[H.A.S.C. No. 112–120]

HEARING

ON

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2013

AND

OVERSIGHT OF PREVIOUSLY AUTHORIZED PROGRAMS

BEFORE THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON MILITARY PERSONNEL HEARING

ON

DEFENSE HEALTH PROGRAM BUDGET OVERVIEW

HEARING HELD
MARCH 21, 2012

U.S. GOVERNMENT PRINTING OFFICE
73–792 WASHINGTON : 2012

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DEFENSE HEALTH PROGRAM BUDGET OVERVIEW

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Wednesday, March 21, 2012.

The subcommittee met, pursuant to call, at 3:10 p.m. in room 2212, Rayburn House Office Building, Hon. Joe Wilson (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Mr. WILSON. Ladies and gentlemen, good afternoon. I would like to welcome you to a meeting of the Military Personnel Subcommittee. This will be a hearing on the Defense Health Program budget overview. And I want to thank people for attending today and certainly thank our witnesses.

Today the subcommittee meets to hear testimony on the Defense Health Program for fiscal year 2013. I would like to begin by acknowledging the remarkable military and civilian medical professionals who provide extraordinary care to our service members and their families and veterans here at home and around the world, often in some of the toughest and most austere environments. I have firsthand knowledge of their dedication and sacrifice from my son, Addison, who is an orthopedic resident in the Navy and who has served in Iraq.

Even in this tight fiscal environment, the Military Health System must continue to provide world-class health care to beneficiaries and remain strong and viable and fully funded in order to maintain that commitment. The Department of Defense has proposed several measures aimed at reducing the cost of the Defense Health Program. Unfortunately, all of the proposals simply shift the cost burden to TRICARE fee and cost-share increases to not only our working-age retirees but, for the first time, to our most senior military retirees.

The subcommittee has a number of concerns about the Department's initiatives. To that end, we would expect the Department's witnesses to address our concerns, including that: first, the proposed TRICARE Prime fee increases, which have been characterized by military leaders as modest, will raise fees in fiscal year 2013 by 30 to 78 percent over the current rate. Over 5 years, the fees would increase by 94 to 345 percent.

The proposed increases may be designed to cause military retirees to opt out of TRICARE, choose a TRICARE option that is less costly to DOD, or decrease their use of TRICARE. The proposal

would establish an annual enrollment fee for retirees who use TRICARE Standard and Extra and, for the first time, would require our most senior retirees to pay an enrollment fee for TRICARE For Life.

What is not clear to me is why, aside from the revenue being generated from the fees, DOD believes enrolling these participants is necessary. What benefit can these individuals expect to receive from enrolling?

And, finally, 60 percent of the estimated cost savings from TRICARE proposals is based on military retirees opting out of TRICARE or using it less. Frankly, I think this plan is wrongheaded.

Finally, I would like to hear from the military surgeons about efforts they are taking within the military departments to increase the efficiency of the military healthcare system and reduce cost. I would also like the military surgeons' views on areas where additional efficiencies can be gained across the DOD health system. I hope our witnesses will address these important issues as directly as possible in their oral statements and in response to Member questions.

Before I introduce our panel, let me offer Ranking Member Susan Davis of California an opportunity to make her opening remarks.

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

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

Mrs. DAVIS. Thank you, Mr. Chairman.

I look forward, as well, to hearing from Assistant Secretary Woodson on his views on the status of the military healthcare system, particularly the TRICARE system, and the Department's efforts to improve the care that we are providing to our service men and women, retiree survivors, and their families.

I am also looking forward to hearing from our Surgeon General, General Green. Welcome back, and thank you for your service.

Admiral Nathan and General Horoho, welcome. I believe that this is your first testimony before the committee. We are happy to have you. Thank you for your service. I know that you will continue the laudable efforts of your predecessors.

And, finally, Mr. Strobridge from The Military Coalition, welcome. We appreciate your joining us to share your views, as well.

The last decade of conflict has been weathered on the backs of our remarkable forces, in particular those who serve in our military healthcare system. The constant demands borne by those in uniform and those in support of them have yielded incredible successes on our battlefields—our battlefields abroad and at home here in the States.

While I suspect that much of this hearing will focus on the healthcare proposals of the Department of Defense, this hearing should also provide the members of the subcommittee an opportunity to understand and to examine some of the difficult challenges facing the military healthcare system, from our reductions

in resources to meeting the ever-increasing demand for mental health services.

Our military personnel and their families consistently exceed expectations under tremendous strains and pressures. And their access to quality health care should not be added to their plights. I look forward to your testimony on how we are caring for our service members and their families, particularly our injured, ill, and wounded, and how we can continue to improve our healthcare system in the new fiscal environment that we will be facing.

Thank you all.

Thank you, Mr. Chairman.

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

Mr. WILSON. Thank you, Ms. Davis.

We have five witnesses today. We would like to give each witness the opportunity to present his or her testimony and each Member an opportunity to question the witnesses. I would respectfully remind the witnesses that we desire you to summarize to the greatest extent possible the high points of your written testimony into 3 minutes. I assure you your written comments and statements will be made part of the hearing record.

At this time, without objection, I ask unanimous consent that additional statements from the Reserve Officers Association, the National Military Family Association, and The Military Coalition would be included in the record of this hearing.

Without objection, so ordered.

[The information referred to can be found in the Appendix on pages 161, 169, and 196, respectively.]

Mr. WILSON. Let me welcome the panel.

Welcome back, Dr. Jonathan Woodson—thank you—as Assistant Secretary of Defense for Health Affairs. And we have Lieutenant General Patricia D. Horoho, the Surgeon General of the Department of the Army—thank you for being here; and Vice Admiral Matthew L. Nathan, Surgeon General, Department of the Navy; and Lieutenant General Charles Bruce Green, Surgeon General, Department of the Air Force; and Colonel (Ret.) Steve Strobridge, co-chairman, The Military Coalition.

Before we begin, I would like to recognize General Horoho and Admiral Nathan and extend a special welcome to them, as this is their first appearance before the subcommittee since becoming Surgeon Generals. Congratulations to both of you.

And I want to join with a fellow nurse of General Horoho, and that is Jeanette James. She is so excited, rightfully so, of you being the first nurse to serve as Surgeon General. So congratulations, and I am very proud for you.

General Green, I understand you are retiring—at an early age—this summer, so this may be your last DHP [Defense Health Program] hearing. Your leadership has been instrumental in the tremendous advances made in the aeromedical evacuation system that is key to the extraordinary survival rate of our wounded and injured around the world. Thank you, and best of luck to you.

I also want to announce that, to ensure that Members have an opportunity to question our witnesses, we will use the 5-minute rule when recognizing Members for questions.

And we will now begin with the testimony from the witnesses. And we have Jeanette James keeping the time, and she is above reproach. So when she says time is up, we will all follow through. So thank you so much.

Dr. Woodson.

STATEMENT OF HON. JONATHAN WOODSON, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE

Secretary WOODSON. Thank you, Mr. Chairman, Ranking Member Davis, members of the committee. Thank you for the opportunity to appear before you today to discuss the future of the Military Health System, in particular our priorities for this coming year.

Over the last 10 years, the men and women serving in the Military Health System have performed with great skill and undeniable courage in combat. Their contributions to advancing military and American medicine are immense. The Military Health System's ability to perform this mission and be able to respond to humanitarian crises around the world is unique among all military and non-military organizations on this globe, and I am committed to sustaining this indispensable instrument of national security.

One of the most critical elements of our strategy is to ensure the medical readiness of men and women in our Armed Forces. We are using every tool at our disposal to assess the service member's health before, during, and following deployment from combat theaters. And for those who return with injuries and illnesses, we continue to provide comprehensive treatment and rehabilitation services supported by medical research and development portfolios appropriately focused on the visible and invisible wounds of war.

Concurrent with our mission of maintaining a medically ready force is our mission of maintaining a ready medical force. This ready-medical-force concept has many interdependent parts. It requires our entire medical team to be well trained. It requires development of our physicians in active accredited graduate medical education programs. It requires our military hospitals and clinics to be operating at near-optimal capacity. And for our beneficiaries, it requires an active decision to choose military medicine as their preferred source of care.

To meet these readiness imperatives means we need to compete with the rest of American medicine to recruit and retain top talent, to provide state-of-the-art medical facilities that attract both patients and medical staff, and to sustain a high-quality care system.

The budget we have proposed provides the resources we need to sustain the system. As we maintain our readiness, we must also be responsible stewards of the taxpayers' dollars. The 2011 Budget Control Act required the Department to identify $487 billion in budget reductions over the next 10 years. Healthcare costs could not be exempt from this effort.

The Military Health System is undertaking four simultaneous actions to reduce costs: one, internal efficiencies to better organize our decisionmaking and execution arm; two, a continuation of our efforts to appropriately pay providers in the private sector; three, initiatives that promote health, reduce illness, injury, and hos-

pitalization; and four, proposed changes to the beneficiary cost-sharing under TRICARE.

The military and civilian leaders in the Department developed these proposals and have publicly communicated their support for these proposals to you in writing and in person. I want to identify the core principles to which we adhered to in developing these proposals.

We believe the TRICARE benefit has always been one of the most comprehensive and generous health benefits in our country, and our proposals keep it that way. In 1996, military retirees were responsible for about 27 percent of overall TRICARE costs. In 2012, the percentage share of costs borne by beneficiaries has dropped to a little over 10 percent of overall costs. If these proposals we put forward are accepted, beneficiary out-of-pocket costs will rise to 14 percent of costs by 2017. This is about half of what beneficiaries experienced in 1996.

Second, we have exempted the most vulnerable populations from our cost-sharing changes. Medically retired service members and the families of service members who died on Active Duty are both protected under this principle. Additionally, we have introduced cost-sharing tiers based upon retirement pay, reducing the increases for those with lower retirement pays. And this was uniform and line-led.

Mr. Chairman, we recognize the concerns the members of the committee and the beneficiary organizations have voiced regarding these proposals. I want to emphasize that these proposals are targeted to mitigate the burden on any one particular group of beneficiaries while simultaneously meeting our congressionally mandated cost-saving responsibilities under the Budget Control Act.

We have also recently submitted to Congress the Secretary's recommended path forward on how we reorganize the Military Health System. We have learned a great deal from our joint medical operations over the last 10 years, and we recognize that there is much opportunity for introducing even a more agile headquarters operation that shares services and institutes common business plans and clinical practices across our system of care.

The budget we have put forward for 2013 is a responsible path forward to sustaining the Military Health System in a changing world and recognizes that the fiscal health of the country is a vital element in our national security. I am proud to be here with you today to represent the men and women who comprise the Military Health System, and I look forward to your questions.

[The prepared statement of Secretary Woodson can be found in the Appendix on page 29.]

Mr. WILSON. Thank you very much.

And Dr. Horoho.

STATEMENT OF LTG PATRICIA D. HOROHO, USA, SURGEON GENERAL, U.S. ARMY

General HOROHO. Chairman Wilson, Ranking Member Davis, and distinguished members of the committee, thank you for providing me this opportunity to share with you today my thoughts on the future of Army Medicine and highlight some of the incredible

work being performed by dedicated men and women, with whom I am honored to serve alongside.

We are American's most trusted premier medical team, and our successful mission accomplishment over these past 10 years is testimony to the phenomenal resilience, dedication, and innovative spirit of soldier medics, civilians, and military families throughout the world.

From July to October of 2011, I was privileged to serve as the International Security Assistance Force Joint Command's special assistant for health affairs. My multidisciplinary team of 14 military health professionals conducted an extensive evaluation of theater health service support to critically assess how well we were providing health care from the point of injury to evacuation from theater. It cannot be overstated that the best trauma care in the world resides with the U.S. military in Afghanistan and Iraq.

The AMEDD [United States Army Medical Department] is focused on building upon these successes on the battlefield as we perform our mission at home and is further cementing our commitment to working as a combined team anywhere, anytime. We are at our best when we operate as part of the joint team, and we need to proactively develop synergy with our partners as military medicine moves toward a joint operating environment. Continuity of care and continuity of information are key to the delivery as DOD [Department of Defense] and the VA [Department of Veterans Affairs] team provides care.

There are significant health-related consequences over the 10 years of war, including behavioral health needs, post-traumatic stress, intensive care of burns or disfiguring injuries, and chronic pain. A decade of war in Afghanistan and Iraq has led to tremendous advances in knowledge and care of combat-related physical and psychological problems. We have partnered with the Department of Veterans Affairs, the Defense and Veterans Brain Injury Center, and the Defense Centers of Excellence for Traumatic Brain Injury and Psychological Health in academia, as well as the National Football League, to improve our ability to diagnose, treat, and care for those affected by traumatic brain injury.

Similar to our approach with concussive head injuries, Army Medicine has harvested the lessons of almost a decade of war and has approached the strengthening of our soldiers' and families' behavioral health and emotional resiliency through the comprehensive behavioral health system of care. It is a system of systems built around the need to support an Army engaged in repetitive deployments, often in intense combat, which then returns to home station to restore, reset the formation, and reestablish family and community bonds. The system is underpinned by the multiple touchpoints across the time, in which soldiers receive mandatory behavioral health assessments from pre-deployment to post-deployment and into garrison life.

The warfighter does not stand alone in support of a nation in persistent conflict with the stresses resulting from 10 years of war. Army Medicine has a responsibility to all those who serve, to include our family members and our retirees who have already answered the call to our Nation. We are committed to ensuring the right capabilities are available to promote health and wellness and

are focused on decreasing variance, increasing standards and standardizations across Army Medicine.

I am incredibly honored and proud to serve as the 43rd Surgeon General and the Army Commander of the U.S. Army Medical Command. There are miracles happening every day at our command outposts, forward operating bases, posts, camps, and stations every day because of the dedicated civilians and soldiers that make up the Army Medical Department.

With the continued support of Congress, we will lead the Nation in health care and health, and our men and women in uniform will be ready when the Nation calls them to action. Army Medicine stands ready to accomplish any task in support of our warfighters and families.

Thank you for the opportunity to talk with you today, and I look forward to your questions.

[The prepared statement of General Horoho can be found in the Appendix on page 55.]

Mr. WILSON. Thank you very much.

And Admiral Nathan.

STATEMENT OF VADM MATTHEW L. NATHAN, USN, SURGEON GENERAL, U.S. NAVY

Admiral NATHAN. Thank you, Chairman Wilson, Ranking Member Davis, distinguished members of the subcommittee. I am pleased to be with you today to provide an update on Navy Medicine, including some of our collective strategic priorities, accomplishments, opportunities, and challenges.

I want to thank the committee members for the tremendous confidence and support shown to Navy Medicine.

I can report to you that Navy Medicine remains strong, capable, and mission-ready to deliver world-class care anywhere, anytime, as is our motto. The men and women of Navy Medicine are flexible; they are agile and resilient. They are meeting their operational and wartime commitments, including humanitarian assistance and disaster relief response, and concurrently delivering outstanding patient- and family-centered care to our beneficiaries.

Force health protection is what we do. And we do it at the very foundation of our continuum of care in support of the warfighter, and optimizes our ability to promote, protect, and restore their health.

One of my top priorities as I assumed my role as Surgeon General in November has been to ensure that Navy Medicine remains strategically aligned with the imperatives and priorities of the Commandant of the Marine Corps and the Chief of Naval Operations. Each day, we are fully focused on executing the operational missions and core capabilities of the Navy and Marine Corps, and we do this by maintaining warfighter health readiness, delivering the continuum of care from the battlefield to the bedside and from the bedside either back to the unit, to the family, or to transition.

We are honored to be entrusted with the health care of all we serve. We are aligned with our Navy and Marine Corps leadership as we support the defense strategic guidance, "Sustaining U.S. Global Leadership: Priorities for the 21st Century," issued by the President and Secretary of Defense earlier this year.

The Chief of Naval Operations, in his sailing directions to us, has articulated the Navy's first principles, and these include: warfighting first, operate forward, be ready. Earlier this month, Secretary Mabus launched the 21st-Century Sailor and Marine Program, a new initiative focused on maximizing each sailor's and marine's personal readiness. This program includes comprehensive efforts in key areas such as reducing suicides, curbing alcohol abuse, and reinforcing zero tolerance on the use of designer drugs or synthetic chemical compounds. It also recognizes the vital role of safety and physical fitness in sustaining the force readiness.

Navy Medicine is synchronized with those priorities and stands ready to move forward at this pivotal time in our history. We appreciate the committee's strong support of resource requirements. The President's budget for FY [fiscal year] 2013 adequately funds Navy Medicine to meet its medical mission for the Navy and Marine Corps. We recognize the significant investments made in supporting military medicine and providing a strong, equitable, and affordable healthcare benefit for beneficiaries.

Moving forward, we must innovate, operate jointly, position our direct care system to recapture private-sector care, and deliver best value to our patients. Briefly, I will share with you a few specific areas of our attention.

Combat casualty care: Navy Medicine, along with our Army and Air Force colleagues, are delivering outstanding combat casualty care. There is occasional discussion about what constitutes "world-class," and I can assure you that the remarkable skills and capabilities in places like the Role 3, a multinational medical unit in Kandahar, is, in fact, world-class trauma care, now even deploying MRI [magnetic resonance imaging] technology to investigate if this can be meaningful in changing the diagnosis and/or therapy in theater.

Another area is TBI [traumatic brain injury] and PTSD [post-traumatic stress disorder]. Caring for our sailors and marines suffering with traumatic brain injury and post-traumatic stress and/or PTSD remains a top priority. While we are making progress, we have much work ahead of us as we determine both the acute and the long-term impact on our service members. Military medicine cannot do this alone. We must continue active and expansive partnerships with the other services, our centers of excellence, the VA, and leading academic, medical, and private sectors. We wish to make the best care available to our warriors affected with TBI. I have been encouraged by our progress, but I am not yet satisfied.

And, also, wounded warrior recovery: Our wounded, ill, and injured service members need to heal in body, mind, and spirit. And they deserve a seamless and comprehensive approach to their recover along that journey with their families. Moving forward, we must continue to connect our heroes to approved emerging and diagnostic therapeutic options, both within our medical treatment facilities and outside of military medicine through collaborations with major centers of reconstructive and regenerative medicine. Our commitment to these men and women will never waiver.

And one last point on Medical Home Port, our adaptation of the successful civilian patient-centered medical home concept of care, which is transforming delivery of primary care across many man-

aged care agencies in the country. We have completed our initial deployment of Medical Home Port throughout the Navy Medical Enterprise, and preliminary results in the first sites show better value, better health—preventative health, cost utilization of those enrolled.

Also, our innovative research, including the critical overseas laboratories that not only provide world-class research but invaluable engagement with host and surrounding nations to strengthen theater security cooperation in places like Egypt, South America, Southeast Asia, along with excellent medical education and training programs ensure that we have the capabilities to deliver the state-of-the-art care now and in the future. They are truly force multipliers.

We continue to welcome and leverage our joint relationships with the Army, the Air Force, the VA, as well as other Federal and civilian partners in these important areas. I believe this interoperability helps us create systemwide synergies and allows us to invest wisely in education, training, research, and information technology.

