



**STATEMENT OF**  
**THE MILITARY OFFICERS ASSOCIATION OF AMERICA (MOAA)**

**before the**

**HOUSE ARMED SERVICES**  
**SUBCOMMITTEE ON MILITARY PERSONNEL**

**DECEMBER 3, 2015**

**Presented by**

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

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

This statement also reflects the views of the following associations:

Air Force Sergeants Association  
Air Force Women Officers Associated  
AMVETS  
Army Aviation Association of America  
Association of Military Surgeons of the United States  
Association of the United States Army  
Chief Warrant and Warrant Officers Association, USCG  
Fleet Reserve Association  
Gold Star Wives of America, Inc.  
Jewish War Veterans  
Marine Corps Reserve Association  
Military Chaplains Association  
National Association for Uniformed Services  
Non Commissioned Officers Association  
The Retired Enlisted Association  
US Army Warrant Officers Association  
US Coast Guard Petty Officers Association and Coast Guard Enlisted Association  
Veterans of Foreign Wars

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

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

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

MOAA understands that the current and future national security situation requires us to maintain a balance of investment in equipment, training, operational capabilities, as well as the personnel requirements which have been the cornerstone of the success of our all-volunteer force. There are finite resources for these competing demands and we strongly agree that the military's health care system (MHS) needs to evolve beyond what it is today, into a modern, high-performing integrated system, delivering quality, accessible care safely and effectively to

its beneficiaries – while simultaneously meeting international health crises and national disasters, and honing its readiness capabilities. No other health care entity in the country is charged with these dual, yet mutually interdependent, mandates.

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

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

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

### **What Is Working**

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

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

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

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

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

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

### Problem Areas

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Rhetoric vs. Reality On DoD Health Care Costs**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	<u>FY10</u>	<u>FY11</u>	<u>FY12</u>	<u>FY13</u>	<u>FY14</u>	<u>FY15</u>
DoD Unified Medical Prog.	\$49.9B	\$51.6B	\$52.9B	\$48.4B	\$49.3B	\$48.5B

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

	<u>FY10</u>	<u>FY11</u>	<u>FY12</u>	<u>FY13</u>	<u>FY14</u>	<u>FY15</u>
DoD Purchased Care	\$14.3B	\$14.8B*	\$15.4B*	\$14.7B*	\$14.8B	\$14.8B

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

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

	<u>FY10</u>	<u>FY11</u>	<u>FY12</u>	<u>FY13</u>	<u>FY14</u>	<u>FY15</u>
DoD Pharmacy Program	\$6.6B	\$7.0B	\$7.1B	\$7.1B	\$7.7B	TBD*

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

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

	<u>FY10</u>	<u>FY11</u>	<u>FY12</u>	<u>FY13</u>	<u>FY14</u>	<u>FY15</u>
Direct Care Program	\$16.1B	\$16.9B	\$17.4B	\$16.1B	\$17.9B	\$17.6B

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

### **MCRMC Proposals**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Key Principles**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Recommendations**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Vice Admiral Norbert R. Ryan Jr., USN (Ret)**  
President and CEO  
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VADM Ryan is a 1967 graduate of the United States Naval Academy and a graduate of George Washington University with a Master of Science Degree in Personnel Administration as well as the Senior Officials in National Security Program at Harvard University's John F. Kennedy School of Government.

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

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

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