilian grades have the same health fee schedule. The TRICARE schedule should be significantly lower than the lowest tier recommended by the Defense Department, recognizing that all retired members paid large up-front premiums for their coverage through decades of arduous service and sacrifice.***

TRICARE Standard Enrollment – Last year, the Department of Defense proposed requiring beneficiaries to take an additional step of signing an explicit statement of enrollment in TRICARE Standard. The Department proposed a one-time $25 enrollment fee. The Task Force on the Future of Military Health Care also endorsed enrollment, and proposed an annual enrollment fee of $120.

The proposals are based on three main arguments:

- Enrollment is needed to define the population that will actually use the program
- Enrollment would allow more accurate budgeting for program needs
- The fee would help offset DoD's cost of implementing the enrollment system (DoD rationale) and "impose some personal accountability for health care costs" (Task Force rationale).

The Coalition believes none of these arguments stands up to scrutiny.

Department officials already know exactly which beneficiaries use TRICARE Standard. They have exhaustive records on what doctors they've seen and what medications they've used on what dates and for what conditions. They already assess trends in beneficiary usage and project the likely effect on those trends for current and future years – such as the effect of changes in private employer changes on the likely return of more beneficiaries to the TRICARE system.

The Defense Department does not have a good record on communicating policy changes to Standard beneficiaries. That means large numbers of beneficiaries won't get the word, or appreciate the full impact if they do get it. They have always been told that their eligibility is based on the DEERS system. A single, bulk-mail communication can't be expected to overwrite decades of experience.

Hard experience is that many thousands of beneficiaries would learn of the requirement only when their TRICARE Standard claims are rejected for failure to enroll. Some would involve claims for cancer, auto accidents and other situations in which it would be unacceptable to deny claims because the beneficiary didn't understand an administrative rule change. DoD administrators who casually dismiss this argument as involving a relative minority of cases see the situation much differently if they found their family in that situation – as hundreds or thousands of military families certainly would.

Inevitably, most beneficiaries who do receive and understand the implications of an enrollment requirement will enroll simply "to be safe", even if their actual intent is to use VA or employer-provided coverage for primary care – thus undercutting the argument that enrollment would increase accuracy of usage projections.

The arguments for a Standard enrollment fee also don't hold water. First, it's inequitable to make beneficiaries pay a fee to cover the cost of an enrollment system that's established solely for the benefit and convenience of the government, with no benefit whatsoever for the beneficiary. Second, the Task Force acknowledges that a $120 fee is more a "nuisance fee" than a behavior modifier, and existing deductibles and copays provide a much more immediate "accountability" sense to the beneficiary. Third and most important, one who pays an enrollment fee expects something extra in return for the fee. An enrollment fee for TRICARE Prime is reasonable, because it buys the beneficiary guaranteed access to a participating provider. TRICARE Standard provides no such guarantee, and in some locations it's very difficult for beneficiaries to find a TRICARE provider.

For all these reasons, establishing an enrollment requirement will neither better define the user population nor better define budget needs.

The Coalition believes the real intent of the enrollment proposal is simply to reduce TRICARE costs by allowing DoD to reject payment for any claims by beneficiaries who fail to enroll.

To the extent any enrollment requirement may still be considered for TRICARE Standard, such enrollment should be automatic for any beneficiary who files a TRICARE claim. Establishing an enrollment requirement must not be allowed to become an excuse to deny claims for members who are unaware of the enrollment requirement.

The Coalition strongly recommends against establishment of any TRICARE Standard enrollment system; to the extent enrollment may be required, any beneficiary filing a claim should be enrolled automatically, without denying the claim. No enrollment fee should be charged for TRICARE Standard until and unless the program offers guaranteed access to a participating provider.

Private Employer Incentive Restrictions – Current law, effective January 1, 2008, bars private employers from offering incentives to TRICARE-eligible employees to take TRICARE in lieu of employer-sponsored plans. This law is well-intended, but inadvertently imposes unfair penalties on many employees of companies that are not, in fact, attempting to shift costs to TRICARE.