None of these things would be possible without our dedicated workforce, a team of over 63,000 Active Component and Reserve Component personnel, Government civilians, as well as contract personnel, all working around the world to provide outstanding health care and support to their beneficiaries. I am continually inspired by their selfless service and sharp focus on protecting the health of sailors, marines, and their families. And I am particularly grateful for your support in helping us recruit and retain the best of these.

In closing, let me briefly address the MHS [Military Health System] governance. We appreciate the opportunity to begin the dialogue with you a month ago, when there was a hearing held on this issue. The Deputy Secretary of Defense has submitted his report to Congress, required by Section 716 of the fiscal year 2012 National Defense Authorization Act. It addresses the Department's plans, subject to review and concurrence by the GAO [Government Accountability Office], to move forward with governance changes.

Throughout my remarks this morning and in my statement for the record, I referred to our jointness in theater, in our classrooms, our laboratories, and our common pursuit of solutions for challenges like TBI. I again stress our commitment to interoperability and cost-effective joint solutions in terms of overall governance.

Navy Medicine looks forward to working on the next phase of the Deputy Secretary's plan. We must proceed and deliver it in a measured manner to ensure that our readiness to support our service's missions and our core warfighting capabilities will be maintained and our excellence in health care will be sustained.

On behalf of the men and women of Navy Medicine, I want to thank the committee for your tremendous support, your confidence, and your leadership. It is my pleasure to testify before you today, and I look forward to your questions.

[The prepared statement of Admiral Nathan can be found in the Appendix on page 83.]

Mr. WILSON. Thank you very much, Admiral.

General Green.

STATEMENT OF LT GEN CHARLES B. GREEN, USAF, SURGEON GENERAL, U.S. AIR FORCE

General GREEN. Thank you.

Chairman Wilson, Representative Davis, and distinguished members of the committee, thank you for inviting me here today. The Air Force Medical Service could not achieve our goals of readiness, better health, better care, and best value without your support, and we thank you.

To meet these goals, the Air Force Medical Service is transforming deployable capability, building patient-centered care, and investing in education, training, and research to sustain world-class health care.

This year, we established 10 new expeditionary medical support health response teams. These 10-bed, deployable hospitals enable us to provide emergency care within 30 minutes of arrival at scene and perform surgery within 5 hours in any contingency. Light and lean, it is transportable in a single C–17, with full base operating support requiring only one additional C–17. The health response team was used successfully in the Trinidad humanitarian mission last May and is our new standard package for rapid battlefield care and humanitarian assistance.

Critical care air transport teams and air evacuation continue to be a dominant factor in our unprecedented high survival rate. To close the gap and enter a critical care continuum, we applied the CCAT [critical care air transport] concept to tactical patient movement, delivering the same level of care during intratheater transports on rotary platforms.

The Tactical Critical Care Evacuation Team was fielded in 2011, and five teams are now trained. Two teams are currently deployed to Afghanistan, and each team has an emergency physician, two nurse anesthetists. And we are able to move critical patients between level 2 and level 3 facilities even more safely.

At home we enrolled 920,000 beneficiaries—actually, today it is 940,000 beneficiaries—into team-based, patient-centered care at all Air Force medical treatment facilities. This care model reduced emergency room visits, is improving health indicators, and achieved unprecedented continuity of care for our military beneficiaries.

The Air Force remains vigilant in safeguarding the wellbeing and mental health of our people. Post-deployment health reassessment completion rates are consistently above 80 percent for Active Duty, Guard, and Reserve personnel. The new Deployment Transition Center at Ramstein Air Base, Germany, provides an effective reintegration program for our deploying troops, and more than 3,000 have been through to date. We focus on our highest-risk patients, our beneficiaries. And a study of the airmen who have attended showed significantly fewer systems of post-traumatic stress and lower levels of both alcohol use and conflict with family or coworkers upon their return home.

By this summer, behavioral health providers will be embedded in every primary care clinic in the Air Force. And we reach our Guard and Reserve members through telemental health efforts and embedded psychological health directors, and we are further increasing mental health provider manning over the next 5 years.

New training to support air evacuation and expeditionary medical capability is now in place. Our training curriculums are continuously updated to capture the lessons from 10 years of war. And our partnerships with civilian trauma institutions have proved so successful in maintaining wartime skills that we have expanded the training sites to establish new programs with the University of Nevada–Las Vegas and Tampa General Hospital.

We also shifted our initial nursing training for new Air Force nurses to three civilian medical centers. The Nurse Transition Program now at the University of Cincinnati, at Scottsdale, and in Tampa broaden our resuscitative skills and experience.

Air Force graduate medical education continues to be the bedrock for recruiting our top-notch physicians. Our graduate programs are affiliated with Uniformed Services University and civilian universities. And these partnerships build credibility, both in the U.S. and international medical communities.

One of our most significant partners is the Department of Veterans Affairs. And we are very proud of our 6 joint ventures, 59 sharing agreements, and 63 joint incentive fund projects, which are improving services to all beneficiaries.

We also note significant progress has been made toward the integrated electronic health record, to be shared by DOD and the Department of Veterans Affairs.

In the coming year, we will work shoulder-to-shoulder with our Army, Navy, and DOD counterparts to be ready, to provide better health, better care, and best value to America's heroes. Together, we will implement the right governance of our Military Health System. We will find efficiencies and provide even higher-quality care with the resources we are given.

I thank this committee for your tremendous support to military medics. Our success, both at home and on the battlefield, would not be possible without your persistent and generous support.

Thank you, and I look forward to answering your questions.

[The prepared statement of General Green can be found in the Appendix on page 109.]

Mr. WILSON. Thank you very much, General Green.

And Mr. Strobridge.

STATEMENT OF COL STEVE STROBRIDGE, USAF (RET.), CO–CHAIR, THE MILITARY COALITION

Colonel STROBRIDGE. Thank you, Mr. Chairman, Ranking Member Davis, and distinguished members of the subcommittee.

Less than 3 months ago, the fiscal year 2012 Defense Authorization Act became law, which let the Administration implement the TRICARE fee increases it recommended last year. Now, when the ink is hardly dry, the new proposal would impose far higher increases for TRICARE Standard, TRICARE Prime, and TRICARE For Life, plus a doubling and tripling of new pharmacy co-pays.

It would raise health costs $1,000 to $2,000 a year or more for retirees, and the large pharmacy fee hikes would affect many currently serving people, as well—families, the family members. Defense leaders say they will keep faith with the currently serving on retirement reform, but thousands who retire in the next year would incur these new fees. If "keeping faith" means no changes for to-

day's troops on retirement, then it is breaking faith to raise their fees by $2,000. That is no different than a $2,000 retired pay cut. And if it is breaking faith to change the rules for someone with 1 year of service, then it is doubly so to do that to those who have already completed 20 or 30 years.

For generations, the Government has induced millions to complete arduous service careers in uniform with promises that, for rendering that sacrifice, they would earn the current retirement and healthcare package. In other words, their extended service and sacrifice constituted their prepaid premium. Now, after retirees have done their part, Pentagon leaders say their service isn't worth so much anymore and they should pony up thousands more every year for the rest of their life.

They blame the budget crunch but balk at changes to make the system significantly more efficient. Many studies document the inefficiencies of DOD's fragmented healthcare systems, but the recent review made only minimal changes, in part because a key decision criterion was how hard the change would be. So the first choice was to make retirees pay more because it was easier.

Another argument is that military programs should move toward market rates and be more like civilian plans. After all, they say, military retirees pay far less for health care than civilians do. Whenever somebody gives me that argument, I ask, "If the military deal is so great, are you willing to pay what they did to earn it? Would you sign up to spend the next 20 or 30 years being deployed to Iraq, Afghanistan, or any other garden spot the Government wanted to send you to?"

Military people pay far steeper premiums for health coverage than any civilian ever has or ever will. That is why military coverage is supposed to be top-tier coverage, not just the civilian median.

One example: Fifty-six percent of civilian employer plans charge $25 co-pays or less for brand-name medications. That puts the new $26 TRICARE proposal in the bottom half of civilian plans. Further, TRICARE's $5 retail generic co-pay that was implemented last October is already more than civilians with no insurance at all pay at Wal-Mart and many other pharmacies. And they want to raise the military co-pay again.

As for the plan to means-test retiree health fees, that is patent discrimination against the military. No other Federal retiree has service-earned health benefits means-tested, and it is rare in the civilian world. Under that perverse system, the longer and more successful you serve, the less benefit you earn. The Coalition believes strongly that the proposed rates are significantly too high for all military beneficiaries.

Finally, the Coalition objects very strongly for tying TRICARE fee growth to any index of health-cost growth. On behalf of the MOAA [Military Officers Association of America] and 22 other associations, we strongly support the position you established in the fiscal year 2012 Defense Authorization Act: that the percent growth in TRICARE fees in any given year should not exceed the percentage growth in military retired pay.

We are grateful for this opportunity to present our views, and I will be pleased to answer any questions.

[The prepared statement of Colonel Strobridge can be found in the Appendix on page 129.]

Mr. WILSON. Thank you very much, Mr. Strobridge.

And as we begin—and I am going to be on the 5-minute clock myself. But as we begin, I want to thank you. And I agree with General Horoho that miracles are performed every day. And as a military parent, as a veteran, I appreciate so much your service. It is so reassuring to know that the survival rate of our military is the highest in world history and, also, the technological advances for our wounded warriors is the best, again, in world history. And it is just reassuring as a parent.

As we prepare today, Dr. Woodson, I am concerned—and I appreciate the points made by Mr. Strobridge. Based on your projections, 60 percent of the savings from the TRICARE proposals will come from beneficiaries choosing not to use the benefit they earned by serving or by using it less.

How did DOD calculate the estimated savings from beneficiaries opting out of TRICARE?

Secretary WOODSON. Thank you, Mr. Chairman, for the question.

I must admit I am a little perplexed at how those numbers are summed up. Our rationale going into deriving the fee adjustments were coming from the issue of what we needed to achieve in cost savings over 10 years. That is the $487 billion and, over the FYDP [Five-Year Defense Plan], of $269 [billion].

And although personnel benefits are a third of DOD's costs, 90 percent of the savings actually comes from reduction in weapons programs, force reductions, and the like. And, as I mentioned in my opening statement, healthcare costs could not be excluded and had been the subject of some review over a number of years, as the fees for TRICARE had not increased for some 15 or 16 years until the recent NDAA [National Defense Authorization Act].

And so we were left with about $29 billion to look at. And even with that $29-billion sort of assessment, we only took really less than half of that, $12.9 billion, really over the FYDP and applied those really to sort of the fee adjustments, and then spread it across all of the programs so, again, no one beneficiary group was unduly affected.

So the real issue is about a rebalancing. And it is not even rebalancing to the original cost-share formula that Congress agreed to when we started the program. And the Secretary and the line leadership, who were heavily invested in both the adjustments and the tiering—remember, these are members in uniform, who spent the 35 years in uniform and are going to retire and are going to be subjected to these fees—felt strongly—and this included the senior enlisted leadership—felt strongly that there should be tiering and that they were the right adjustments to make at this time.

And I remind the committee also that we were guided by prior studies, such as the 2007 task force on the future of health care, which specifically, among other things, noted that these are one of the reforms that we should undertake.

So that is how we arrived at it. It wasn't an issue of trying to force people out of TRICARE. And, in fact, our numbers suggest that, considering the rise in premiums in the private sector and considering some of the other issues that affect health care, we

may have more people taking advantage of their TRICARE benefits, so quite the opposite.

Now, the truth is that maybe some may want to switch to Standard, which has a different cost share, but there is no attempt, absolutely no attempt, to drive people away from their TRICARE benefit.

Mr. WILSON. Well, I know of your personal commitment, but I am concerned about the formula, particularly with TRICARE fee increases, that an E–7 who served 28 years is going to pay more than an E–7 who served 20 years. And that doesn't seem fair to me, that people who serve longer pay more.

Secretary WOODSON. Well, you are speaking to the formula—again, line-driven, uniform-driven on this. I can't emphasize that enough, that they took the mantle on this. The issue is that they felt strongly that those who make more should pay more. Their increases over the years, in fact, have been proportionally more because they come out with more retired pay. But for 16 years there has been no increase. So the issue is, they felt strongly that this was a fair way to go.

Mr. WILSON. Thank you.

We now proceed to Ms. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

And I certainly can acknowledge that we are all probably going to dig in on this issue to a certain extent. But I think it is also very fair to ask what would happen if, in fact, approval of these changes did not go forward.

Secretary WOODSON. Thanks again for that very important question because if—as I mentioned, 90 percent of the savings came from other areas, so planes, ships, people. If we don't go forward with these TRICARE fee adjustments, we will have to look at planes, ships, and people again.

And so the issue is that, if we look at people, we are looking at maybe a 50 percent more increase in the reduction of the force. And while I wouldn't want to fix a number on this, we are talking about anywhere from, you know, 30,000 to 50,000 troops.

Mrs. DAVIS. Okay. Well, thank you. I mean, we know we are in a very difficult space.

And I guess, Mr. Strobridge, you probably have the most difficult job of anybody up there, in many ways. And I think in your comments you also were looking at ways that we could expand benefits while at the same time, I think quite eloquently, saying that, you know, this is not the place to increase these on the men and women who serve and sacrifice for our country.

But, within that, of looking to expand and wanting to not change anything, where do you see any kind of wiggle room there?

Colonel STROBRIDGE. Well, there are various views among the associations. And, as I said a little earlier, MOAA and 22 other associations have not taken the view that there should never be a single fee increase. We think that, you know, over time, as retired pay rises, there is an expectation that fees will rise. But we think that they have to be reasonable. And we think that the standard that the committee established last year, by tracking to the COLA [cost-of-living adjustment] percentage, is reasonable.

I would like to make one comment in terms of, you know, what are the alternatives. One of the things that we have said very consistently is that there are ways to make the system more efficient without raising beneficiary fees. We have talked to people who have done reviews in the last couple of years who have raised the figure of a potential savings of 30 percent if you reorganized the system, with no requirement to cut benefits and no increases in beneficiary fees. That entails significant reorganization of how health care is delivered in the military system.

I was the defense implementation officer for the Goldwater-Nichols provisions, the jointness provisions. And I can tell you, at that time, all the hearings said it was too hard, we can't do it. None of the Services wanted to do it. We did it, because Congress directed it. And I believe the same potential lies here.

Mrs. DAVIS. Yeah. Thank you.

You asked my next question for me. I appreciate that. Because I wanted to turn to Dr. Woodson, because we know that the Department of Defense has proposed another change in governance structure. In 2006, we saw a change to that.

And I am just wondering, of the—I believe there were seven governance initiatives that were supposed to achieve some economies of scale and operational efficiencies, how many have projected any estimated savings? Do we see savings there? How much of the $200 million annual savings has been realized that I think we were hoping for? And going back to Mr. Strobridge's question—and I know I am running out of time—how does that improve jointness?

Secretary WOODSON. Thank you very much for this important question.

Clearly, it improves jointness, and I will return to that in just a minute.

But just to put it in context, you know, when we talk about 30 percent savings and what is achieved by reorganization, you are focusing really on the least costly part of the Military Health System—that is, the headquarters and sort of the administrative activities. And so that is about 2 percent of budget. The real area that you need to affect is in sort of the cost of delivery of care, so what we call Budget Area Group 1 and 2, which is the big balloons, you know, accounting for probably out of the DHP $25 billion or more in that situation.

And so the thing that everyone needs to understand is that we are committed to restructuring the MHS to produce the most efficient administrative system. So we are already bought off on that, and that is why we made the proposal to the DHA [Defense Health Agency]. But it really is a leverage to produce the efficiencies and developing the strategies for delivering the care so that we improve access and quality at a lower cost, so a better value for the dollars that are spent.

But to speak to what we have already done, clearly, you know, we have made amazing changes over the years in terms of the administrative structure to drive out that waste. We accepted, actually, MOAA's suggestion some years ago about looking at our pharmacy approaches and going to Federal ceiling pricing, and we have already saved $3.4 billion in talking about administrative process; and fraud and recuperation of fees, $2.6 billion; medical acquisi-

tions, $31 million a year. We have reduced headquarters already last year by 440 FTEs [Full Time Equivalents] and are on track to reducing it to the total of the 680 that we talked about with Congress last year.

And so we have undertaken a lot of initiatives, some of which I won't talk about now. So the issue is, we have really squeezed that lemon called an administrative process. And with the report to Congress, I think we are doing the right things in terms of reform.

With the Defense Health Agency that is proposed, you know, we will be focusing on the issues of health IT [information technology], of medical education, of medical logistics, of sort of research and development, and being able to reduce an additional probable, at least, on the conservative side, 300 FTEs out of the administrative process.

So I think we have worked diligently together to look forward and design a system that is responsive, not only to sort of our mission, to try and do our mission better, but to do it in a cost-efficient way. But the key is that that is only 2 percent of our budget.

Mr. WILSON. Thank you, Ms. Davis.

And we will now proceed by order of appearance. And Dr. Heck ran across the street. I saw him, so he was here first.

Dr. Joe Heck from Nevada.

Dr. HECK. Thank you, Mr. Chairman.

And thank you all for being here, and thank you all for your service to our Nation, both in and out of uniform, and to the men and women that are still serving.

We talk a lot about dollars, but to me it doesn't make a difference, the dollar amount, if there is no access. And so, Dr. Woodson, primarily I have two questions regarding access that I would like to bring up, two issues.

One is the contracting process by which the TRICARE contracts are awarded. As I am sure you are aware, there was recently an appeal in the TriWest region, in the west region, that resulted in a change of the contract provider. And that appeal occurred almost 2 years after the contract was awarded and after the other entity lost an appeal in another region.

And so I am wondering, what is the process that allows that to happen, where you are appealing in one region, you are not successful, and then you reserve the right to appeal in another region 2 years later after the awardee has already, you know, been providing very good quality care?

And in full disclosure, I say it as a former not only TriWest beneficiary but a TriWest provider. How does that—I mean, that whole acquisition and contracting process just doesn't seem like it is something that should be working in that regard.

Secretary WOODSON. Thank you very much for the question. And I think it is actually quite the reverse. The acquisition process is a difficult, somewhat cumbersome process, but it is carried out according to due process to ensure fairness. And some of the protests that have been raised have been protests about the process, and that is why you have to do it with all due diligence.

We have, you know, in place the requirement that no one provider or group can operate in two different regions. And that has to do with making sure that if there was a serious problem in any

one provider, it would put at jeopardy too much of our network, if you will.

And so what happens is that you just have to go through the rather laborious legal and regulatory steps in order to get to a final decision and give the competing entities the right to appeal. It is just part of the process. And we know it takes time.

But one of the things that we have done is, we have actually reformed our acquisition process to ensure that there is fair adjudication of the individuals or the entities that are competing for these contracts. And it is understandable that they would protest. These are very large contracts, and it is important to their business. And it is just a process that needs to be played out.

Dr. HECK. Well, I can appreciate that, but it would just seem odd that you can maintain a right of appeal in one region while you are being adjudicated on a protest in another region, and if that doesn't work, then you can come back, you know, and protest another place after that original awardee has put together their care provisions.

Is that a statutory, a regulatory, is that a DOD policy? Where does that fall, that process that is in use?

Secretary WOODSON. Well, it is statutory, regulatory. It is all of those things, if you will.

I am not sure that the two are necessarily tied, as suggested. Each of the regions went through their process of sort of looking at the proposals and adjudicating them and ranking them and making decisions by the source authority, basically, and it was played out.

Dr. HECK. Well, I appreciate that.

Secretary WOODSON. And it is a complicated process, but it is there for everybody's protection.

Dr. HECK. And just quickly in my last few remaining seconds here, I recently received a letter that the Department of Defense is considering not recognizing the accreditation of osteopathic residency programs. And when we talk about maintaining access to quality healthcare providers, I was wondering if you have had any visibility on that. We sent a letter off asking for further information, but we would certainly appreciate follow-up on that, as well.

Secretary WOODSON. I had not heard about that as an issue, but I will take that for the record and I will respond to you.

[The information referred to can be found in the Appendix on page 223.]

Dr. HECK. Thank you.

Thank you, Mr. Chair. I yield back.

Mr. WILSON. Thank you very much, Doctor.

And we now proceed to Congresswoman Madeleine Bordallo of Guam.

Ms. BORDALLO. Thank you, Mr. Chairman.

And to all of our witnesses, I thank you for your testimony today.

Dr. Woodson, I have a question for you. Do you have any statistics in regards to the rise and/or fall of military healthcare costs as we drew down in Iraq?

Secretary WOODSON. Thank you for the question, and it is a little bit of a complicated answer, and here is the reason why.

Some of the costs of medical care are funded by OCO [Overseas Contingency Operations] funds. And if you look at probably the last

10 years of war, as best as we can dissect out sort of the relative cost, the increase in costs for the overall DHP is probably only in the range of about 6 percent. But I want you to understand that it depends on how you dissect out the cost.

But the point I want to make is that most of the rise in costs is really parallel to what is experienced in the civilian sector in terms of health inflation costs, which has been relatively steep over—at least particularly in the first part of the first 5 years of the century. So the issue of the defense health costs are really driven by that equation, what we pay for care in the private sector and the cost of delivering care in our direct care setting, the medical treatment facilities.

And that is why I pointed out before that, as much time as we spend talking about reorganizing and restructuring the administrative process, most of the money is in bag one and bag two, which is what we pay for care in the direct care system and in the purchased care system.

So, to sum up, it is hard to answer your question. We haven't seen a reduction in the cost coming out of Iraq.

The other thing I would mention to you is that, just because the kinetic war stops today, we have a huge tail in terms of taking care of the wounded and injured. So we are not likely to see, even if there was a precipitous increase in cost due to the war, a drop-off.

What is interesting, also, for the committee to know about is that last week we convened a 1-day conference looking at the long-term healthcare needs of wounded, ill, and injured. So we are talking about what they are going to need 10, 20 years down the pike or more. And we got a lot of interesting information about what that tail looks like and what we should be focusing on going forward.

So the answer to your question is, no, we haven't seen a reduction in the cost. The tail will be there for a long time. And there still are unknown factors that will affect those costs.

Ms. BORDALLO. Thank you.

Another question for you, Dr. Woodson. What efforts is the Department of Defense taking to find efficiencies within its overall medical system?

For example, we may have moved to a joint medical facility up in Bethesda, but I am not certain we have a truly joint medical system that reduces redundancies between each of the Services' healthcare providers. So I hope you can elaborate on what is being done to make a more joint healthcare delivery system and finding ways to reduce cost.

Secretary WOODSON. Thanks again. And I think that speaks to the report to Congress and our proposal to develop a defense health agency. It is looking at all of those shared and common services that have redundancies within each of the Services, trying to move them into a single management agency, reduce the cost. We talked about probably saving 300 FTEs. And that is just one model of looking at how do you reduce costs.

We really do believe that there are other efficiencies that will be driven, so that within the health IT we will be able to make some additional reductions. Within medical training, we will be able to make some reduction. Medical logistics, we will make some reductions. So the modest end of what we will achieve is represented by,

you know, the 300 FTE reduction, which equates to about $50 million to $100 million a year.

Ms. BORDALLO. Fifty million to $100 million?

Secretary WOODSON. Yes.

Ms. BORDALLO. Great. Thank you very much, Doctor.

And I yield back my time. Thank you, Mr. Chairman.

Mr. WILSON. Thank you very much.

We now proceed to Colonel Allen West of Florida.

Mr. WEST. Thank you, Mr. Chairman and Ranking Member.

And thanks to the panel for being here.

And, look, I am going to be very honest. I didn't go to law school, nursing school, medical school. I went to airborne school, so I am going to use a little paratrooper logic here.

Mr. Strobridge, Dr. Woodson, did we have any consultation about this whole plan with military veteran organizations?

Colonel STROBRIDGE. No.

Secretary WOODSON. We had no direct consultation with the military organizations in putting this proposal together. What we did have is information that they had provided to us over years about their thoughts on these same issues, since this is not a new set of issues that has come up.

Colonel STROBRIDGE. Well, I would say, no, there wasn't any consultation.

A couple of examples: You know, the one comment was made that we are talking about just the headquarters. The issue on reorganization isn't the headquarters. The issue is consolidation of responsibility and accountability for the budget, which we don't have right now. When a base wants to save money and they get ordered to cut their budgets, they can reduce the medications and the formularies, send people downtown, which costs more money but it doesn't affect them because the charge goes to DOD. It is those kinds of inefficiencies that you have to eliminate by the reorganization in terms of how you deliver care, so that you get rid of that, you know, "I will just shift my expense over to somebody else."

The other example was the mail-order pharmacy, which Dr. Woodson is correct, we have pushed the Defense Department for several years to put more effort into promoting the mail-order pharmacy. We had a formal proposal to form a partnership with them by which the associations would go out and put out a common package developed by the Department of Defense that we would work with the Medicare supplement insurance companies, who also have an incentive to reduce their expenses if people reduce their drug expenses. After a year, we got one meeting for a half-hour. We have had nothing since.

Mr. WEST. If I am correct, the population of the United States of America is about 350 million. Correct? Somewhere thereabout? And when I am reading through this, you provide to about 9.6 million beneficiaries. Are we supposed to believe that less than 1 percent are causing the fiscal woes of this country? That is something that really disturbs me.

Furthermore, I read that in fiscal year 2013 we are looking at $452 million of savings; fiscal year 2013 to 2017, we are talking about $5.5 billion of savings. Last year, the GAO put out a report, February 2011, that said there is $200 billion to $300 billion of re-

dundant and duplicative Government programs out there. Why don't we look at that before we start penalizing the people that have, you know, given a lifetime of service to this country?

The next question, is there any effect to DOD civilian healthcare plans, any changes to their plans?

Secretary WOODSON. Let me address a couple of things.

Your last question first: No. And in part because we don't control that, but, more importantly, they already go through a yearly adjustment in fees and have done so over the last decade so that they pay about 30 percent of the cost. They already have had those adjustments, and civilians have had a pay freeze. But that is not within our line of authority, really, to address.

In regards to your first point about the issue of military folks being responsible for the national debt crisis, I don't think anyone is really saying that. What we are really saying is that——

Mr. WEST. I mean, let's look at it. I mean, $487 billion, and now we are talking about another $600 billion, you know, through sequestration. I think that the message coming out of Washington, D.C., is that the military is going to be the bill payer for the fiscal irresponsibility of Washington, D.C. Furthermore, we are going to look at the men and women who have given a lifetime of service and say that you are on the cut line. That is the message.

When I briefed this at a town hall meeting in south Florida, which has one of the highest percentages of the retirees, they were livid because no one is talking about this.

So this is not about a dollar amount, this is really about a trust factor. And what are we saying to future generations of retirees and veterans? I mean, we already talked about the ink hadn't dried off of fiscal year 2012 and we are doing this in 2013. What is going to happen in 2014?

I am not upset with you all here, but I am telling you, that is the message that is getting out there and to friends of mine that are still in uniform. So, you know, I know my time has run out, but I have to tell you something. You have to tell Secretary Panetta this is FUBAR [fouled up beyond all recognition].

I yield back.

Mr. WILSON. Thank you very much.

We proceed to Colonel—Congressman Mike Coffman of Colorado.

Mr. COFFMAN. Thank you, Mr. Chairman. I was a sergeant in the Army, a major in the Marines, so I didn't get to that rank.

Let me first say that, in visiting the wounded in Bethesda, how impressed I am with the care that they are receiving. And I want to commend you for that.

I come from a military family. My father was in military medicine for the second half of his career. And I volunteered at Fitzsimons Army Medical Center in Aurora, Colorado, when I was a young person, 14, in 1969. And, you know, obviously, the technology, we have learned a lot about how to take care of particularly amputees, but I remember the morale just being terrible for those wounded.

And I think as America became divided about the war in Vietnam, they became divided about support for our veterans. And they felt—that was an Army installation, and they felt completely disconnected once they were wounded, that they were no longer really

soldiers, where the wounded that I see in Bethesda are connected to their units. They feel that they are still a part of the military. And I like it that their rehabilitation is done in the military and they are not shuttered off to VA facilities. And that is a separate discussion, in terms of improving those.

And I have tracked a double amputee coming out of my district, a lance corporal in the Marine Corps, who is able to not just walk but run on his prosthetics. He is competing in athletic events. He is at Balboa now, naval medical center. And I talked to him on the phone last week. He said he is in the best shape that he has ever been in. And so I am impressed with that.

One thing, there is one gap that I want to ask you about in military medicine that I am concerned about, and that is post-traumatic stress disorder. And the reason why I am concerned about it is because I think that our approach is that we seem to have a disability-centric approach and not a treatment-centric approach. And I think that it would cost us more money in the short run but save money in the long run if we would shift to more of a treatment-centric approach.

Those in the mental health profession that I talk to all feel that it could be brought—that the symptoms could be brought down to where they are not debilitating if given the proper modalities of treatment. So I wondered if any of you could respond to that issue.

General HOROHO. Sure. I will take that first, if that is okay.

Mr. COFFMAN. Yes.

General HOROHO. What we have looked at is really shifting more toward prevention, and I believe that is what you are talking about.

And so we have, over the last couple years, we have a comprehensive behavioral health system of care, where we have five touchpoints where our soldiers see a behavioral health specialist prior to deployment. In theater, we have increased our behavioral health assets. We are using tele-behavioral health, so that instead of waiting until they redeploy back to deal with some of the stressors and the symptoms associated with deployment, they are able to do that through tele-behavioral health in some of the remote areas in Afghanistan. And then we are also—we have overhired across each of our regions, using tele-behavioral health so we can shift that capability where the demand is.

We are also looking, when you look at not just behavioral health, but it is looking at stress reduction, anger management, alcohol use. So the approach now is more toward that prevention and looking at incorporating mindfulness, yoga, acupressure, acupuncture, so that we really help with decreasing some of that stress.

Because we agree with you. We have focused more on treatment, and over the last couple years it has been more toward prevention. And we have a ways to go, though.

General GREEN. Sir, if I could add to that, the most recent of statistics is—we just went and looked at it. There was a perception that, because of the wounded warriors going through the IDES [Integrated Disability Evaluation System] system that so many of them, as high as 80, 85 percent, also had PTSD, that we were putting a lot of people out because they had PTSD. But the reality is,

of those diagnosed with PTSD, 75 percent are returned to duty. So our focus is on treatment.

Obviously, I agree with General Horoho in terms of what we are doing to try and prevent this in the first place. But I do think that it is a bit of a misperception to think that we are not focused on treatment when we are bringing 75 percent back to duty.

Mr. COFFMAN. Admiral.

Admiral NATHAN. And if I may just add one caveat, sir, which is, my previous command role to this was the commander at Walter Reed Bethesda. And you talked about the two signature injuries in your question, one was amputations and limb loss, and the other is traumatic brain injury and post-traumatic stress.

And what we have learned in PTS and PTSD is that it not only takes the individual or the patient with it, it takes the family along, too. In other words, it is a family illness and, basically, can be devastating not only to a single patient, such as loss of limb, but to family. And so we provide a much more holistic approach now across the military, engaging family care at the same time that we engage the patient.

We actually created the national center of excellence for TBI at Bethesda, the National Intrepid Center of Excellence, NICoE, which is this avant-garde building there which is basically designed to be a prototypical facility to create and try innovative and new procedures, garnering the best academic, private, and military specialists available to look at new diagnostic and therapeutic techniques.

And as they treat their cohorts of patients, they treat them at the same time as the families. The families are flown in, brought in. And the entire family, including children, are taken through diagnostic and therapeutic trials along with the patient.

We are seeing some marvelous results from that. It is labor-intensive, it is personnel-intensive, and so it is going to be hard to replicate that across the entire spectrum. But we are starting to create satellite NICoEs in places like Camp Lejeune and Belvoir, and I think we will see more of those grow.

Mr. COFFMAN. Thank you, Mr. Chairman. Just to say that I think that is a much cheaper approach than sending somebody a disability check for the rest of their life.

With that, Mr. Chairman, I yield back.

Mr. WILSON. Thank you all very much.

And if there are no further questions—and Congressman Walter Jones of North Carolina had an appointment at the office, and so I have questions that he wanted submitted for the record for Dr. Woodson. And so, with unanimous consent, they shall be included.

As we conclude, again, thank you for your sincere and genuine concern for our military personnel, military families, and veterans. And we look forward to working with you to provide the world-class health care that you are providing.

Thank you, and we shall now be adjourned.

[Whereupon, at 4:20 p.m., the subcommittee was adjourned.]

A P P E N D I X

MARCH 21, 2012

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 21, 2012

Statement of Hon. Joe Wilson

Chairman, House Subcommittee on Military Personnel

Hearing on

Defense Health Program Budget Overview

March 21, 2012

Even in this tight fiscal environment, the Military Health System must continue to provide world-class health care to beneficiaries and remain strong and viable and fully funded in order to maintain that commitment. The Department of Defense has proposed several measures aimed at reducing the cost of the Defense Health Program. Unfortunately, all of the proposals simply shift the cost burden to TRICARE fee and cost-share increases to not only our working-age retirees but, for the first time, to our most senior military retirees.

The subcommittee has a number of concerns about the Department's initiatives. To that end, we would expect the Department's witnesses to address our concerns, including that the proposed TRICARE Prime fee increases, which have been characterized by military leaders as modest, will raise fees in fiscal year 2013 by 30 to 78 percent over the current rate. Over 5 years, the fees would increase by 94 to 345 percent.

The proposed increases may be designed to cause military retirees to opt out of TRICARE, choose a TRICARE option that is less costly to DOD, or decrease their use of TRICARE. The proposal would establish an annual enrollment fee for retirees who use TRICARE Standard and Extra and, for the first time, would require our most senior retirees to pay an enrollment fee for TRICARE For Life.

What is not clear to me is why, aside from the revenue being generated from the fees, DOD believes enrolling these participants is necessary. What benefit can these individuals expect to receive from enrolling? Sixty percent of the estimated cost savings from TRICARE proposals is based on military retirees opting out of TRICARE or using it less. Frankly, I think this plan is wrongheaded.

Finally, I would like to hear from the military surgeons about efforts they are taking within the military departments to increase the efficiency of the military healthcare system and reduce cost. I would also like the military surgeons' views on areas where additional efficiencies can be gained across the DOD health system.

Statement of Hon. Susan A. Davis

Ranking Member, House Subcommittee on Military Personnel

Hearing on

Defense Health Program Budget Overview

March 21, 2012

The last decade of conflict has been weathered on the backs of our remarkable forces, in particular, those who serve in our military healthcare system. The constant demands borne by those in uniform and those in support of them have yielded incredible successes on our battlefields abroad and at home here in the States. While I suspect that much of this hearing will focus on the healthcare proposals of the Department of Defense, this hearing will also provide the members of this subcommittee an opportunity to understand and examine some of the difficult challenges facing the military healthcare system—from reductions in resources to meeting the ever-increasing demand for mental health services.

Our military personnel and their families consistently exceed expectations under tremendous strains and pressures, and their access to quality health care should not be added to their plight.

I look forward to your testimony on how we are caring for our service members and their families, particularly our injured, ill, and wounded, and how we can continue to improve our military healthcare system in the new fiscal environment we will be facing.

Prepared Statement

of

The Honorable Jonathan Woodson
Assistant Secretary of Defense for Health Affairs

REGARDING
THE DEFENSE HEALTH PROGRAM
BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
MILITARY PERSONNEL SUBCOMMITTEE

March 21, 2012

Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to appear before you today on behalf of the men and women who comprise the Military Health System (MHS) and address our strategic priorities for the coming year.

We enter 2012 now having over ten years of experience in preparing for and responding to the consequences of war. We have seen the end of one major conflict and the implementation of a concrete timeline for the drawdown of the other. Yet, even with these milestones in our sights, we have many challenges to address in the coming year, both operational and fiscal.

I am proud of the performance of our military medical personnel on the battlefield and here at home. Last year, I provided this Committee with some of the accomplishments achieved in combat – the lowest levels of disease, non battle injury (DNBI) rates in warfare; the highest survival from wounds rate; the safety and speed of an aeromedical evacuation system that has no peer; and the treatment and rehabilitation of wounded warriors that is allowing ever greater numbers of our severely wounded to return to their units, or to pursue careers in the civilian sector.

These accomplishments bear repeating. I do this not simply to honor the men and women who made them happen, but also to point out that the actions and lessons that led to these outcomes are now being replicated in trauma centers, surgical suites, and rehabilitation centers around the country and around the world. The MHS is transferring our medical knowledge gained from battlefield medicine to the rest of society.

As we share our experiences with our colleagues in American medicine, we are also mindful of the need to look internally and assess what lessons we have learned – and consider how we should be organized to meet our future missions. In June 2011, the Deputy Secretary of Defense established an internal task force to study this issue. We have now also shared the task force report and the Deputy Secretary's planned reorganization with the Congress, consistent with Section 716 of the National Defense Authorization Act for fiscal year (FY) 2012. The plan we developed increases unity of effort, agility, and the opportunity for cost savings both through reduced overhead and, more importantly, through the implementation of common clinical and business practices across the enterprise. Our ability to implement this model will enhance virtually all of the programmatic issues we discuss in the MHS today.

The Department has proposed a $32.5 billion Defense Health Program (DHP) appropriation (Figure 1), reflecting a small increase from the FY2012 enacted budget.

Figure 1: FY2013 Defense Health Program (DHP) Summary

$ in Millions

Appropriation Summary	FY 2011[1] Actual	Price Growth	Program Growth	FY 2012[2] Enacted	Price Growth	Program Growth	FY 2013[3] Estimate
Operation & Maintenance	29,953.5	721.7	-89.0	30,586.2	859.6	-96.6	31,349.3
RDT&E	1,205.8	22.9	38.1	1,266.8	22.8	-616.6	673.0
Procurement	546.7	12.4	73.4	632.5	14.2	-140.2	506.5
Total, DHP	**31,706.0**	**757.0**	**22.5**	**32,485.5**	**896.4**	**-853.4**	**32,528.7**
MERHCF Receipts[4]	8,600.0			9,470.6			9,727.1
Total Health Care Costs	**40,306.0**			**41,956.1**			**42,255.8**
					Numbers may not add due to rounding		

[1] FY 2011 actuals include Operation and Maintenance (O&M) funding of $1,394.0M and Research and Development funding of $24.0M from the FY 2011 Overseas Contingency Operations (OCO), Title IX, Public Law 112-10.