The Armed Services Committees have tasked the Secretary of Defense for a report on the issue, which may not protect current beneficiaries and, even with a favorable response, in no way restricts future Secretaries of Defense who may impose a strict interpretation of the law.

In the meantime, Coalition associations have heard from hundreds of TRICARE beneficiaries whose civilian employers are using the new law to bar equal payments to TRICARE beneficiaries that are available to other company employees (e.g., if the company offers $100 per month to any employee who uses insurance available through a spouse's coverage or a previous employer).

TRICARE coverage is an extremely important career benefit that is earned by decades of service in uniform. TMC believes it is contradictory to the spirit of this earned benefit to impose statutory provisions that deny access to TRICARE by those who have earned it or that deny TRICARE beneficiaries the same options available to non-TRICARE beneficiaries who work for the same civilian employer.

The Coalition recommends Congress modify the law restricting private employer TRICARE incentives to explicitly exempt employers who offer only cafeteria plans (i.e., cash payments to all employees to purchase care as they wish) and employers who extend specific cash payments to any employee who uses health coverage other than the employer plan (e.g., FEHBP, TRICARE, or commercial insurance available through a spouse or previous employer).

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 to expand TRICARE Standard provider and beneficiary 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 participating providers 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 – We are pleased that Congress added the requirement to survey beneficiaries in addition to providers. The Coalition believes this will help correlate beneficiary inputs with provider inputs for a more accurate view of participation by geographic location.

The Coalition is concerned that DoD has not yet 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 hopes 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 grateful to the Subcommittee for provisions in the FY2008 NDAA that will require DoD to establish benchmarks for participation adequacy and follow-up reports on actions taken.

The Coalition urges the Subcommittee to continue monitoring DoD and GAO reporting on provider participation to ensure proper follow-on action.

Administrative Deterrents to Provider Participation – The Coalition is pleased that Congress has directed DoD to modify current claims procedures to be identical to those of Medicare. We look forward to implementation with the next generation of Managed Care Support Contracts. 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 two 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.

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.

Additionally, changes to the TRICARE pharmacy formulary are becoming increasingly burdensome for providers. The number of medications added to non-formulary status ($22 copay) has increased tremendously, and changing prescriptions has added to the providers' workload, as have increases in prior-authorization (Step Therapy) requirements. The increase in the number of third tier drugs and DoD's reliance on pharmacy medical necessity requests has increased provider workload to the extent that many now charge beneficiaries extra to complete this form. For others, it's yet another TRICARE-unique administrative hassle that makes them less likely to agree to see TRICARE beneficiaries.

The Coalition urges the Subcommittee to continue its efforts to reduce administrative impediments that deter providers from accepting TRICARE patients.

TRICARE Reimbursement Rates – Physicians consistently report that TRICARE is virtually the lowest-paying insurance plan in America. Other national plans typically pay providers 25-33% more. In some cases the difference is even higher.

While TRICARE rates are tied to Medicare rates, TRICARE Managed Care Support Contractors make concerted efforts to persuade providers to participate in TRICARE Prime networks at a further discounted rate. Since this is the only information providers receive about TRICARE, they see TRICARE as 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 even 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 four years, but the failure to provide a payment increase for 2006 and 2007 was 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 and 2007 along with a small increase for the first part of 2008 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. Additionally, the Medicare pay package that was enacted in Public Law 109-432 included a provision for doctors to receive a 1.5 percent bonus next year if they report a basic set of quality-of-care measures. The TRICARE for Life beneficiaries should not be affected as their claims are submitted directly to Medicare and should be included in the physicians' quality data. But there's been no indication that TRICARE will implement the extra increases for treating beneficiaries under 65, and this could present a major problem. If no such bonus payment is made for TRICARE Standard patients, then TRICARE will definitely be the lowest payer in the country and access could be severely decreased.

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. As mentioned previously, the Department has been reluctant to establish a standard for adequacy of participation and should use survey data to apply adjustments nationally.

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 along with the affect of an absence of bonus payments.

Minimize Medicare/TRICARE Coverage Differences – A 2006 DoD report to Congress contained 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 TRICARE coverage should at least equal Medicare's in every area and include recommended preventive services at no cost. As an example, the Army Medical department has implemented the "Adult Pneumovax" program and projects savings of $500 per vaccine given.