[2] FY 2012 enacted (base), excludes O&M funding of $1,215.3M of OCO.
[3] FY 2013 estimate excludes O&M funding of $993.9M for OCO. The Department of Defense projects $135.6M O&M funding should transfer in FY 2012, and $139.2 million in FY 2013 to the Joint Department of Defense – Department of Veterans Affairs Medical Facility Demonstration Fund established by section 1704 of Public Law 111-84 (National Defense Authorization Act for Fiscal Year 2011).
[4] Reflects Departmental DoD Medicare-Eligible Retiree Health Care Fund (MERHCF) for FY 2011, FY 2012, and FY 2013 (O&M

Our proposal includes realistic cost growth for pharmacy, TRICARE contracts and other services provided both in our medical treatment facilities (MTFs) and care purchased from the private sector; as well as sustained investment in medical research and development.

I will outline the major elements of our strategy for 2013, using the Quadruple Aim -- the MHS strategic framework -- to discuss our initiatives. This framework captures the core mission requirements of the MHS: Assure Readiness; Improve Population Health; Enhance the Patient Experience of Care; and Responsibly Manage the Cost of Care.

Assuring Readiness

The MHS continues to closely monitor the health and medical readiness of the military force. We have consistently witnessed improvements in the medical preparedness of our service members, both active and Reserve Component.

We have ensured that our medical forces are also ready through sustained investments in our enlisted and officer training programs, through our comprehensive Graduate Medical Education (GME) programs conducted at a number of our MTF training platforms throughout the MHS and with select civilian partners; at the Medical Education and Training Center

(METC) in San Antonio, Texas, in our military medical school, the Uniformed Services University of the Health Sciences.

We also assess the health of the force upon their return from deployment. In our continued commitment to ensuring the mental health of our service-members, the Department has issued policy that Service members deployed in connection with a contingency operation receive a person-to-person, privately-administered mental health assessment before deployment, and three times after return from deployment. These person-to-person assessments are conducted by licensed mental health professionals or by designated individuals trained and certified to perform the assessments.

As part of our monitoring of the medical readiness of the force, we also assess our performance in ensuring that those service members who are identified as needing behavioral health services receive a referral and seek treatment. In this area, we have also witnessed improvement each year in both the referral for behavioral health services, and the rate at which service members seek ongoing treatment.

Senior leaders, both officer and enlisted, have led the effort to reduce the stigma associated with seeking mental health care. A DoD Mental Health Advisory Team (MHAT) survey from February 2011 showed that Marines who screened positive for mental health issues, had a substantial (and statistically significant) decrease in behavioral health stigma levels from 2006. The percent of Marines who agreed that seeking mental health care would harm their career dropped by more than fifty percent. Responses by the Marines on whether seeking mental

health care would cause members of their unit to have less confidence in them, cause unit leaders to treat them differently, cause unit leaders to blame them for the problem, or cause the Marine to be seen as weak, also saw similar statistically significant decreases.

Together with the Department of Veterans Affairs (VA), we have developed an integrated Mental Health Strategy that has 28 discrete strategic actions designed to strengthen access to clinical services, improve continuity of care across the Departments, streamline the adoption and implementation of evidence-based practices and ensure our mental health providers are delivering state-of-the-art care.

We have increased the number of behavioral health care providers over the past 3 years and embedded more in front line units. Along with providing care, we have undertaken the largest study of mental health risk and resilience ever conducted among military personnel. This study will identify risk and protective factors as well as moderators of suicide-related behaviors by 2014.

The Department continues to improve access to behavioral health services through a number of initiatives. In FY12, we have begun the process of embedding, over a four-year period, over 400 behavioral health providers into our patient-centered medical homes. We enhanced confidential, non-medical counseling through the Military Family Life Consultants (MFLC) and Military OneSource (MOS) programs, to include surge support – for both deployment/reintegration points in time, as well as other crises that emerge on a short-notice basis, such as the Ft Hood shooting and the Japanese earthquake/tsunami/nuclear incident.

Recent legislation now permits mobile VA Readjustment Counseling Services to provide outreach and readjustment counseling to active duty service members.

We have also made efforts to ensure continuity of behavioral health care for members in transition – to a new installation, from active to reserve status, or to the VA. We offer a diverse set of services to reach those military members seeking greater support. One notable program -- "*inTransition*" – was developed in response to the Mental Health Task Force recommendation to "maintain continuity of care across transitions for service members and veterans," and offers a voluntary telephonic coaching program designed to facilitate a smooth transition to a new source of care. *Afterdeployment.org* is another program, serving over 5,000 users monthly, that provides service members and their families with behavioral health information in a setting that preserves anonymity, and offers tools to help them recognize problematic behavioral health issues early and how to address these challenges. Recently, the VA has been using the site's interactive workshops in their walk-in clinics.

Just as the Department has established a comprehensive approach to its mental health destigmatization efforts, we have employed the same model for our suicide prevention programs. The Deputy Assistant Secretary of Defense for Readiness is standing up the Defense Suicide Prevention Office that will be staffed and resourced to develop, implement, integrate, and evaluate suicide prevention policies, procedures, and surveillance activities across the Department. This action specifically addresses a key recommendation contained in the DoD Task Force Report on Suicide Prevention and will greatly facilitate the timely implementation of additional recommendations contained in the report.

The Department of Defense has made great strides in implementing early identification and treatment programs for traumatic brain injuries (TBIs). Through the work of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), the DoD in-theater concussion policy has significantly improved the early detection of Service members with concussion by providing clear and specific guidelines for the management of acute concussions. The Department's focus on TBI treatment has resulted in the standardization of 62 TBI programs at military treatment facilities (MTFs) in the non-deployed setting and the cultivation of 11 concussion restoration/care centers in the deployed setting. We have also helped update the behavioral health curriculum for all medical technicians and corpsmen at our Medical Education and Training Center (METC) to ensure our knowledge base is advanced throughout the MHS.

Our FY13 program sustains the significant investments we have made in all of our medical research and development programs, and in particular in the area of TBI and Post-Traumatic Stress (PTS). The Center for Neuroscience and Regenerative Medicine (CNRM) is a collaborative intramural federal program that bridges DoD and the National Institutes of Health (NIH) in order to catalyze innovative approaches to TBI research, and emphasizes research that is relevant to military populations. Our other focus areas for the Defense Medical Research and Development Program include polytrauma and blast injury; operational health and performance; regenerative medicine; rehabilitation; psychological health and well-being for military personnel and families; and military medical training systems and health information technology applications.

Within the readiness area, the health of our service members is also protected through sound occupational health practices. This past fall, the Institute of Medicine (IOM) concluded its independent study of the long-term health consequences of exposure to burn pits in Iraq and Afghanistan. The IOM was unable to identify any long-term health risks from these exposures. Nonetheless, DoD and the VA are continuing to monitor of the health of deployed Service members and veterans and provide for a longer period of post-exposure health assessments to ensure these initial findings are sustained over time.

Finally, at the core of our medical readiness posture is our people. Our recruitment of medical professionals – physicians, dentists, nurses, ancillary professionals and administrators – remains high. With the support of Congress, through the use of flexible bonuses and special salary rates, we have been able to meet most of our recruiting goals. Yet we recognize that competition for medical professionals will grow in the coming years, amidst a growing shortage of primary care providers and nurses. We will continue to work with Congress on potential new flexibilities to ensure we remain competitive in this environment.

Improving Population Health

Closely linked with our readiness mission are our efforts to improve the health of the entire MHS population. We are going to engage in a multi-year effort on two of the greatest contributors to ill health --- tobacco use and obesity in our population.

Our service members use tobacco and tobacco products at a much higher rate than their peers; we have started to reduce tobacco use, but we plan to do more. In addition to the existing suite of smoking cessation pharmaceuticals available at MTFs, and counseling services, we will soon offer the pharmaceutical benefit through our mail order program, and allow for a 24/7 smoking cessation line with counseling services over the phone.

In the area of obesity and overweight persons, in some circumstances we reflect what is occurring within the larger society. Our active-duty service members – as you would expect –do well in maintaining their weight and their fitness, and exceptionally well when compared to their peers. However, the influence of nutritional habits in the larger society is having effects on the military population and particularly on entry-level candidates. When those in uniform leave active service, too many reverse the physical fitness habits and discipline of military service. There is a financial cost to this; one DoD study found that $1.4 billion could be attributed to overweight and obesity-related medical problems and services. But, more importantly, the quality of life for our overweight and obese beneficiary population is often far worse than it should be as many are affected by obesity-related disease, such as diabetes and heart disease.

We have worked across the Services to develop and launch both adult and childhood obesity management and prevention guidelines, emphasizing the provider's role and positive steps to take in assisting and advising patients. We have also implemented a demonstration project to determine whether monetary incentives can be used to improve the overall health and wellness of the MHS population. We do not yet have the results of this demonstration project, but will report interim findings to the Congress this year. Finally, we have joined with a broader

set of partners in DoD, that includes bringing together everyone on a military installation – commanders, senior enlisted advisors, the military family program leaders and medical personnel – in a set of initiatives aimed at further improving the fitness of our entire community. Our military dining halls, schools and child development centers are offering healthier food choices – both here and in Afghanistan; our commissaries and exchanges will help identify better nutritional choices; and we're redesigning our military communities in ways that will increase exercise and fitness.

Enhancing the Patient Experience of Care

As the MHS moves into 2012, we will re-evaluate our efforts and mission through the lens of enhancing the patient experience of care by focusing on maximizing the value we provide to our beneficiaries.

The MHS is continuing the implementation of the Patient-Centered Medical Home (PCMH), a program with the principle focus of developing a cohesive relationship between the patient and the provider team. The PCMH is a transformative effort within our system, with the potential to positively affect all aspects of our strategic focus – readiness, population health, patient experience and per member cost. Begun in 2009 as a strategic initiative, the MHS has formalized through directive and accreditation our PCMH program. In 2011, 44 of our facilities were formally recognized by the National Committee on Quality Assurance (NCQA), with 93 percent recognized as Level 3 PCMHs (as compared to a private sector rate of 60 percent with Level 3 recognition). Our more mature PCMHs – at facilities throughout the Army, Navy and

Air Force, and representing more than 25% of our medical homes -- are achieving the outcomes we sought: improved access to care (increased percentage of the enrolled population getting an acute appointment within 24 hours, and a routine appointment in 72 hours); improved continuity with the same team of providers (increased percentage receiving care from their assigned primary care manager); and reduced emergency room utilization. In FY12, we will further augment our medical homes with a 24/7 nurse advice line to offer both enrollees (and all beneficiaries) access to essential health information. This nurse advice line will be linked with MTF appointing to further improve access to care, and reduce bureaucratic hurdles for our patients.

The Department has long been a national leader in developing and deploying a global, electronic health record (EHR). Our first EHR was put into the field in the late 1980s. We are now on the cusp of developing our third generation EHR – and the first to be co-developed with the Department of Veterans Affairs – the integrated Electronic Health Record (iEHR). Both DoD and the VA are encouraged by the progress that our interagency teams have made in refining or developing the IPO charter, and the principles, strategies and architectural framework for the iEHR as we embark upon this landmark effort.

The DoD/VA Interagency Program Office has been rechartered to give them more responsibility and authority as the program execution office for the iEHR. In addition, the VA has signed an agreement with the Defense Information Systems Agency to move the data centers for two of VA's regions into DoD data centers. Most recently, this week we announced the selection for the Director of the Interagency Program Office.

As we expand the amount of health care information that we collect and share, we remain vigilant about the security of this sensitive health information. In the last year, a DoD contractor responsible for the maintenance of aspects of our electronic health record experienced a serious security breach in which 4.9 million medical records were potentially compromised. In the wake of that incident, we have conducted a critical review of the contractor's performance, as well as a review of our existing policies and procedures, and we have strengthened our guidance and future contract requirements for a number of security and encryption standards.

Our work with the VA on the iEHR is only one element of a comprehensive strategy to further partner with the Department of Veterans Affairs. We have successful joint ventures or fully integrated operations at ten locations in the United States, and, in addition, we are pursuing other opportunities for joint purchasing, shared education and training opportunities, and joint construction, where feasible.

The Military Construction (MILCON) program continues to recapitalize our inventory of MTFs. Our current investment program was substantially increased five years ago and has been essential in facilitating the BRAC transition and continued improvement of our MTFs. Both the Walter Reed National Military Medical Center in Bethesda, Maryland and the Fort Belvoir Community Hospital in Fort Belvoir, Virginia have opened their doors, showcasing the investments made, using evidence-based design standards. Construction and renovation of medical facilities in San Antonio is also complete. Along with other military medical facility projects in the U.S. over the last seven years, with the support of Congress we have just

completed one of the most transformative periods in the history of our military medicine infrastructure.

As budgets and force structure are reduced in the Department, we recognize that there is a need to reassess the size and scope of major construction projects, as we are currently doing with the Landstuhl Regional Medical Center in Germany. We will, however, sustain our commitment to the operational mission, patient-centered design and clinical quality, even if sizing issues are reconsidered. The recapitalization of military medical facilities is essential to our efforts to recapture health care that has migrated to the civilian sector.

Responsibly Managing Cost

We are proud of our achievements in combat and peacetime medicine. We offer a superb benefit to our 9.7 million beneficiaries, no matter where they live, through our direct health care system and through our managed care support contracts. This health care benefit is justifiably one of the finest and most generous in the county and is an appropriate benefit for those who serve our country. However, the costs of providing this care continue to increase more rapidly than overall inflation. For a number of years, and through several Administrations, there have been continuous, incremental steps taken to reduce the rate of growth in the costs of healthcare.

In addition, the requirements of the Budget Control Act of 2011 compelled the Department to identify $487 billion in budget reductions over the next ten years. The process of identifying these budget cuts was developed by the senior civilian, military officer and enlisted

leadership from throughout the Department. Difficult choices were made. Over ninety percent of the cost reductions were external to personnel compensation and benefits. Still, health care was not exempt from this process. The proposals being put forward in this budget appropriately balance the need for a superb benefit that assists with both recruitment and retention of an all-volunteer force with our need to sustain a cost-effective approach for the long-term.

This Administration is pursuing a four-pronged approach by which all stakeholders share responsibility for improving the health of our population and the financial stability of the system of care.

Our four approaches – moving from a system of healthcare to one of health; continuing to improve our internal efficiencies; implementing provider payment reform; and rebalancing cost-sharing – are further described below. In some instances, they reflect efforts already underway, or new initiatives that the Department is implementing within existing legislative and regulatory authorities.

Moving from Healthcare to Health

The Department of Defense's military medical leaders are leading a strategic effort to move our system to one that promotes and sustains the optimal health of those we serve, while providing world class healthcare when and where it is needed.

Central to this effort are the Department's investments in initiatives that keep our people well; that promote healthy lifestyles; and that reduce inappropriate emergency room visits and unnecessary hospitalizations. These initiatives have been addressed in earlier parts of my testimony and include the Patient-Centered Medical Home (PCMH) initiative; the embedding of behavioral health staff within these medical homes; the introduction of a 24/7 nurse advice line; and our many population health initiatives. We have also taken a number of steps to support preventive services. Our TRICARE beneficiaries – whether enrolled to TRICARE Prime or in TRICARE Standard – have no co-payments for recommended preventive services, such as influenza immunizations.

The "Healthcare to Health" element of our strategy will not produce immediate cost savings. Nonetheless, based on knowledge of well-constructed wellness programs in the private sector, we are confident that these, and other ongoing enhancements to the TRICARE program, will produce improvements to health that also "bend the cost curve." In the longer term, it is the strategy most likely to produce the greatest amount of savings to our system.

Internal Efficiencies

The Department has instituted internal cost reduction efforts by decreasing headquarters administrative overhead; jointly purchasing medical supplies and equipment; and directing patients to lower cost venues for medications. The cumulative savings from all of these internal efforts for FY2013 are estimated at $259 million.

I have also previously noted the proposed reorganization of the MHS, following the work of the Task Force on Military Health System (MHS) Governance, which evaluated options for the long-term governance of the MHS as a whole; governance in those areas where more than one Service operates medical treatment facilities – referred to as multi-Service markets, and governance for the National Capital Region (NCR).

Implementation of any organizational efficiencies resulting from this Task Force has been placed on hold at the direction of Congress, subject to a review by Congress and by the Comptroller General. We have provided Congressional Committees with the information requested regarding the Task Force work. The initial cost and savings estimates were necessarily preliminary, given the short duration of the task force. We will develop more detailed cost and savings estimates for any eventual governance model. The Deputy Secretary of Defense has also provided the planned "way ahead" for the governance of the MHS following congressional and GAO review. We believe that further integration of health services across the Services and with the TMA are needed in order to provide a continued high quality of care in an environment of diminishing resources while ensuring the preservation of the health benefit for future generations.

Provider Payment Reform

We are committed to identifying greater efficiencies and cost savings in all areas of our operations. In addition to internal efficiencies, we are also seeing significant savings through a number of provider payment reforms that we have introduced in the last several years. These

include the implementation of the outpatient prospective payment system; the policy changes we made for reimbursement to select hospitals and health plans in the TRICARE network; and further use of federal ceiling prices for acquisition of pharmaceuticals.

The Department has undertaken a broad-based, multi-year effort to ensure all aspects of our provider payments for care purchased from the civilian sector are aligned with best practices in Medicare and in private sector health plans. The most notable efforts have included implementation of changes to the outpatient prospective payment system (OPPS) and reform of payment to Sole Community Hospitals.

OPPS is modeled after the payment process that Medicare uses for similar health care services – setting a fixed fee per procedure, inclusive of provider and institutional charges for care. In order to allow medical facilities to transition to this new method of payment, TRICARE phased in the reimbursement levels over four years, with the full implementation of this policy set to occur in 2013. In FY 2012, we project $840 million in savings, and $5.5 billion over the fiscal years 2012-2017.

Our provider payment reform for Sole Community Hospitals (SCH) was also phased-in over time, and will provide a projected $31 million in savings in the first year, and will grow to about $100 million in savings through 2017.

In the area of purchasing prescription drugs, in 2009 we instituted a process for obtaining discounts on drugs distributed through retail network pharmacies, pursuant to authority provided

in the 2008 National Defense Authorization Act. Known as Federal Ceiling Prices (FCP), prescriptions purchased under FCP are at least 24 percent less than non-Federal Average Manufacturer prices. In 2012, the FCP program will save the Department over $1.6 billion, and will grow to over $2 billion in savings by 2017.

Beneficiary Cost-Shares

In addition to the focus on internal and external efficiencies, our proposed budget introduces changes to the health care out-of-pocket costs for our beneficiaries.

I want to make three critical points related to these proposals. First, even accounting for these proposed fee changes, the TRICARE benefit will remain one of the finest and most generous health benefits available in the country, with among the lowest beneficiary out-of-pocket costs available to anyone – and certainly lower than costs by other federal government employees. We believe that is appropriate and properly recognizes the special sacrifices of our men and women in uniform, past and present.

Second, as mentioned earlier in my testimony, these proposals were developed within the Department, and represent the input and consensus of our uniformed leadership, both officer and enlisted.

Third, we recognize that some beneficiary groups should be insulated from increases in out-of-pocket costs. We propose to exempt those service members, and their families, who were

medically retired from military service, as well as the families of service members who died on active duty. We also propose to establish cost-sharing tiers, with lower increases for retirees based on their military retirement pay. More junior enlisted retirees, for example, will experience the lowest dollar increases in out-of-pocket costs. Finally, we have also avoided any changes in cost-sharing for active duty families with the exception of prescription drug co-payments obtained outside of our MTFs. Prescription drugs distributed within MTFs will continue to be free of charge for all beneficiaries.

For over fifteen years, the Department had not increased patient out-of-pocket costs for any beneficiary. In fact, the TRICARE benefit was enhanced in many ways, and a number of out-of-pocket costs were decreased. A few of these enhancements include: active duty family members enrolled in TRICARE Prime had their co-pays eliminated; retirees and their families using TRICARE Prime had their catastrophic cap reduced from $7,500 to $3,000 per year; Medicare-eligible retirees and their families received TRICARE For Life coverage, and a TRICARE pharmacy benefit. Last year, we introduced very modest changes in one segment of our population – increasing TRICARE Prime enrollment fees for retiree families by $5/month, and indexed these fees so that future increases continue to be modest and beneficiaries can plan for them. We greatly appreciate the Congress' support for these proposals in the FY2012 budget, and have implemented those fee changes in the current year.

Although last year's changes were a necessary step, the Department has proposed further cost reduction efforts in 2013 as an element of our strategy to meet the requirements of the 2011 Budget Control Act. All of these changes are phased in over time. For select fees the

Department has proposed "tiers" of co-pays based on the retirement pay of the beneficiary. Fee changes are distributed across the various TRICARE programs, so that no one beneficiary group bears the entire burden for these changes in cost-sharing. Retirees in TRICARE Prime, TRICARE Standard and TRICARE For Life each have a share of the increases; all beneficiaries (except uniformed personnel) have additional costs for prescription drugs outside of MTFs.

The following sections provide a high-level overview of the proposed changes in beneficiary out-of-pocket costs. Figure 2 summarizes the proposed fees:

- Fee increases for TRICARE programs. The following proposed changes represent increases from existing patient out-of-pocket costs.
    - TRICARE Prime Enrollment Fees. We propose to raise the enrollment fees in 2013 for retired service members and their families from between $80 – $300 per year, based on the retirement pay of the service member, and continue to provide similar increases through 2016.
    - TRICARE Deductibles. We propose to increase deductibles for the TRICARE Standard program for retired service members and their families beginning in FY13. TRICARE deductibles have not been changed since before the TRICARE program was introduced, having last been adjusted over 20 years ago.
    - TRICARE Pharmacy Co-Pays. We propose to increase pharmacy copayments for generic, brand name and non-formulary prescriptions in both the retail and mail order settings, although we will continue to offer significant incentives for beneficiaries to elect mail order over retail pharmacy networks. Additionally, non-formulary prescription drugs will no longer be available in the retail network.

These changes are proposed for all non-active duty beneficiaries, to include active duty family members. Prescription drugs obtained in military hospitals and clinics will continue to be provided without co-pay for any beneficiaries.

- New fees for TRICARE programs. Our proposed budget also calls for the introduction of new fees not previously part of the TRICARE program.
    - TRICARE Standard/Extra Enrollment Fee. We propose to introduce an annual enrollment fee in TRICARE Standard for retired service members and their families. The proposed fee for 2013 will be $70/ year for an individual retired beneficiary, or $140 per retired family.
    - TRICARE For Life (TFL) Enrollment Fee. When TFL was introduced in 2002, there was no enrollment fee in the program, only a requirement that beneficiaries be enrolled in Medicare Part B to enjoy their TFL benefit. Medicare Part B was always a step that we recommended our retirees elect, and prior to 2002, over 95% of eligible military retirees were enrolled in Medicare Part B. The TFL benefit has reduced beneficiary out-of-pocket costs by thousands of dollars per year in co-payments or Medicare supplemental health insurance plan payments. The proposed TFL enrollment fees, similar to the TRICARE Prime enrollment fees, are tiered, based on an individual's retirement pay – and range from $35 to $115 per beneficiary per year in FY2013.
    - Exclusion of Enrollment Fees from the Catastrophic Cap. We propose that enrollment fees, which had previously accumulated toward a retiree's catastrophic cap limit, will not be counted toward the cap beginning in 2013.

- In addition to the indexing of the TRICARE Prime enrollment fee, which is already indexed, we propose to index other beneficiary out-of-pocket costs identified in this set of proposals, to include the TRICARE Standard deductible, TRICARE Standard enrollment fee, TRICARE For Life enrollment fees, pharmacy co-payments, and catastrophic caps.

Figure 2. Summary of TRICARE Proposals

- TRICARE Prime for Working Age Retirees (under Age 65)
- As part of the FY 2013 President's Budget, the Department will seek additional increases in the **TRICARE Prime** (Health Maintenance Organization (HMO) type plan) enrollment fees in order to bring the beneficiary cost share closer to the original levels mandated by Congress when the program was established. These increases will be phased-in over a 4-year period and will be tiered based on the amount of the beneficiary's military retirement pay.

- Table 1 displays the proposed fees by fiscal year for the three tiers of retired pay. After FY 2016, the enrollment fees will be indexed to increases in National Health Expenditures (NHE). The retired pay tiers will also be indexed to ensure beneficiaries are not pushed into a higher tier as a result of annual cost-of-living (COLA) increases. The construct and tiering are generally based on recommendations of the 2007 *Task Force on the Future of Military Health Care.*

Table 1 – TRICARE Prime Annual Family Enrollment Fees (Individual Fees = 50%)

Retired Pay	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016*	FY 2017
Tier 1: $0 – $22,589	$460/$520	$600	$680	$760	$850	$893
Tier 2: $22,590 – $45,178	$460/$520	$720	$920	$1,185	$1,450	$1,523
Tier 3: $45,179 & above	$460/$520	$820	$1,120	$1,535	$1,950	$2,048

- * Indexed to medical inflation (National Health Expenditures) after FY 2016

- TRICARE Standard and Extra for Working Age Retirees (under Age 65)
- The **TRICARE Standard and Extra** (fee-for-service type) benefit programs currently have no enrollment fees and modest annual deductibles of $150 per individual and $300 per family. For FY 2013, the Department proposal will seek to implement an annual enrollment fee and increase deductibles. These increases displayed in Table 2 will be phased-in over a 5 year period and will then be indexed to increases in NHE.

Table 2 – TRICARE Standard/Extra Fees/Deductibles

Annual Enrollment Fees	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017*
Individual	$0	$70	$85	$100	$115	$130
Family	$0	$140	$170	$200	$230	$250
Annual Deductibles						
Individual	$150	$160	$200	$230	$260	$290
Family	$300	$320	$400	$460	$520	$580

- * Indexed to medical inflation (National Health Expenditures) after FY 2017

- TRICARE-for-Life Benefit (TFL) Benefit Program for Retirees age 65 and Older
- Like almost all Americans, upon reaching age 65, TRICARE beneficiaries must enroll in Medicare and begin paying Medicare Part B (outpatient care coverage) premiums. With Part B coverage, Medicare typically covers only 80 percent of eligible health care services and some people choose to be covered by "Medigap" or other private insurance policies to lower cost-sharing and receive additional coverage. Enacted in 2001, the TFL program acts as a second payer plan for

TRICARE beneficiaries covering the costs not paid by Medicare. While the average "Medigap" plan with comparable coverage carried premiums $2,100 per individual in 2009, there are currently no annual fees for TFL coverage. As part of the FY 2013, President's Budget, the Department is proposing to implement modest annual fees for TFL coverage. These fees will be phased in over a 4-year period and use the same tiering based on the beneficiary's retired pay along with the same indexing and exemptions as the proposed TRICARE Prime fees. Table 3 displays the proposed TFL fees by fiscal year for the three tiers of retired pay.

Table 3 – TRICARE-for-Life Annual Enrollment Fees – Per Individual

Retired Pay	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016*	FY 2017
Tier 1: $0 – $22,589	$0	$35	$75	$115	$150	$158
Tier 2: $22,590 – $45,178	$0	$75	$150	$225	$300	$317
Tier 3: $45,179 & above	$0	$115	$225	$335	$450	$475

- * Indexed to medical inflation (National Health Expenditures) after FY 2016

- Pharmacy Co-Pays
- This proposal will adjust pharmacy co-pay structure for retirees and active duty family members to incentivize the use of mail order and generic drugs. Prescriptions will continue to be filled at no cost to beneficiaries at Military Treatment Facilities (MTFs). No fees would continue to apply to prescriptions for active duty service members.

- Table 4 displays the proposed co-pays for prescriptions filled through the TRICARE retail and mail order pharmacy programs.

Table 4 – Pharmacy Co-Pays

Retail – 1 month fill	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Generic	$5	$5	$6	$7	$8	$9
Brand	$12	$26	$28	$30	$32	$34
Non-Formulary*	$25	N/A	N/A	N/A	N/A	N/A
Mail-Order – 3 month fill						
Generic	$0	$0	$0	$0	$0	$9
Brand	$9	$26	$28	$30	$32	$34
Non-Formulary*	$25	$51	$54	$58	$62	$66
Military Treatment Facilities	No Change – Still $0 Co-Pay					

- * Non-Formulary pharmaceuticals will have limited availability in retail pharmacies
- Catastrophic Cap
- In order to maintain the adjusted beneficiary cost share, the annual catastrophic cap $3,000 per family will also be indexed to NHE and exclude enrollment fees.

- Finally, to protect the most vulnerable, these proposals exempt survivors of members who die on active duty and medically retired and their family members from these increases. However, it should be noted that even once the proposal is fully implemented, the TRICARE Prime program remains a very generous benefit with the average beneficiary cost share well below the original 27 percent of health care costs when the program was fully implemented in 1996.

These proposed changes continue to be modest by historic standards of cost-sharing in the TRICARE program. In 1996, when TRICARE was implemented, a working age retiree's family of three contributed approximately 27% towards the total cost of their care; today that

percentage has dropped to just over 10 percent. Even with these proposed changes, the percentage would still remain below the percentage originally set by Congress, averaging approximately 14% of range of overall health care costs in 2017 – and stabilizing at that level for the out-years.

These adjustments are an important step to setting the TRICARE benefit on a more sustainable path that maintains the quality of the medical benefit for future generations. Moreover, the overwhelming majority of these adjustments will be phased in over a four to ten year period and will be appropriately indexed to ensure future sustainability and guarantee transparency. These proposals – one element of a four-pronged effort at cost control – will help shift us toward more effective and cost-efficient processes that will allow us to provide better care while meeting our obligations to help reduce our budgets.

We are cognizant of the strains placed on our economy and the government by federal budget deficits and long-term debt. We recognize that the Department of Defense must shoulder its share of responsibility and that we must tighten our belts just as so many Americans have been forced to do in recent years. We have not taken any proposed change lightly. The health benefit exemplifies the Department's gratitude to veterans for their service and acts as an integral part of recruiting, retaining, and maintaining a healthy force. We worked to ensure that cost changes would be minimized and that any reforms would not degrade the quality of the benefit. We are confident that this is the case.

I am honored to represent the men and women of the Military Health System before you today, and I look forward to answering any questions you may have.

RECORD VERSION

STATEMENT BY

LIEUTENANT GENERAL PATRICIA D HOROHO
THE SURGEON GENERAL OF THE UNITED STATES ARMY
AND COMMANDER, US ARMY MEDICAL COMMAND

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL

SECOND SESSION, 112TH CONGRESS

ON DEFENSE HEALTH PROGRAM OVERVIEW

MARCH 21, 2012

NOT FOR PUBLICATION UNTIL RELEASED BY
THE COMMITTEE ON ARMED SERVICES

Chairman Wilson, Ranking Member Davis and distinguished members of the committee. Thank you for providing me this opportunity to share with you today my thoughts on the future of the U.S. Army Medical Department (AMEDD) and highlight some of the incredible work being performed by the dedicated men and women with whom I am honored to serve alongside. We are America's most trusted premier medical team, and our successful mission accomplishment over these past ten years is testimony to the phenomenal resilience, dedication, and innovative spirit of Soldier Medics, Civilians, and Military Families throughout the world.

Since 1775, Army Medicine has been there. In every conflict the US Army has fought, Army Medicine stood shoulder to shoulder with our fighting forces in the deployed environment and received them here at home when they returned. The past ten years have presented the AMEDD with a myriad of challenges, encompassing support of a two-front war while simultaneously delivering healthcare to beneficiaries across the continuum. Our experiences in Iraq and Afghanistan have strengthened our capacity and our resolve as a healthcare organization. Army Medicine, both deployed and at home, civilian and military, has worked countless hours to ensure the wellness of our fighting force and its Families. Army Medicine continues to support in an era of persistent conflicts, and it is our top priority to provide comprehensive healthcare to support War-fighters and their Families. The Soldier is America's most sacred determinant of the Nation's force projection and the Army's most important resource; it is our duty to provide full spectrum healthcare for our Nation's best. Committed to the health, wellness, and resilience of our force and its Families, we will stand alongside and inspire confidence in our Warriors when our Nation calls. Through the development of adaptive, innovative, and decisive leaders, we stand poised to support the foundation of our Nation's strength.

Over the past decade, Army Medicine has led the joint healthcare effort in the most austere environments. As part of the most decisive and capable land force in the world, we stand ready to adapt to the Army's reframing effort. Ten years of contingency operations have provided numerous lessons learned. We will use these as the

foundations from which we deliver the Army's vision. The following focus areas are the pillars upon which we deliver on that effort.

Support the Force

I was privileged to serve as the International Security Assistance Force Joint Command (COMIJC) Special Assistant for Health Affairs (SA-HA) from July – October 2011. My multi-disciplinary team of 14 military health professionals conducted an extensive evaluation of Theater Health Services Support (HSS) to critically assess how well we were providing healthcare from point of injury to evacuation from theater. It cannot be overstated that the best trauma care in the world resides with the US military in Afghanistan and Iraq. From the most forward combat outposts to the modern Role 3 facilities on the mature forward operating bases, the performance and effectiveness of the US military health system is remarkable. The medical community holds the trust of the American Service Member sacred. The fact that Service Members are willing to go out day to day and place themselves in harm's way in support of our freedom is strongly dependent on the notion that, if they become injured, we will be there providing the best medical care in the world. This has been proven time and time again with MEDEVAC remaining an enduring marker of excellence in the CJOA-A. The average mission time of 44 minutes is substantially below the 60 minute mission standard established by the Secretary of Defense in 2009. The survival rate for the conflict in Afghanistan is 90.1 %. This ability to rapidly transport our wounded Service Members coupled with the world-class trauma care delivered on the battlefield has resulted in achievement of the highest survival rate of all previous conflicts. The survival rate in WWII was about 70%; in Korea and Vietnam it rose to slightly more than 75%. In WWII only 7 of 10 wounded troops survived, today more than 9 out of 10 do. Not only do 9 in 10 survive, but most are able to continue serving in the Army.

Enhanced combat medic training has without question contributed to the increased survival rates on the battlefield by putting the best possible care far forward. The need for aerial evacuation of critical, often post-surgical patients, presented itself in Afghanistan based on the terrain, wide area dispersement of groundbased forces, as

well as increased use of forward surgical teams. En route management of these patients required critical care experience not found organic to MEDEVAC. In response to these needs, our flight medic program (AD, NG, AR) is raising the standard to the EMT-Paramedic level to include Critical Care nursing once Paramedic certified for all Components. This will enhance our capabilities to match the civilian sector and make our flight medics even more combat ready for emergencies while on mission. We've just begun the first course that will pave the way with 28 flight medics coming from all components. By 2017, we will have all flight medics paramedic certified. In the area of standardization of enlisted medical competencies, we are ensuring that our medics are being utilized as force multipliers to ensure world-class health care in our facilities. We are working with our sister services to ensure that all medics, corpsmen, and medical technicians are working side-by-side in our joint facilities and training to the highest joint standard.

We have an enduring responsibility, alongside our Sister Services and the Department of Veterans Affairs (VA), to provide care and rehabilitation of wounded, ill and injured service members for many years to come. We will stand alongside the Soldier from point of injury through rehabilitation and recovery, fostering a spirit of resiliency. The Warrior Care and Transition Program is the Army's enduring commitment to providing all Wounded, Ill and Injured Soldiers and their Families a patient-centered approach to care. Its goal is to empower them with dignity, respect, and the self-determination to successfully reintegrate either back into the force or into the community. Since the inception of Warrior Transition Units in June 2007, more than 51,000 wounded, ill, or injured Soldiers and their Families have either progressed through or are being cared for by these dedicated caregivers and support personnel. Twenty-one thousand of these Soldiers, the equivalent of two Divisions, have been returned to the force, while another 20,000 have received the support, planning, and preparation necessary to successfully and confidently transition to civilian status. Today, we have 29 Warrior Transition Units (WTU) and 9 Community Based Warrior Transition Units (CBWTU). More than 9,600 Soldiers are currently recovering in Warrior Transition Units (WTUs) and Community-Based Warrior Transition Units with more than

4,300 professional Cadre supporting them. Standing behind these Soldiers each stage of their recovery and transition is the Triad of care (Primary care manager, Nurse Case Manager and Squad Leader) and the interdisciplinary team of medical and non-medical professionals who work with soldiers and their families to ensure that they receive the support they deserve.

The Army remains committed to supporting Wounded, Ill, or Injured Soldiers in their efforts to either return to the force or transition to Veteran status. To help Soldiers set their personal goals for the future, the Army created a systematic approach called the Comprehensive Transition Plan, a multidisciplinary and automated process which enables every Warrior in Transition to develop an individualized plan, which will enable them to reach their personal goals. These end goals shape the Warrior in Transition's day-to-day work plan while healing.

For those Soldiers who decide to transition to Veteran status the Warrior Transition Command's (WTC) mission is to assist them to successfully reintegrate back into the community with dignity, respect and self-determination. One example of how the WTC is working to better assist this group of Soldiers is the WTC sponsored, joint service Wounded Warrior Employment Conference (WWEC) held in February. This is the second year the WWEC has brought together key stakeholders in the federal government and private industry. The goal is improved alliance and collaboration between military, civilian, federal entities and employers to encourage them to cooperatively support employment related objectives and share best practices in hiring, retaining, and promoting Wounded Warriors, recently separated Disabled Veterans, their Spouses and Caregivers.

The Care Experience

The Warfighter does not stand alone. Army Medicine has a responsibility to all those who serve, to include Family members and our Retirees who have already answered the call to our Nation. We continue to fully engage our patients in all aspects of their

healthcare experience. At each touch point, starting with the initial contact, each team member plays an important role in enhancing patient care. We will make the right care available at the right time, while demonstrating compassion to those we serve and value to our stakeholders. Beneficiaries will choose hospitals who give them not only outstanding outcomes but the best possible experience. And we aim to elevate the patient care experience across the enterprise to make the direct care system the preferred location to receive care. I am proud to share today that our patient satisfaction rate is currently above 92% and we are in the top 10 percent of health plans in the United States according to Healthcare Effectiveness and Data Information Set (HEDIS®), a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care. This said, my challenge --and my personal belief is that we can get better--we must be better. I'd like to outline a few areas where we continue to better ourselves in order to better the care experience for our patients.