Our military retirees 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 and provide preventive services at no cost.

National Guard and Reserve Healthcare

The Coalition is grateful to the Subcommittee for its leadership in extending lower-cost TRICARE eligibility to all drilling National Guard and Reserve members. This was a major step in acknowledging that the vastly increased demands being placed on Selected Reserve members and families needs to be addressed with adjustments to their military compensation package.

While the Subcommittee has worked hard to address the primary health care hurdle, there are still some areas that warrant attention.

TRICARE Reserve Select (TRS) Premium – The Coalition believes the premium-setting process for this important benefit needs to be improved and was incorrectly based upon the basic Blue Cross Blue Shield option of the FEHBP. This adjustment mechanism has no relationship either to the Department's military health care costs or to increases in eligible members' compensation.

When the program was first implemented, the Coalition urged DoD to base premiums (which were meant to cover 28% of program costs) on past TRICARE Standard claims data to more accurately reflect costs. Now a GAO study has confirmed that DoD's use of Blue Cross Blue Shield data and erroneous projections of participation resulted in substantially overcharging beneficiaries.

GAO found that DoD projected costs of $70M for FY05 and $442M for FY06, whereas actual costs proved to be $5M in FY05 and about $40M in FY06. GAO found that DoD estimates were 72% higher than the average single member cost and 45% higher than average family cost. If DoD were to have used actual FY06 costs, the annual individual premium would have been $48/month instead of $81/month. The corresponding family premium would have been $175/month instead of $253/month.

GAO recommended that DoD stop basing TRS premiums on Blue Cross Blue Shield adjustments and use the actual costs of providing the benefit. DoD concurred with the recommendations and says, "it remains committed to improving the accuracy of TRS premium projections." However, GAO observed that DoD has made no commitment to any timetable for change.

The Coalition believes our obligation to restrain health cost increases for Selected Reserve members who are periodically being asked to leave their families and lay their lives on the line for their country is should be even greater than our obligation to restrain government cost increases. These members deserve better than having their health premiums raised arbitrarily by a formula that has no real relationship to them.

The Coalition believes strongly that TRS premiums should be reduced immediately to $48/month (single) and $175/month (family), with retroactive refunds to those who were overcharged in the past.

For the future, as a matter of principle, the Coalition believes that TRS premiums should not be increased in any year by a percentage that exceeds the percentage increase in basic pay.

The Coalition also is concerned that members and families enrolled in TRS are not guaranteed access to TRICARE-participating providers and are finding it difficult to locate providers willing to take TRICARE. As indicated earlier in this testimony, the Coalition believes that members who are charged a fee for their health coverage should be able to expect assured access, and hopes the Subcommittee will explore options for assuring such access for TRS enrollees.

The Coalition recommends reducing TRS premiums to $48/month (single) and $175/month (family), as envisioned by the GAO, with retroactive refunds as appropriate. For the future, the percentage increase in premiums in any year should not exceed the percentage increase in basic pay.

The Coalition further recommends that the Subcommittee request a report from the Department of Defense on options to assure TRS enrollees' access to TRICARE-participating providers.

Private Insurance Premium Option – The Coalition thanks Congress for authorizing subsidy of private insurance premiums for reservists called to active duty in cases where a dependent possesses a special health care need that would be best met by remaining in the member's civilian health plan.

The Coalition believes Congress is missing an opportunity to reduce long-term health care costs by failing to authorize eligible members the option of electing a partial subsidy of their civilian insurance premiums during periods of mobilization. Current law already authorizes payment of up to 24 months of FEHBP premiums for mobilized members who are civilian employees of the Defense Department.

Congress directed GAO to review this issue and submit a report in April 2007 – a report that, to our knowledge, has not been completed. We hope that report will address not only the current wartime situation, but the longer-term peacetime scenario. Over the long term, when Guard and Reserve mobilizations can be expected at a considerably lower pace, the Coalition believes subsidizing continuation of employer coverage during mobilizations periods offers considerable savings opportunity relative to funding year-round family TRICARE coverage while the member is not deployed.