Army Medicine is committed to accountable care - where our clinical processes facilitate best practice patterns and support our health care team in delivering competent, compassionate care. In everything we do, there is a need for accountability — to our patients, our team members, and ourselves. Accountability is not just providing competent delivery of health care; our Warfighters deserve more than that. Accountability is about taking ownership of the product we create and how it is delivered, considering it a reflection of ourselves and the organization. At the end of the workday, accountability is not measured by Relative Value Units, but by impact on patients. It is not about the final outcome, but about the process and upholding our commitment to Soldiers and their Families. Soldier well-being and health are absolutely our top priorities. The Army Medicine Team will continue advocating for patients and their well-being. As an Army at war for over a decade, we stand shoulder-to-shoulder with the Warfighter, both on the battlefield and at home. This means never losing sight of the importance of caring for our Nation's heroes and their Families. Realizing that this Army Medicine team is working around the clock and around the world to ensure Soldiers and their Families are cared for with compassion and dignity, I have asked our leaders to focus on caring for those who are giving care. The Army Medicine Team is

not immune to the stress of deployments, workload demands, and challenging circumstances. We provide the best care for our patients when we take care of each other. By doing that, we give our best to all those entrusted to our care.

Army Medicine has consciously committed to building a "Culture of Trust." Trust in patient care, trust within Army Medicine and the Army Family. In healthcare, trust plays a critical and important role. This strategic initiative is focused on an organizational culture change within Army Medicine and creating a lifestyle of trust. A culture of trust in Army Medicine is a shared set of relationship skills, beliefs and behaviors that distinguish our commitment to our beneficiaries to provide the highest quality and access to health services. Every initiative aimed at reducing variance and standardizing and improving patients' healthcare experiences, outcomes and readiness will be founded on a Culture of Trust. Last fall the Culture of Trust task force began piloting the initial Culture of Trust training. This foundational training provides information on trust behaviors, tenets and fundamentals creating a baseline upon which we will grow and expand.

We constantly seek to establish stronger more positive relationships with all that we serve in Army Medicine, to produce the very best possible individual care experience. To that end, Army Medicine has implemented a training program titled, "Begin with the Basics." The central theme of this training is individual personalized engagement practiced by each and every member of Army Medicine. Through these relationships we increase understanding and in understanding our patients better, we are able to provide better solutions. The goal is full deployment of the basics of this model across Army Medicine in the next eighteen months. We are using this model for care and service training as we deploy our medical home care model across Army Medicine.

In February 2011, Army Nursing began implementing a patient-centered outcomes focused care delivery system encompassing all care delivery environments; inpatient, outpatient, and deployed. The Patient Caring Touch System (PCTS) was designed to reduce clinical quality variance by adopting a set of internally and externally validated best practices. PCTS swept across Army Medicine, and the last facility completed implementation in January 2012. PCTS is a key enabler of Army Medicine's

Culture of Trust and nests in all of Army Medicine's initiatives. PCTS is enhancing the quality of care delivery for America's Sons and Daughters. PCTS has improved communication and multi-disciplinary collaboration and has created an increased demand and expanded use of multi-disciplinary rounds. Several facilities have reported that bedside report, hourly rounding, and multi-disciplinary rounding are so much a part of the routine that they cannot recall a time when it was not part of their communication process.

The collective healthcare experience is driven by a team of professionals, partnering with the patient, focused on health promotion and disease prevention to enhance wellness. Essential to integrated health care delivery is a high-performing primary care provider/team that can effectively manage the delivery of seamless, well-coordinated care and serve as the patient's medical home. Much of the future of military medicine will be practiced at the Patient-Centered Medical Home (PCMH). We have made Patient Centered Medical Homes and Community Based Medical Homes a priority. The Army's 2011 investment in patient centered care is $50M. Patient Centered Medical Home (PCMH) is a primary care model that is being adopted throughout the Military Health System (MHS) and in many civilian practices throughout the nation. Army PCMH is the foundation for the Army's transition from a "health care system to a system for health" that improves Soldier Readiness, Family wellness and overall patient satisfaction through a collaborative team based system of comprehensive care that is ultimately more efficient and cost effective. The PCMH will strengthen the provider-patient relationship by replacing episodic care with readily available care with one's personal clinician and care team emphasizing the continuous relationship while providing proactive, fully integrated and coordinated care focusing on the patient, his or her Family, and their long term health needs. The Army is transforming all of its 157 primary care practices to PCMH practices. A key component of transformation to the Army Patient Centered Medical Home requires each practice to meet the rigorous standards established by the National Committee for Quality Assurance (NCQA). In December of 2011, 17 Army practices received NCQA recognition as PCMHs and I anticipate we will have 50 additional practices that will obtain NCQA recognition by the end of this calendar year. It is expected that all Army

primary care clinics will be transformed to Army Medical Homes by FY15. Transformation to the PCMH model should result in an increased capacity within Army military treatment facilities of over 200,000 beneficiaries by FY16. The Army has established Community Based Medical Homes to bring Army Medicine closer to our patients. These Army operated clinics in leased facilities are in off-post communities closer to our beneficiaries and aim to improve access to healthcare services, including behavioral health, for active duty family members by expanding capacity and extending the military treatment facility services off post. Currently we are approved to open 21 clinics and are actively enrolling beneficiaries at 13 facilities.

Unity of Effort

The ability to form mixed organizations at home and on the battlefield with all Service and coalition partners contributing to a single mission of preserving life is proof of the flexibility and adaptability of America's medical Warfighters. It is our collective effort – Army, Air Force and Navy - that saves lives on the battlefield. It is an Army MEDEVAC crew who moves a wounded service member from the point of injury to a jointly staffed Role III field hospital. It's the Air Force provided aeromedical evacuation to Landstuhl Regional Medical Center where a triservice medical care team provides further definitive care. And then finally it's a joint team's capabilities at locations such as Walter Reed National Military Medical Center and the San Antonio Military Medical Center that provide the critical care and rehabilitative medicine for this Service member, regardless if they are a Soldier, Sailor, Airman, or Marine. The AMEDD is focused on building upon these successes on the battlefield as we perform our mission at home and is further cementing our commitment to working as a combined team, anywhere, anytime.

We are at our best when we operate as part of a Joint Team, and we need to proactively develop synergy with our partners as military medicine moves toward a joint operating environment. The wars in Afghanistan and Iraq have led to increased collaboration and interoperability with allied medical services, and have highlighted differences and gaps in our respective combat health service support systems. While the Combatant Commands have a responsibility to harvest and publicize lessons

learned and implement new best practices operationally, the MHS has the opportunity to address and apply, at the strategic, operational and tactical levels, the lessons learned regarding combat casualty care and medical coalition operations.

MHS governance changes will change the way we currently operate for everyone. These recommended changes will strengthen our system. In the delivery of military medicine, the Military Departments have more activities in common than not – together we will drive toward greater common approaches in all areas, except where legitimate uniqueness requires a service-specific approach. Our commitment is to achieve greater unity of effort, improve service to our members and beneficiaries, and achieve greater efficiency through a more rapid implementation of common services and joint purchasing, as well as other opportunities for more streamlined service delivery.

Our MHS is not simply a health plan for the military it is a military health system. A system that has proven itself in war and peace time. Our focus continues to be on supporting Soldiers, other Warriors and their Families--past, present and future--and on the most effective and efficient health improvement and healthcare organization to add value in the defense of the Nation. The best way to do that is through a unified and collaborative approach to care, both on the battlefield and in garrison. We must have outcome and economic metrics to measure and accountability assigned. And we must develop standard and unified performance measures across a wide range of health and care indicators e.g., population health, clinical outcomes, access, continuity, administrative efficiency, agile operational support, Warrior care and transition programs, patient satisfaction, cost, and others, to ensure we are effective, efficient and timely.

Innovate Army Medicine and Health Service Support

Many innovations in healthcare have their origins on the battlefield. Army Medicine's medical innovations borne from lessons learned in combat have become the worldclass standard of care for Soldiers on the battlefield and civilians around the world. As our presence in the current war begins to change, we must remain vigilant in developing and assessing strategies to protect, enhance, and optimize Soldier wellness,

prevention and collective health. Through leverage of information technology and militarily relevant research strategies, we will continue to develop new doctrine and education programs to reflect best practice healthcare on and off the battlefield, while ensuring that Army Medicine remains responsive and ready. Our speed of execution, combined with the ability to leverage knowledge and actionable ideas quickly, is paramount to optimize the constancy of improvement. Our biggest competitive edge is our knowledge and our people.

In 2004 the Assistant Secretary of Defense for Health Affairs directed to the formation of the the Joint Theater Trauma System (JTTS) and the Joint Theater Trauma Registry (JTTR). The Joint Theater Trauma System coordinates trauma care for our wounded warriors. Since that time the Services, working together, have created a systematic and integrated approach to battlefield care which has minimized morbidity and mortality and optimized the ability to provide essential care required for the battle injuries our Soldiers are facing. The vision of the JTTS is for every Soldier, Marine, Sailor or Airman wounded or injured in the theater of operations to have the optimal chance for survival and maximal potential for functional recovery and they are. Our 8,000 mile operating room stretches from Kandahar to Landstuhl to Walter Reed National Military Medical Center at Bethesda, to San Antonio Military Medical Center to the Veteran's Administration and other facilities throughout the United States. It's collaborative, it's integrated, and it knows no boundaries. JTTS changed how the world infuses blood products for trauma patients. In fact we just had a patient receive 400 units of blood. He coded three times on the battle field. And today he is recovering in Walter Reed National Medical Center at Bethesda. The JTTS also led to materiel changes in helmets, body armor and vehicle design. This is not a success of technology or policy. This is a success of a trauma community that expects and values active collaboration across its 8,000 mile operating room.

The JTTR, is the largest combat injury data repository and is an integral and integrated part of the JTTS. It provides the information necessary to advance the improvement of battlefield and military trauma care and drive joint doctrine and policy, while enabling process improvement and quality assurance. Additionally it enables more efficient and effective medical research in a resource-constrained environment.

The improvements in trauma care driven by both the JTTS and JTTR are increasing the survival rate on today's battlefield and saving lives in our Nations civilian trauma centers through shared lessons learned. We must maintain this critical capability to ensure that we continue to drive innovation and are able to respond to our next threat.

An area in which the Army and our Sister Services have innovated to address a growing problem is in concussion care. The establishment of a mild Traumatic Brain Injury (TBI)/concussive system of care and implementation of treatment protocols has transformed our management of all battlefield head trauma. Traumatic Brain Injury (TBI) is one of the invisible injuries resulting from not only the signature weapons of this war, improvised explosive devices and rocket propelled grenades, but also from blows to the head during training activities or contact sports. Since 2000, 220,430 Service Members have been diagnosed with TBI worldwide (Armed Forces Health Surveillance Center, 2011). In 2010, Military Medicine implemented a new mild traumatic brain injury management strategy to disseminate information that our healthcare workers needed and outlined the unit's responsibilities, creating a partnership between the medical community and the line units. This policy directed that any Soldier who sustained a mandatory reportable event must undergo a medical evaluation including a mandatory 24 hour down time followed by medical clearance before returning to duty. The mandatory events are a command-directed evaluation for any Soldier who sustains a direct blow to the head or is in a vehicle or building associated with a blast event, collision or rollover, or is within 50 meters of a blast. Since the DoD implemented Policy Guidance for Management of Concussion/mTBI in the Deployed Setting in June 2010, deployed Commanders screened over 10,000 Service Members for concussion/mild TBI, temporarily removed them from the battlefield to facilitate recovery, and ensured that each of them received a mandatory medical evaluation. Codification of this concussive care system into AMEDD doctrine is ongoing. To further support the TBI care strategy over the past 21 months the Services have stood up 11 facilities devoted to concussive care far forward on the battlefield, staffed with concussion care physicians and other medical providers, in order to care for those with TBI at the point of

injury. The Army has medical staff at 9 of these facilities. These centers provide around-the-clock medical oversight, foster concussion recovery, and administer appropriate testing to ensure a safe return to duty. The current return to duty rate for Soldiers who have received care at Theater concussion centers is over 90%.

To further the science of brain injury recovery, the Army relies on the US Army Medical Research and Materiel Command's TBI Research Program. The overwhelming generosity of Congress and the DoD's commitment to brain injury research has significantly improved our knowledge of TBI in a rigorous scientific fashion. Currently, there are almost 350 studies funded by DoD to look at all aspects of TBI. The purpose of this program is to coordinate and manage relevant DoD research efforts and programs for the prevention, detection, mitigation and treatment of TBI. In the absence of objective diagnostic tools, MRMC is expediting research on diagnostic biomarkers and other definitive assessment tools that will advance both military and civilian TBI care. By identifying and managing these injuries on the battlefield, we have eliminated many unnecessary medical evacuation flights and facilitated unprecedented return to duty rates. The Army realizes that there is much to gain from collaboration with external partners and key organizations. We have partnered with the Department of Veterans Affairs, the Defense and Veterans Brain Injury Center, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, academia, civilian hospitals and the National Football League, to improve our ability to diagnose, treat, and care for those affected by TBI.

There are significant health related consequences of over ten years of war, including behavioral health needs, post-traumatic stress, burn or disfiguring injuries, chronic pain or loss of limb. Our Soldiers and their Families need to trust we will be there to partner with them in their healing journey, a journey focused on ability vice disability.

A decade of war in Afghanistan and Iraq has led to tremendous advances in the knowledge and care of combat-related physical and psychological problems. Ongoing research has guided health policy, and multiple programs have been implemented in theater and post-deployment to enhance resiliency, address combat operational stress

reactions and behavioral health concerns. Similar to our approach to concussive injuries, Army Medicine harvested the lessons of almost a decade of war and has approached the strengthening of our Soldiers and Families' behavioral health and emotional resiliency through a campaign plan to align the various Behavioral Health programs with the human dimension of the ARFORGEN cycle, a process we call the Comprehensive Behavioral Health System of Care (CBHSOC). This program is based on outcome studies that demonstrate the profound value of using the system of multiple touch points in assessing and coordinating health and behavioral health for a Soldier and Family. The CBHSOC creates an integrated, coordinated, and synchronized behavioral health service delivery system that will support the total force through all ARFORGEN phases by providing full spectrum behavioral health care. We leveraged experiences and outcome studies on deploying, caring for Soldiers in combat, and redeploying these Soldiers in large unit movements to build the CBHSOC. The CBHSOC is a system of systems built around the need to support an Army engaged in repeated deployments - often into intense combat – which then returns to home station to restore, reset the formation, and re-establish family and community bonds. The intent is to optimize care and maximize limited behavioral health resources to ensure the highest quality of care to Soldiers and Families, through a multi-year campaign plan.

The CBHSOC campaign plan has five lines of effort: Standardize Behavioral Health Support Requirements; Synchronize Behavioral Health Programs; Standardize & Resource AMEDD Behavioral Health Support; Access the Effectiveness of the CBHSOC; and Strategic Communications. The CBHSOC campaign plan was published in September 2010, marking the official beginning of incremental expansion across Army installations and the Medical Command. Expansion will be phased, based on the redeployment of Army units, evaluation of programs, and determining the most appropriate programs for our Soldiers and their Families.

Near-term goals of the CBHSOC are implementation of routine behavioral health screening points across ARFORGEN and standardization of screening instruments. Goals also include increased coordination with both internal Army programs like Comprehensive Soldier Fitness, Army Substance Abuse Program, and Military Family

Life Consultants. External resources include VA, local and state agencies, and the Defense Centers of Excellence for Psychological Health.

Long-term goals of the CBHSOC are the protection and restoration of the psychological health of our Soldiers and Families and the prevention of adverse psychological and social outcomes like Family violence, driving under intoxication violations, drug and alcohol addiction, and suicide. This is through the development of a common behavioral health data system; development and implementation of surveillance and data tracking capabilities to coordinate behavioral health clinical efforts; full synchronization of Tele-behavioral health activities; complete integration of the Reserve Components; and the inclusion of other Army Medicine efforts including TBI, patient centered medical home, and pain management. We are leveraging predictive modeling tools to improve our insight into data, research advances, and electronic medical record systems in order to provide "genius case management" for our patients with BH disease, that is, care that is tailored for each patient, and a care plan aimed at better understanding the patient, and not just their disease. Integral to the success of the CBHSOC is the continuous evaluation of programs, to be conducted by the Public Health Command.

For those who do suffer from PTSD, Army Medicine has made significant gains in the treatment and management of PTSD as well. The DoD and VA jointly developed the three evidenced based Clinical Practice Guidelines for the treatment of PTSD, on which nearly 2,000 behavioral health providers have received training. This training is synchronized with the re-deployment cycles of US Army Brigade Combat Teams, ensuring that providers operating from MTFs that support the Brigade Combat Teams are trained and certified to deliver quality behavioral healthcare to Soldiers exposed to the most intense combat levels. In addition, the US Army Medical Department Center & School collaborates closely with civilian experts in PTSD treatment to validate the content of these training products to ensure the information incorporates emerging scientific discoveries about PTSD and the most effective treatments.

Work by the Army Medical Department and the Military Health System over the past 8 years has taught us to link information gathering and care coordination for any

one Soldier or Family across the continuum of this cycle. Our Behavioral Health specialists tell us that the best predictor of future behavior is past behavior, and through the CBHSOC we strive to link the management of issues which Soldiers carry into their deployment with care providers and a plan down-range and the same in reverse. We have embedded behavioral health personnel within operational units circulate across the battlefield to facilitate this ongoing assessment.

The management of combat trauma pain with medications and the introduction of battlefield anesthesia was a tremendous medical breakthrough for military medicine. The first American use of battlefield anesthesia is thought to have been in 1847 during the Mexican-American War, and the use of opioid medication during the Civil War was not uncommon. Military Medicine has worked very hard to manage our Service Members' pain from the point of injury through the evacuation process and continuum of care. The management of pain- both acute and chronic or long-standing pain – remains a major challenge for military health care providers and for the Nation at large. We have launched a major initiative through a multi-disciplinary, multi-service and DOD-VA Pain Management Task Force to improve our care of pain. The use of medications is appropriate, if required, and often an effective way to treat pain. However, the possible overreliance on medication-only pain treatment has other unintended consequences, such as prescription medication use. The goal is to achieve a comprehensive pain management strategy that is holistic, multi-disciplinary and multi-modal in its approach, uses state of the art modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain. The military is developing regional pain consortiums that combine the pain expertise from DoD with local Veterans Health Administration and civilian academic medical centers. The first of many of these relationships has been established in Washington State between Madigan Army Medical Center, VA Puget Sound Health Care System, and University of Washington Center for Pain Relief. Some of the largest research projects dealing with wounded-warrior pain have been facilitated through partnerships with VHA research leaders. Collaborations of this type will ensure the latest, evidence-based pain-care techniques and protocols are available to patients. Pain research in direct support of military requirements will also be facilitated by these federal and civilian partnerships. Other

partnerships include working with organizations such as the Bravewell Collaborative and the Samuelli Institute, both of whom provide DoD with expertise in building mature integrative medicine capabilities to compliment and improve our existing pain medicine resources.