In fact, the Department could calculate a maximum monthly subsidy 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 continuation of a Reserve employer's private family health insurance during periods of deployment as an alternative to permanent TRICARE Reserve Select coverage.

Involuntary Separatees – The Coalition believes it is unfair to deny TRS coverage for Individual Ready Reserve (IRR) members who have returned from deployment or terminate coverage for returning members who are involuntarily separated from the Selected Reserve (other than for cause).

The Coalition recommends authorizing one year of post- Transitional Assistance Management Program (TAMP) TRS coverage for every 90 days deployed in the case of returning members of the IRR or members who are involuntarily separated from the Selected Reserve. The Coalition further recommends that voluntarily separating Reservists subject to disenrollment from TRS should be eligible for participation in the Continued Health Care Benefits Program (CHCBP).

Gray Area Reservists – The Coalition is sensitive that Selected Reserve members and families have one remaining "hole" in their military health coverage. They are eligible for TRS while currently serving in the Selected Reserve, then lose coverage while in "Gray area" retiree status, then regain full TRICARE eligibility at age 60.

The Coalition believes some provisions should be made to allow such members to continue their TRICARE coverage in gray area status. Otherwise, we place some members at risk of losing family health coverage entirely when they retire from the Selected Reserve. We understand that such coverage likely would have to come with a higher premium.

The Coalition urges the Subcommittee to authorize an additional premium-based option under which members entering "gray area" retiree status would be able to avoid losing health coverage.

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. DoD should be fiscally responsible for dental care to Reservists to ensure service members meet dental readiness standards when DoD facilities are not available within a 50 mile radius of the members' home for at least 90 days prior and 180 days post mobilization.

The Coalition supports providing dental coverage to Reservists for 90 days pre- and 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 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 Survivors' TRICARE Coverage – When a TRICARE-eligible widow/widower remarries, he/she loses TRICARE benefits. When that individual's second marriage ends in death or divorce, the individual has eligibility restored for military ID card benefits, including SBP coverage, commissary/exchange privileges, etc. – with the sole exception that TRICARE eligibility is not restored.

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

Remarried surviving spouses deserve equal treatment.

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

TRICARE Prime Remote Exceptions – Longer deployments and sea/shore and overseas assignment patterns leave many military families faced with tough decisions. A spouse and children may find a greater level of support by residing with or near relatives during extended separations from the active duty spouse. DoD has the authority to waive the requirement for the spouse to reside with the service member 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. 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 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, when the family separation is due to a military-directed move or deployment.

BRAC, Re-Basing, and Relocation – Relocation from one geographic region to another and base closures brings multiple problems. A smooth health care transition is crucial to the success of DoD and Service plans to transform the force.. And that means ensuring a robust provider network and capacity is available to all beneficiary populations, to include active and reserve component and retirees and their family members, and survivors at both closing and gaining installations. It is incumbent upon the Department and its Managed Care Support Contractors to ensure smooth beneficiary transition from one geographic area to another. We stress the importance of coordination of construction and funding in order to maintain access and operations while the process takes place.

The Coalition recommends codifying the requirement to provide a TRICARE Prime network at all areas impacted by BRAC or rebasing. Additionally, we recommend that DoD be required to provide an annual report to Congress on the adequacy of health resources, services, quality and access of care for those beneficiary populations affected by transformation plans.

Pharmacy

The TRICARE Pharmacy benefit must remain strong to meet the pharmaceutical needs of millions of military beneficiaries. While we are pleased at the overall operation of the program, the Coalition has significant concerns about certain recent trends.

Beneficiary Migration – One issue highlighted by the Task Force report is that a large share of the growth in retail pharmacy use has been the result of beneficiaries migrating from military treatment facilities to local retail pharmacies. In that regard, the number of beneficiaries using only military pharmacies declined by 900,000 between FY02 and FY07, whereas the number of beneficiaries using only retail pharmacies increased by about 1,000,000 in the same period.

Some of the shift is because enactment of TFL and TSRx meant that Medicare beneficiaries who live some distance from military installations no longer have to make long treks to the military pharmacy.

But the change also coincides with the onset of increased wartime deployments and installation security measures. The deployment of large numbers of military medical professionals has forced shifting more beneficiaries of all kinds to see civilian providers, which reduces proximity access to the military pharmacy and ease the convenience of using retail stores. Increased installation security measures also increase the "hassle factor" for retirees to use on-base facilities. Finally, local budget pressures and DoD "core formulary" guidance removes many medications from the installation formulary that retirees use, leaving many no choice but to use alternative venues.

Coalition associations have heard anecdotal reports that some local commanders have actively discouraged retirees from using the military pharmacies, primarily for budget savings purposes. What's worse is that MTFs have failed to educate beneficiaries of the next most cost-effective venue – the TRICARE Mail Order Pharmacy (TMOP).

The point is that it is inappropriate to punish beneficiaries (through higher retail copayments) for migration that may be dictated more by military operational and budget requirements than by retiree preferences.

Pharmacy Co-payment Changes – The Coalition thanks the Subcommittee for freezing pharmacy co-payments for FY08. 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. The DoD Health Care Task Force would dramatically raise most military pharmacy copays. For example, they'd raise the copay for generic drugs purchased in retail pharmacies from the current $3 to $15. But Wal-Mart is now dispensing generic drugs to the general public for $4. Shouldn't the military pharmacy benefit be better than what civilians can get through Wal-Mart?

One important consideration in the mail-order-vs.-retail discussion is that some medications are simply not appropriate or available for delivery through the TMOP. If the purpose of imposing higher retail copays is to incentivize beneficiaries to use military or mail-order pharmacies, application of this philosophy is inappropriate when the beneficiary has no access to those lower-cost venues.

The Coalition believes any further discussion of pharmacy copayment increases should be deferred pending review of the implications of requiring federal pricing in the retail system. We believe that this action by Congress in the FY2008 has shifted the dynamic of pharmacy costs, and that the primary cost differential may no longer be the venue of dispensing.

Rather, the Coalition urges the Subcommittee to consider the findings of RAND, Pharma, and others cited by the Task Force that considerable cost savings can be gained by establishing positive motivations for beneficiaries with chronic diseases to take any of the medications – regardless of generic, brand, or nonformulary – that reduce the adverse effects of their conditions over the long term. Those steps included eliminating copays for the lowest-cost and most effective medications, reducing copays for some effective nonformulary medications, and reducing prior authorization requirements that impede beneficiaries from using the medications they and their doctors believe are best for them.

We note with regret that the Department has declined to comply with the Subcommittee's urging to eliminate copayments for generic medications in the mail-order system – a recommendation echoed by the Task Force. In this case, the administrative cost of processing the co-pay actually wipes out a large percentage of the co-pay revenue.

The Coalition believes pharmacy cost growth concerns have missed the mark by focusing on current-year dollars rather than long-term effects. For example, the Task Force report highlights as part of the cost "problem" that some drugs, including medications to treat diabetes, grew more than 15% in a single year. Viewed in terms of long-term effects, it's a good thing to identify patients who have diabetes and a good thing for diabetes patients to take their medications. So growing use (and cost) of medications for such chronic diseases is a positive, not a negative, and the copay structure should be remodeled to incentivize beneficiaries and make it as easy as possible for them to take whatever medication will mitigate the effects of their condition through whatever venue they are most likely to be satisfied with and therefore will be most likely to take their medications.

The Coalition recommends deferral of any pharmacy copay increases pending assessment of the effects of the new federal pricing law on usage and cost patterns for the different venues, and that the Subcommittee instead urge DoD to pursue copay reductions and ease prior authorization requirements for medications for chronic diseases, based on private sector experience that such initiatives reduce long-term costs associated with such diseases.

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 over 90 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. 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 BAP would be allowed substantive input in the Uniform Formulary decision process, but that has not happened. In fact, BAP discussion issues and recommendations (other than the final vote tallies) are routinely excluded from information provided to the Assistant Secretary of Defense (Health Affairs) for decision-making purposes, and there has been no formal feedback to the BAP on the reasons why their recommendations were not accepted.

Although the Subcommittee has tasked GAO for a report on the effectiveness of the BAP process, that report has not been issued to date.