Another concerning area of emphasis for military medicine that has emerged from the current wars is "Dismounted Complex Blast Injury" (DCBI), an explosion-induced battle injury (BI) sustained by a warfighter on foot patrol that produces a specific pattern of wounds. In particular, it involves traumatic amputation of at least one leg, a minimum of severe injury to another extremity, and pelvic, abdominal, or urogenital wounding. The incidence of dismounted complex blast injuries has increased during the last 15 months of combat in the Afghanistan Theater of Operations (ATO). The number of Service Members with triple limb amputation has nearly doubled this past year from the sum of all those seen over the last eight years of combat. The number of genital injuries increased significantly from previous OIF rates. The severity of these injuries presents new challenges to the medical and military communities to prevent, protect, mitigate and treat. Army Medicine has spearheaded a Task Force comprised of clinical and operational medical experts from the Departments of Defense (DoD) and Veterans Affairs (VA) and solicited input from subject matter experts in both Federal and civilian sectors to determine the way forward for healing these complex injuries.

Evidence-based science makes strong Soldiers and for this we rely heavily on the US Army Medical Research and Material Command (MRMC). MRMC manages and executes a robust, ongoing medical research program for the MEDCOM to support the development of new health care strategies. I would like to highlight a few research programs that are impacting health and care of our Soldiers today.

The Combat Casualty Care Research Program (CCCRP) reduces the mortality and morbidity resulting from injuries on the battlefield through the development of new life-saving strategies, new surgical techniques, biological and mechanical products, and the timely use of remote physiological monitoring. The CCCRP focuses on leveraging cutting-edge research and knowledge from government and civilian research programs to fill existing and emerging gaps in combat casualty care. This focus provides

requirements-driven combat casualty care medical solutions and products for injured Soldiers from self-aid through definitive care, across the full spectrum of military operations.

The mission of the Military Operational Medicine Research Program (MOMRP) is to develop effective countermeasures against stressors and to maximize health, performance, and fitness, protecting the Soldier at home and on the battlefield. MOMRP research helps prevent physical injuries through development of injury prediction models, equipment design specifications and guidelines, health hazard assessment criteria, and strategies to reduce musculoskeletal injuries.

MOMRP researchers develop strategies and advise policy makers to enhance and sustain mental fitness throughout a service member's career. Psychological health problems are the second leading cause of evacuation during prolonged or repeated deployments. MOMRP psychological health and resilience research focuses on prevention, treatment, and recovery of Soldiers and Families behavioral health problems, which are critical to force health and readiness. Current psychological health research topic areas include behavioral health, resiliency building, substance use and related problems, and risk-taking behaviors.

The Clinical and Rehabilitative Medicine Research Program (CRMRP) focuses on definitive and rehabilitative care innovations required to reset our wounded warriors, both in terms of duty performance and quality of life. The Armed Forces Institute of Regenerative Medicine (AFIRM) is an integral part of this program. The AFIRM was designed to speed the delivery of regenerative medicine therapies to treat the most severely injured US service members from around the world but in particular those coming from the theaters of operation in Iraq and Afghanistan. The AFIRM is expected to make major advances in the ability to understand and control cellular responses in wound repair and organ/tissue regeneration and has major research programs in Limb Repair and Salvage, Craniofacial Reconstruction, Burn Repair, Scarless Wound Healing, and Compartment Syndrome.

The AFIRM's success to date is at least in part the result of the program's emphasis on establishing partnerships and collaborations. The AFIRM is a partnership

among the US Army, Navy, and Air Force, the Department of Defense, the VA, and the National Institutes of Health. The AFIRM is composed of two independent research consortia working with the US Army Institute of Surgical Research. One consortium is led by the Wake Forest Institute for Regenerative Medicine and the McGowan Institute for Regenerative Medicine in Pittsburgh while the other is led by Rutgers – the State University of New Jersey and the Cleveland Clinic. Each consortium contains approximately 15 member organizations, which are mostly academic institutions.

The health of the total Army is essential for readiness, and prevention is the best way to health. Protecting Soldiers, retirees, Family members and Department of Army civilians from conditions that threaten their health is operationally sound, cost effective and better for individual well-being. Though primary care of our sick and injured will always be necessary, the demands will be reduced. Prevention—the early identification and mitigation of health risks through surveillance, education, training, and standardization of best public health practices—is crucial to military success. Army Medicine is on the pathway to realizing this proactive, preventive vision.

The newest addition to the Army Medicine team is the Public Health Command,. having reached initial operational capability in October 2010 with full operational capability is targeted for October 2011. As part of the overall US Army Medical Command reorganization initiative, all major public health functions within the Army, especially those of the former Veterinary Command and the Center for Health Promotion and Preventive Medicine have been combined into a new PHC, located at Aberdeen Proving Ground in Maryland. The consolidation has already resulted in an increased focus on health promotion and has created a single accountable agent for public health and veterinary issues that is proactive and focused on prevention, health promotion and wellness. Army public health protects and improves the health of Army communities through education, promotion of healthy lifestyles, and disease and injury prevention. Public health efforts include controlling infectious diseases, reducing injury rates, identifying risk factors and interventions for behavioral health issues, and ensuring safe food and drinking water on Army installations and in deployed environments. The long-term value of public health efforts cannot be overstated: public health advances in the past century have been largely responsible for increasing human

life spans by 25 years, and the PHC will play a central role in the health of our Soldiers, deployed or at home. A significant initiative driven by the Public Health Command which will be instrumental to achieving public health is our partnering with Army installations to standardize existing Army Wellness Centers to preserve or improve health in our beneficiary population. The centers focus on health assessment, physical fitness, healthy nutrition, stress management, general wellness education and tobacco education. They partner with providers in our Military Treatment Facilities (MTFs) through a referral system. I hold each MTF Commander responsible for the health of the extended military community as the installation Director of Health Services (DHS).

Army Medicine has put a closer lens on women's health through a recently established Women's Health Task Force to evaluate issues faced by female Soldiers both, in Theater and CONUS. Women make up approximately 14 percent of the Army Active Duty fighting force. As of August 2011, almost 275,000 women have deployed in support of OIF/OND/OEF. The health of female Soldiers plays a vital role in overall Army readiness. Army medicine recognizes the magnitude and impact of women's health and appreciates the unique challenges of being a woman in the Army. In order for women to be fully integrated and effective members of the team, we must ensure their unique health needs are being considered and met. The Task Force combines talent from different disciplines: civilian and military, officer and enlisted, as well as collaborates with our private industry partners. We will assess the unique health needs and concerns of female Soldiers, conducting a thorough review of the care currently provided, identifies best practices and gaps, and revises, adapts and initiates practices so that we may continue to provide first class care to our female Warriors. The Women's Health Campaign Plan will focus on standardized education and training on women's health, logistical support for women's health items, emphasis on the fit and functionality of the Army uniform and protective gear for females; and research and development into the psychosocial effects of combat on women. While Sexual Assault is not a gender specific issue, the Women's Health Task Force is working with HQDA G1 to evaluate Theater policy with regards to distribution of Sexual Assault Forensic Examiners and professionalizing the role of the Victim Advocate. The Task Force is

collaborating with Tri-Service experts to investigate the integration of Service policies and make recommendations.

While proudly acknowledging our many healthcare accomplishments at home and in theater, I want to turn to the future. It is time we further posture Army Medicine in the best possible manner that aligns with the MHS strategic vision that moves us from healthcare to health. We must ask, where does "health" happen, and I have charged Army Medicine leadership to spearhead the conversion to health and to fully integrate the concept into readiness and the overall strategy of health in the Force. Improved readiness, better health, better care, and responsibly managed costs are the pillars on which the MHS Quadruple Aim stands, but between those pillars, or in that "White Space", is where we can create our successful outcomes. Sir William Osler, considered to be the Father of Modern Medicine, said "One of the first duties of the physician is to educate the masses not to take medicine". A snapshot of the average year with the average patient shows that healthcare provider spend approximately 100 minutes with their patient during that year. How much health happens in those 100 minutes? There are approximately 525,600 minutes in that year, yet we focus so much of our time, effort, and spending on those 100 minutes; the small fraction of a spot on the page. But what happens in the remaining 525,600 minutes of that year? What happens in the "White Space?" I will tell you what I think happens – that is where health is built, that is where people live. The "White Space" is when our Soldiers are doing physical fitness training, choosing whether to take a cigarette break, or deciding whether they will have the cheeseburger or the salad for lunch. It's when Family Members are grocery shopping or cooking a meal. The "White Space" is when Soldiers spend time with their family, or get a restful night of sleep, or search the internet to self-diagnose their symptoms to avoid adding to those 100 minutes in the clinician's office. We want to lead the conversation with Army leadership to influence the other 525,600 minutes of the year with our Soldiers...the "White Space". In order for us to get to health, we must empower patients, move beyond the 100 minutes, and influence behaviors in the white space. The way ahead is connected, collaborative, and patient centered.

I have discussed but a few of the important medical issues and programs that are relevant to the current wars and vital to the future of Military Medicine require solutions

and funding that will go years beyond the end of the current wars. Our Nation, our Army and Army Medicine have a duty and responsibility to our Soldiers, Families, and retirees. There will be considerable ongoing health care costs for many years to support for our wounded, ill, or injured Soldiers. The programs we have established to care for our Soldiers and Families cannot falter as our deployed footprint diminishes. The level of care required does not end when the deployed Soldier returns home.

Optimize Resources

One of Army Medicine's greatest challenges over the next 3-5 years is managing the escalating cost of providing world-class healthcare in a fiscally constrained environment. People are our most valuable resource. We will employ everyone to their greatest capacity and ensure we are good stewards of our Nation's resources. To capitalize on the overall cost savings of procurement and training, we will standardize equipment, supplies, and procedures. And we will leverage our information technology solutions to optimize efficiencies.

Despite the cost containment challenges we face, we must accomplish our mission with an eye on reducing variance, focusing on quality, and expecting and adapting to change. These are our imperatives. Army Medicine will focus on collaborative international, interagency, and joint partnerships and collective health, including prevention and wellness, to ensure the enduring capabilities required to support the current contemporary operating environment and those of the future are retained.

We will be methodical and thoughtful in our preparation for budget restraints to ensure that the high quality care our Warriors and Military Family demand is sustained. With the anticipated downsizing of forces, there will be a need to critically look at where medical services could be consolidated. However, we will use this as an opportunity to evaluate workloads to maximize efficiencies while maintaining effectiveness and focus on what services are best for our beneficiary population and dedicate resources to those.

The rising cost of healthcare combined with the increasingly constrained defense budget poses a challenge to all within the MHS. The Department of Defense offers the

most comprehensive health benefit, at lower cost, to those it serves than the vast majority of other health plans in the nation - and deservedly so. The proposed changes in TRICARE fees do not change this fact - the TRICARE benefit remains one of the best values for medical benefits in the United States with lower out-of-pocket costs compared to other health care plans. Adjustment to existing fees, and introduction of new fees are proposed. Importantly, these benefit changes exempt Soldiers, and their Families, who are medically retired from active service, and Families of Soldiers who died on active duty from any changes in cost-sharing. I support these modest fee changes when coupled by the MHS's shift in focus from healthcare to health, maintaining health and wellness, identifying internal efficiencies to capitalize on, and instituting provider payment reform.

A major initiative within Army Medicine to optimize talent management and move towards a Culture of Trust, discussed earlier in this testimony, is the Human Systems Transformation, led by a newly established Human Systems Transformation Directorate. Army Medicine's ability to efficiently transform our culture requires a roadmap for achieving planned systemic change. The plan focuses on enhanced investment in four human system tiers (lines of effort) to: Improve senior leader development (new command teams/designated key staff positions), increase investment in the development of Army Medicine workforce members, establish a cadre of internal Organizational Development professionals, leverage partnering and collaboration opportunities with internal and external stakeholders. In order to change the culture of our organization, we must invest in our people.

Develop Leaders

At the core of our medical readiness posture is our people. The Army calls each of us to be a leader, and Army Medicine requires no less. We will capitalize on our leadership experiences in full spectrum operations while continuing to invest in relevant training and education to build confident and competent leaders. Within this focus area, we will examine our leader development strategy to ensure that we have clearly identified the knowledge, skills, and talent required for leaders of Army Medicine. We

will continue to develop adaptive, innovative, and decisive leaders who ensure delivery of highly-reliable, quality care that is both patient-centered and inherently trustworthy. Being good stewards of our Nation's most treasured resources, through agile, decisive, and accountable leadership, we will continue to build on the successes of those who have gone before us. Our recruitment, development and retention of medical professionals – physicians, dentists, nurses, ancillary professionals and administrators – remains high. With the support of Congress, through the use of flexible bonuses and special salary rates, we have been able to meet most of our recruiting goals. Yet we recognize that competition for medical professionals will grow in the coming years, amidst a growing shortage of primary care providers and nurses.

Support the Army Profession

Army Medicine has a rich history of sustaining the fighting force, and we need to tell our story of unprecedented successes across the continuum of care – from the heroic efforts of our medics at the point of injury to the comprehensive rehabilitation of our Wounded Warriors in overcoming exceptional challenges. After more than ten years of persistent conflict, it is time to renew our collective commitment to the Army, its ideals, traditions, and ethos. As we have stood alongside our warfighters on the battlefield we have earned the trust of our combat tested Warfighters, and it is critical that we continue to demonstrate integrity and excellence in all that we do.

Worldwide Influence

Army Medicine reaches around the world; from those supporting two theaters of war and humanitarian relief efforts to those conducting militarily relevant research and providing care to our military Families overseas, Army Medical Department Soldiers and civilians answer our Nation's call. The time that two oceans protected our freedom-loving nation is long gone, and replaced with ever-present risks to our way of life. The Nation relies on its Army to prepare for and conduct full spectrum operations from humanitarian and civil support to counterinsurgency and general war throughout the world. Army Medicine stands committed to sustain the Warfighter and accomplish the mission, supporting the world's most decisive land force and the strength of the Nation.

In the MHS, one of our biggest challenges lies in integrating the shared electronic health record information available in our systems with the information that is provided through our civilian network providers and VA partners. Without that seamless integration of data, health care cannot be coordinated properly for the patient's across all providers and settings. To support DoD and VA collaboration on treating PTSD, pain, and other health care issues, the Electronic Health Record (EHR) should seamlessly transfer patient data between and among partners to improve efficiencies and continuity of care. The DoD and the VA share a significant amount of health information today and no two health organizations in the nation share more non-billable health information than the DoD and VA. The Departments continue to standardize sharing activities and are delivering information technology solutions that significantly improve the secure sharing of appropriate electronic health information. We need to include electronic health information exchange with our civilian partners as well – a health information systems which brings together three intersecting domains – DoD, VA, civilian – for optimal sharing of beneficiary health information and to provide a common operating picture of health care delivery. These initiatives enhance healthcare delivery to beneficiaries and improve the continuity of care for those who have served our country. Previously, the burden was on service members to facilitate information sharing; today, we are making the transition between DOD and VA easier for our service members. The AMEDD is committed to working collaboratively with our partners across the MHS to seek solutions that will deliverable a fully integrated electronic health record that will enhance healthcare delivery to beneficiaries and improve the continuity of care for those who have served our country.

At the core of our Army is the Warfighter. A focus on wellness and prevention will ensure that our Warriors are ready to heed the Nation's call. Yet in the Army today we have more than a Division of Army soldiers who are medically not ready. This represents a readiness problem. We created a Soldier Medical Readiness Campaign to ensure we maintain a health and resilient force. The deployment of healthy, resilient and fit Soldiers and increasing the medical readiness of the Army is the desire end state of this campaign. The campaign's key tasks are to provide Commanders the tools to manage their Soldiers' medical requirements; coordinate, synchronize and integrate

wellness, injury prevention and human performance optimization programs across the Army; identify the medically not ready population; implement medical management programs to reduce the MNR population; assess the performance of the campaign; and educate the force.

Those Soldiers who no longer meet retention standards must navigate the Physical Disability Evaluation System (PDES). The present disability system dates back to the Career Compensation Act of 1949. Since its creation problems have been identified include long delays, duplication in DOD and VA processes, confusion among Service members, and distrust of systems regarded as overly complex and adversarial. In response to these concerns, DOD and VA jointly designed a new disability evaluation system to streamline DOD processes, with the goal of also expediting the delivery of VA benefits to service members following discharge from service. The Army began pilot testing the Disability Evaluation System (DES) in November 2007 at Walter Reed Army Medical Center and has since expanded the program, now known as the Integrated Disability Evaluation System (IDES), to 16 military treatment facilities. DOD has replaced the military's legacy disability evaluation system with the IDES.

The key features of the of the IDES are a single physical disability examination conducted according to VA examination protocols, a single disability rating evaluation prepared by the VA for use by both Departments for their respective decisions, and delivery of compensation and benefits upon transition to veteran status for members of the Armed Forces being separated for medical reasons. The DoD and VA continue to move towards reform of this process by identifying steps that can be reduced or eliminated, ensuring the service members receive all benefits and entitlements throughout the process. Within the Army, I recently appointed a task force focused on examining the Integrated Disability Evaluation Process in parallel with ongoing MHS efforts. The AMEDD is committed to working collaboratively with our partners across the MHS to seek solutions that will best serve those who have selflessly served our country.

I would like to close today by discussing the Army Medicine Promise. The Promise, a written covenant that will be in the hands of everyone entrusted to our care over the next year, tells those we care for what we, the Army Medicine Team, believe

they deserve from us. It articulates what we believe about the respect and dignity surrounding the patient care experience. The Promise speaks to what we believe about the value of the care we deliver, about the compassion contained in the care we deliver and how we want to morally and ethically provide care for those we serve. I'll share two items from the Promise with you---

"We believe our patients deserve a voice in how army medicine cares for them and all those entrusted to our care." Our patients want to harness innovation to improve or change their health and we are empowering their efforts via our wellness centers. At our premier wellness clinics, we collaborate with patients to not only give them the tools they need to change their health, but also a lifespace partner to help them change their life. Our wellness clinics are new and still evolving but I am committed to increasing their numbers and expanding their capabilities in order to dramatically impact those over 500,000 minutes out of the year when our patients are living life outside the walls of our hospitals. The wellness clinics allow us to reach out to those we care for rather than them having to reach in.

"We believe our patients deserve an enhanced care experience that includes our belief in their desire to heal, be well, and have an optimal life." The warrior transition care comprehensive transition plan supports this promise by providing countless wounded warriors with a dynamic plan for living that focuses on the soldier's future across six domains of strength---career, physical, emotional, social, family and spiritual strength. The plan empowers soldiers to take control of their lives."

In conclusion, the AMEDD has served side-by-side with our sister services in Iraq and Afghanistan, and at home we will continue to strengthen those collaborative partnerships to provide responsive, reliable, and relevant healthcare that ensures a healthy fighting force and healthy Families. To succeed, we must remain ready and relevant in both our medical proficiencies as well as our Soldier skills. We will continue to serve as a collaborative partner with community resources, seek innovative treatments, and conduct militarily relevant research to protect, enhance, and optimize Soldier and military Family well-being. Soldiers, Airmen, Sailors, Marines, their Families and our Retirees will know they are receiving care from highly competent and compassionate professionals.