The Coalition urges the Subcommittee to reassert its intent that the Beneficiary Advisory Panel should have a substantive role in the formulary-setting process, including access to meaningful data on relative drug costs in each affected class, consideration of all BAP comments in the decision-making process, and formal feedback concerning rationale for rejection of BAP recommendations.

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 Coalition associations in their process improvement activities and will continue to partner 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, including input from each Managed Care Support Contractor, concerning the referral process within DoD and reliance on Civilian Network Providers within an MTF's Prime Service Area.

Health-Related Tax Law Changes

The Coalition understands fully that tax law changes are not within the Subcommittee's jurisdiction. However, there are numerous military-specific tax-related problems that are unlikely to be addressed without the Subcommittee's active advocacy and intervention with members and leaders of the Ways and Means Committee.

Deductibility of Health and Dental Premiums – Many uniformed services beneficiaries pay annual enrollment fees for TRICARE Prime, TRICARE Reserve Select, 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. A 2007 court case extended similar pre-tax premium payment eligibility to certain retired public safety officers. Similar legislation for all active, reserve, and retired military and federal civilian beneficiaries would restore equity with private sector employees and retired public safety officers.

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

CONCLUSION

The Military Coalition reiterates its profound gratitude for the extraordinary progress this Subcommittee has made in advancing a wide range of personnel and health care initiatives for all uniformed services personnel and their families and survivors. The Coalition is eager to work with the Subcommittee in pursuit of the goals outlined in our testimony. Thank you very much for the opportunity to present the Coalition's views on these critically important topics.

Colonel Steven P. Strobridge, USAF (Retired)
Director, Government Relations, Military Officers Association of America (MOAA); and
Co-Chairman, The Military Coalition

Steven P. Strobridge, a native of Vermont, is a 1969 graduate from Syracuse University. Commissioned through ROTC, he was called to active duty in October 1969.

After several assignments as a personnel officer and commander in Texas, Thailand, and North Carolina, he was assigned to the Pentagon from 1977 to 1981 as a compensation and legislation analyst at Headquarters USAF. While in this position, he researched and developed legislation on military pay, health care, retirement and survivor benefits issues.

In 1981, he attended the Armed Forces Staff College in Norfolk, VA, en route to a January 1982 transfer to Ramstein AB, Germany. Following assignments as Chief, Officer Assignments and Assistant for Senior Officer Management at HQ, U.S. Air Forces in Europe, he was selected to attend the National War College at Fort McNair, DC in 1985.

Transferred to the Office of the Secretary of Defense upon graduation in June 1986, he served as Deputy Director and then as Director, Officer and Enlisted Personnel Management. In this position, he was responsible for establishing DoD policy on military personnel promotions, utilization, retention, separation and retirement.

In June 1989, he returned to Headquarters USAF as Chief of the Entitlements Division, assuming responsibility for Air Force policy on all matters involving pay and entitlements, including the military retirement system and survivor benefits, and all legislative matters affecting active and retired military members and families.

He retired from that position on January 1, 1994 to become MOAA's Deputy Director for Government Relations.

In March 2001, he was appointed as MOAA’s Director of Government Relations and also was elected Co-Chairman of The Military Coalition, an influential consortium of 35 military and veterans associations.

Joseph L. Barnes
National Executive Director, FRA; and
Co-Chairman, The Military Coalition

Joseph L. (Joe) Barnes was selected to serve as the Fleet Reserve Association's (FRA's) National Executive Director (NED) in September 2002 during a pre-national convention meeting of the FRA's National Board of Directors (NBOD) in Kissimmee, Fla. He is FRA's senior lobbyist and chairman of the Association's National Committee on Legislative Service. He is also the chief assistant to the National President and the NBOD, and responsible for managing FRA's National Headquarters.

A retired Navy Master Chief, Barnes served as FRA's Director of Legislative Programs and advisor to FRA's National Committee on Legislative Service since 1994. During his tenure, the Association realized significant legislative gains, and was recognized with a certificate award for excellence in government relations from the American Society of Association Executives (ASAE).

In addition to his FRA duties, Barnes is a member of the Defense Commissary Agency's (DeCA's) Patron Council, and was elected Co-Chairman of the 35-organization Military Coalition (TMC) in November 2004. He also serves as Co-Chairman of TMC's Personnel, Compensation and Commissaries Committee and testifies frequently on behalf of FRA and TMC on Capitol Hill.

He received the United States Coast Guard's Meritorious Public Service Award for providing consistent and exceptional support of Coast Guard from 2000 to 2003 and was appointed an Honorary Member of the United States Coast Guard by Admiral James Loy, former Commandant of the Coast Guard, and then-Master Chief Petty Officer of the Coast Guard Vince Patton at FRA's 74th National Convention in September 2001. Barnes is also an ex-officio member of the U.S. Navy Memorial Foundation's Board of Directors.

Barnes joined FRA's National Headquarters team in 1993 as editor of On Watch, FRA's quarterly publication distributed to Navy, Marine Corps, and Coast Guard personnel. While on active duty, he was the public affairs director for the United States Navy Band in Washington, DC. His responsibilities included directing marketing and promotion efforts for extensive national concert tours, network radio and television appearances, and major special events in the nation's capital. His awards include the Defense Meritorious Service and Navy Commendation Medals.

Barnes holds a bachelor's degree in education and a master's degree in public relations management from The American University, Washington, DC, and earned the Certified Association Executive (CAE) designation from ASAE in 2003. He's an accredited member of the International Association of Business Communicators (IABC), a member of ASAE, the American League of Lobbyists, the U.S. Naval Institute, Navy League, and National Chief Petty Officer's Association.

He is a member of the FRA Branch 181 board of directors and has served in a variety of volunteer leadership positions in community and school organizations. He is married to the former Patricia Flaherty of Wichita, Kansas and the Barnes' have three daughters, Christina, Allison, and Emily and reside in Fairfax, Virginia.

Kathleen B. Moakler
Director, Government Relations Department
National Military Family Association

Mrs. Moakler has been associated with the National Military Family Association since 1995 as a member of the headquarters staff. She has served as Legislative Administrative Assistant and Senior Issues Specialist in the Government Relations Department, NMFA Office Manager, and Deputy Director, Government Relations. In February 2007, Ms. Moakler was appointed as interim Director of Government Relations and was appointed as Director in October 2007. In that position, she monitors the range of issues relevant to the quality of life of the families of the seven uniformed services and coordinates a staff of four deputy directors. Mrs. Moakler represents the interests of military families on a variety of advisory panels and working groups, including the American Red Cross "Get to Know Us Before You Need Us" working group, the DoD/VA Survivors Forum, and the State Department Interagency Roundtable. Mrs. Moakler is co-chair of the Survivors Committee and the Awards Committee for the Military Coalition (TMC), a consortium of 35 military and veteran organizations and serves on the Retiree Committee. She is often called to comment on issues pertaining to military families for such media outlets as the NY Times, CNN, NBC news and the Military Times. She writes regularly for "Military Money" and NMFA publications.

An Army spouse of over 28 years, Mrs. Moakler has served in various volunteer leadership positions in civilian and military community organizations in that time. Through the years, Mrs. Moakler has worked with many military community programs including hospital consumer boards, commanders' advisory boards, family readiness groups, church councils, youth programs, and the Army Family Action Plan at all levels. She believes that communication is paramount in the efficient delivery of services and the fostering of a rich community life for military families. She holds a Bachelor of Science degree in Business Administration from the State University of New York at Albany. Mrs. Moakler has been awarded the Army Commanders Award for Public Service and the President's Volunteer Service Award.

In addition to her work at NMFA, Mrs. Moakler participates as a member of the Contemporary Choir at the Chapel at Fort Belvoir, Virginia. She has a new role as a military mom. Her daughter is an Army nurse recently returned from a second tour in Iraq as an operating room nurse in the Green Zone and one son is an Army major stationed at Ft. Belvoir, Virginia. Her oldest son is an aspiring actor in Hollywood, California. Mrs. Moakler and her husband, retired Colonel Martin W. Moakler Jr. USA, reside in Alexandria, Virginia.