I am incredibly honored and proud to serve as the 43rd Surgeon General of the Army and Commander, US Army Medical Command. There are miracles happening at our command outposts, forward operating bases, posts, camps and stations every day because of the dedicated Soldiers and civilians that made up the Army Medical Department. With continued support of Congress we will lead the Nation in healthcare, and our men and women in uniform will be ready when the Nation calls them to action. Army Medicine stands ready to accomplish any task in support of our Warfighters and Military Family.

STATEMENT OF

VICE ADMIRAL MATTHEW L. NATHAN, MC, USN

SURGEON GENERAL OF THE NAVY

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL
OF THE

HOUSE ARMED SERVICES COMMITTEE

SUBJECT:

DEFENSE HEALTH PROGRAM BUDGET OVERVIEW

MARCH 21, 2012

NOT FOR PUBLICATION UNTIL RELEASED BY
THE HOUSE ARMED SERVICES COMMITTEE

Introduction

Chairman Wilson, Congresswoman Davis, distinguished Members of the Subcommittee, I am pleased to be with you today to provide an update on Navy Medicine, including some of our collective strategic priorities, accomplishments, and opportunities. I want to thank the Committee Members for the tremendous confidence and support of Navy Medicine.

I can report to you Navy Medicine remains strong, capable and mission-ready to deliver world class care, anytime, anywhere. We are operating forward and globally engaged, no matter what the environment and regardless of the challenge. The men and women of Navy Medicine remain flexible, agile and resilient in order to effectively meet their operational and wartime commitments, including humanitarian assistance; and concurrently, delivering outstanding patient and family-centered care to our beneficiaries. It is a challenge, but one that we are privileged to undertake.

One of my top priorities since becoming the Navy Surgeon General in November 2011 is to ensure that Navy Medicine is strategically aligned with the imperatives and priorities of the Secretary of the Navy, Chief of Naval Operations and Commandant of the Marine Corps. We are fully engaged in executing the operational missions and core capabilities of the Navy and Marine Corps – and we do this by maintaining warfighter health readiness, delivering the continuum of care from the battlefield to the bedside and protecting the health of all those entrusted to our care. Our focus remains in alignment with our Navy and Marine Corps leadership as we support the defense strategic guidance, *"Sustaining U.S. Global Leadership: Priorities for the 21st Century"* issued by the President and Secretary of Defense earlier this year. The Chief of Naval Operations in his "Sailing Directions" has articulated the Navy's core

responsibilities and Navy Medicine stands ready as we move forward at this pivotal time in our

history.

Navy Medicine appreciates the Committee's strong support of our resource requirements. The President's Budget for FY2013 adequately funds Navy Medicine to meet its medical mission for the Navy and Marine Corps. We recognize the significant investments made in supporting military medicine and remain committed to providing outstanding care to all our beneficiaries. Moving forward, we must innovate, position our direct care system to recapture private sector care and deliver best value to our patients. Driving these changes is critical and necessary, but not sufficient. The Secretary of Defense has articulated that the current upward trajectory of health care spending within the Department is not sustainable. Accordingly, the President's Budget includes important health care proposals designed to address this situation, including adjustments in TRICARE fees. The Department of Navy supports these proposals and believes they are important for ensuring a sustainable and equitable benefit for all our beneficiaries. We deliver one of the most comprehensive health benefits available and these changes will help us better manage costs, provide quality, accessible care and keep faith with our beneficiaries. As the Navy Surgeon General, I appreciate the tremendous commitment of our senior leaders in this critical area and share the imperative of controlling costs and maintaining an affordable and sustainable benefit.

Value – a key analytic in our decision-making – must inherently address cost and quality as we implement efficiencies and streamline operations. All of us in the MHS recognize the challenges ahead are significant, including rising health care costs, increased number of beneficiaries and maintaining long-term care responsibilities for our medically-retired warriors.

Additionally, we are very focused on improving internal controls and financial procedures in response to Congressional priorities to obtain a clean financial audit. We have mandated the use

of standard operating procedures at all our activities for those business processes which impact financial transactions. I have also emphasized the responsibility of every commanding officer in setting and maintaining appropriate internal controls. We are regularly evaluating our progress through financial transactions and process reviews which help us identify if any changes need to be made. We are making progress and our leadership is fully engaged and leaning forward to ensure the best possible stewardship of our resources.

Alignment is also critical as we focus on more joint solutions within the Military Health System (MHS) and in conjunction with the Army and Air Force. We see tremendous progress in joint medical operations, from battlefield medicine to education and training to research and development. As we continue to synchronize our collective efforts through deliberative planning and rigorous analyses, I believe we will have more opportunities to create synergies, reduce redundancies and enhance value across the MHS.

Our continuing joint efforts in the integration of the Quadruple Aim initiative is helping to develop better outcomes and implement balanced incentives across the MHS. The Quadruple Aim applies the framework from the Institute for Healthcare Improvement (IHI) and customizes it for the unique demands of military medicine. It targets the MHS and Services' efforts on integral outcomes in the areas of readiness, population health and quality, patient experience and cost. Our planning process within Navy Medicine is complementary to these efforts and targets goals that measure our progress and drive change through constructive self-assessment. I have challenged Navy Medicine leaders at headquarters, operational and regional commands and treatment facilities to maintain strategic focus on these key metrics.

Our Mission is Force Health Protection

Force Health Protection is at the epicenter of everything we do. It is an expression of our

Core Values of Honor, Courage and Commitment and the imperative for our world-wide engagement in support of expeditionary medical operations and combat casualty care. It is at the very foundation of our continuum of care in support of the warfighter and optimizes our ability to promote, protect and restore their health. It is both an honor and obligation.

Our Force Health Protection mission is clearly evident in our continued combat casualty care mission in Operation ENDURING FREEDOM (OEF). Navy Medicine personnel are providing direct medical support to the operating forces throughout the Area of Responsibility (AOR). We continue to see remarkable advances in all aspects of life-saving trauma care. These changes have been dramatic over the last decade and enabled us to save lives at an unprecedented rate. We are continuously implementing lessons learned and best clinical practices, ensuring our providers have the most effective equipment available and focusing on providing realistic and meaningful training. Mission readiness means providing better, faster combat casualty care to our warfighters.

The NATO Role 3 Multinational Medical Unit (MMU), operating at Kandahar Airfield, Afghanistan is a world-class combat trauma hospital that serves a unique population of U.S. and Coalition forces, as well as Afghan National Army, National Police and civilians wounded in Afghanistan. Led by Navy Medicine, the Role 3 MMU is an impressive 70,000 square foot state-of-the-art facility that is the primary trauma receiving and referral center for all combat casualties in Southern Afghanistan. It has 12 trauma bays, four operating rooms, 12 intensive care beds and 35 intermediate care beds. The approximately 250 staff of active component (AC) and reserve component (RC) personnel includes 30 physicians with multiple surgical specialties as well as anesthesia, emergency medicine and internal medicine. RC personnel currently make up 27% of overall manning and provide us unique and invaluable skill sets.

With trauma admissions averaging 175 patients per month, the unit achieved unprecedented survival rates in 2011. In addition, MMU has two Forward Surgical Teams deployed in the region to provide frontline surgical trauma care demonstrating agility to meet changing operational requirements.

Training is critical for our personnel deploying to the MMU Role 3. This year, we established a targeted training program at the Naval Expeditionary Medical Training Institute (NEMTI) onboard Marine Corps Base Camp Pendleton for our personnel deploying to the MMU. The training is part of an effort designed to foster teamwork, and build medical skills specific to what personnel require while on a six-month deployment. Navy Medicine and U.S. Fleet Forces Command (FFC) recognized the need to integrate medical training scenarios to expand upon the knowledge and skills required to fill positions at the Kandahar Role 3 facility. In January, I had the opportunity to see this impressive training in action during the course's final exercise and saw our personnel implement the clinical skills they honed during the two-week course. They participated in a scenario-driven series of exercises, including staffing a fully equipped hospital receiving patients with traumatic injuries, simulated air strike, and a mass casualty drill. This training, as well as the program at the Navy Trauma Training Center (NTTC) at Los Angeles County/ University of Southern California Medical Center where our personnel train as teams in a busy civilian trauma center, help ensure our deployers have the skills and confidence to succeed in their combat casualty care mission.

Recognizing the importance of ensuring our deployed clinicians have access to state-of-the-art capabilities, Navy Medicine, in conjunction with the Army, Air Force, and our contracted partners worked successfully to deliver the first ever magnetic resonance imaging (MRI) technology in a combat theatre to aid the comprehensive diagnosis and treatment of

concussive injuries. Efforts included the planning, design and execution of this new capability as well as ensuring that clinical, logistical, transportation, environmental, and sustainment considerations for the MRIs were fully addressed prior to the deployment of the units to the battlefield. The fact that we were able to design, acquire and deliver this new capability to the battlefield in approximately six months from contract award is a testament to the commitment of the joint medical and logistics teams. MRIs are now in place Role 3 MMU in Kandahar, Role 3 Trauma Hospital in Camp Bastion and the Joint Theatre Hospital located on Bagram Airfield.

Navy Medicine also supports stability operations through multiple types of engagements including enduring, ship-centric humanitarian assistance (HA) missions such as PACIFIC PARTNERSHIP and CONTINUING PROMISE, which foster relationships with partner countries. During 2011 PACIFIC PARTNERSHIP 2011, 86 Navy Medicine personnel augmented with non-governmental organization, interagency and other Service personnel conducted activities in Tonga, Vanuatu, Papua New Guinea, Timor Leste, and Federated States of Micronesia. Engagements included engineering projects, veterinary services, preventive medicine/public health, and biomedical equipment repair. CONTINUING PROMISE 2011 involved 480 Navy Medicine personnel conducting activities in Jamaica, Peru, Ecuador, Colombia, Nicaragua, Guatemala, El Salvador, Costa Rica, and Haiti. Over 67,000 patients were treated and 1,130 surgeries were performed during this important mission. In addition to our efforts at sea, Navy Medicine also supports land-based HA engagements including Marine Corps exercises such as AFRICA PARTNERSHIP STATION and SOUTHERN PARTNERSHIP STATION as well as multiple Joint exercises such as BALIKATAN in the Philippines.

Medical Home Port: Patient and Family-Centered Care

We completed our initial deployment of Medical Home Port (MHP) throughout the Navy Medicine enterprise. MHP is Navy Medicine's adaptation of the successful civilian Patient-Centered Medical Home (PCMH) concept of care which transforms the delivery of primary care to an integrated and comprehensive suite of services. MHP is founded in ensuring that patients see their assigned provider as often as possible, and that they can access primary care easily rather than seeking primary care in the emergency room. Strategically, MHP is a commitment to total health and, operationally, it is foundational to revitalizing our primary care system and achieving high quality, accessible, cost efficient health care for our beneficiaries.

We are also working with the Marine Corps to implement the Marine-Centered Medical Home (MCMH) as a complementary analogue to the MHP. Likewise, we are working with U.S. Fleet Forces Command to establish a fleet-based model of the PCMH using the same principles. The first prototype carrier-based PCMH concept will be developed for USS ABRAHAM LINCOLN (CVN-72).

Initial results are encouraging. MHP performance pilots at the Walter Reed National Military Medical Center (WRNMMC) and Naval Hospital Pensacola have shown improvement in key health care outcomes such as: increased patient satisfaction: improved access to care: and improved quality of care associated with decreased use of the emergency room (an important cost driver). Data show similar results enterprise-wide through October 2011, and also indicate improved continuity with assigned provider, decreased emergency room utilization and better cost containment when compared with FY2010.

Healing in Body, Mind and Spirit

Health is not simply the absence of infirmity or disease – it is the complete state of physical, mental, spiritual and social well being. As our wounded warriors return from combat and begin

the healing process, they deserve a seamless and comprehensive approach to their recovery. Our focus is integrative, complementary and multidisciplinary-based care, bringing together clinical specialists, behavioral health providers, case managers, and chaplains. There are approximately 170 medical case managers who work closely with their line counterparts in the Marine Corps' Wounded Warrior Regiment and the Navy's Safe Harbor program to support the full-spectrum recovery process for Sailors, Marines and their families.

We have made remarkable progress in ensuring our wounded service members get the care they need – from medical evacuation through inpatient care, outpatient rehabilitation to eventual return to duty or transition from the military. With our historically unprecedented battlefield survival rate, we witness our heroes returning with the life-altering wounds of war which require recovery and long-term care. We must continue to adapt our capabilities to best treat these conditions and leverage our systems to best support recovery.

To that end, we are committed to connecting our wounded warriors to approved emerging and advanced diagnostic and therapeutic options within our MTFs and outside of military medicine. We do this through collaborations with major centers of reconstructive and regenerative medicine while ensuring full compliance with applicable patient safety policies and practices. The Naval Medical Research and Development Center in Frederick, Maryland, is aggressively engaged in furthering support for cooperative medical research between multiple centers of regenerative and reconstructive medicine. Their collaborative efforts, in conjunction with the Armed Forces Institute of Regenerative Medicine (AFIRM), are essential in developing new regenerative and transplant capabilities, both at the civilian and the military institutions with ultimate sharing of knowledge, expertise and technical skills in support of restoration of our wounded warriors.

Navy Medicine continues a robust translation research program in wound healing and wound care, moving technologies developed at the bench to deployment in the clinic to enhance the care of the wounded warfighter. Concurrently, we are focused on improving the capability and capacity to provide comprehensive and interdisciplinary pain management from the operational setting to the MTF to home. This priority includes pain management education and training to providers, patients, and families to prevent over-prescribing, misuse of medications and promoting alternative therapies.

Preserving the psychological health of service members and their families is one of the greatest challenges we face today. The Navy continues to foster a culture of support for psychological health as an essential component to total force fitness and readiness. Navy and Marine Corps Combat Operational Stress Control (OSC) programs provide Sailors, Marines, leaders and families the skills and resources to build resiliency. We also continue to address stigma by encouraging prevention, early intervention, and help-seeking behaviors. Training is designed to build teams of leaders, Marines, Sailors, medical and religious ministry personnel to act as sensors for leadership by noticing small changes in behavior and taking action early. These efforts support in fostering unit strength, resilience, and readiness.

Navy Medicine has continued to adapt psychological health support across traditional and non-traditional health care systems. Access to psychological health services have increased in venues designed to reduce the effects associated with mental health stigma. These efforts are also focused on suicide prevention and are designed to improve education, outreach and intervention. In 2011, more than 1,000 health providers received targeted training in assessing and managing suicide risk. We are also integrating behavioral health providers in our MHP program to help address the needs of our patients in the primary care setting.

Post-Traumatic Stress Disorder (PTSD) is one of many psychological health conditions that adversely impacts operational readiness and quality of life. Navy Medicine has an umbrella of psychological health programs that target multiple, often co-occurring, mental health conditions including PTSD. These programs support prevention, diagnosis, mitigation, treatment, and rehabilitation of PTSD. Our efforts are also focused on appropriate staffing, meeting access standards, implementing recommended and standardized evidence-based practices, as well as reducing stigma and barriers to care.

We recently deployed our fifth Navy Mobile Mental Health Care Team (MCT) in Afghanistan. Consisting of two mental health clinicians, a research psychologist and an enlisted behavioral health technician, their primary mission is to administer the Behavioral Health Needs Assessment Survey (BHNAS). The results give an overall assessment and actionable intelligence of real-time mental health and well-being data for our deployed forces. It can also identify potential areas or sub-groups of concern for leaders on the ground and those back in garrison. The survey assesses mental health outcomes, as well as the risk and protective factors for those outcomes such as combat exposures, deployment-related stressors, positive effects of deployment, leadership perceptions, and morale and unit cohesion. The MCT also has a preventive mental health and psycho-education role and provides training in Combat and Operational Stress Control (COSC) and Combat and Operational Stress First Aid (COSFA) to Sailors in groups and individually to give them a framework to mitigate acute stressors and promote resilience in one another.

Data from previous MCT deployments and BHNAS analyses indicate continued need for implementation of COSC doctrine and command support in OEF. In addition, the Joint Mental Health Assessment Team (J-MHAT 7) surveillance efforts conducted in Afghanistan during

2010 indicate an increase in the rate of Marines screening at-risk for PTSD relative to similar surveys conducted in Marine samples serving in Iraq during 2006 and 2007. This assessment also shows increases in training effectiveness regarding managing combat deployment stress, as well as a significant reduction in stigma associated with seeking behavioral health treatment.

In collaboration with the Marine Corps, the Operational Stress Control and Readiness (OSCAR) program represents an approach to mental health care in the operational setting by taking mental health providers out of the clinic and embedding them with operational forces to emphasize prevention, early detection and brief intervention. OSCAR-trained primary care providers recognize and treat psychological health issues at points where interventions are often most effective. In addition, OSCAR includes chaplains and religious personnel (OSCAR Extenders) who are trained to recognize stress illness and injuries and make appropriate referral. Over 3,000 Marine leaders and individual Marines have been trained in prevention, early detection and intervention in combat stress through OSCAR Team Training and will operate in OSCAR teams within individual units.

Through the Caregiver Occupational Stress Control (CgOSC) Program, Navy Medicine is also working to enhance the resilience of caregivers to the psychological demands of exposure to trauma, wear and tear, loss, and inner conflict associated with providing clinical care and counseling. The core objectives include: early recognition of distress; breaking the code of silence related to stress reactions and injuries; and engaging caregivers in early help as needed to maintain both mission and personal readiness.

Our emphasis remains ensuring that we have the proper size and mix of mental health providers to care for the growing need of service members and their families who need care. Within Navy Medicine, mental health professional recruiting and retention remains a top

priority. Although shortfalls remain, we have made progress recruiting military, civilian and contractor providers, including psychiatrists, clinical psychologists, social workers and mental health nurse practitioners. We have increased the size of the mental health workforce in these specialties from 505 in FY2006 to 829 in FY2012. Notwithstanding the military is not immune to the nation-wide shortage of qualified mental health professionals. Throughout the country, the demand for behavioral health services remains significant and continues to grow.

Caring for our Sailors and Marines suffering with Traumatic Brain Injury (TBI) remains a top priority. While we are making progress, we have much work ahead of us as we determine both the acute and long-term impact of TBI on our service members. Our strategy must be both collaborative and inclusive by actively partnering with the other Services, our Centers of Excellence, the Department of Veterans Affairs (VA), and leading academic medical and research centers to make the best care available to our warriors afflicted with TBI.

Navy Medicine is committed to ensuring thorough screening for all Sailors and Marines prior to deployment, while in theatre, and upon return from deployment. Pre-deployment neurocognitive testing is mandated using the Automated Neuropsychological Assessment Metrics (ANAM). The ANAM provides a measure of cognitive performance, that when used with a patient with confirmed concussion, can help a provider determine functional level as compared to the service member's baseline. In-theatre screening, using clinical algorithms and the Military Acute Concussion Evaluation (MACE), occurs for those who have been exposed to a potentially concussive event, as specified by the event driven protocols of the TBI Directive-type Memorandum (DTM) 09-033 released in June 2010.

DTM-09-033 has changed the way we treat TBI in theatre. It requires pre-deployment on point of injury care, improved documentation and tracking of concussion by line and medical

leaders, as well as a move towards standardization of system-wide care.

In-theatre, the Concussion Restoration Care Center (CRCC) at Camp Leatherneck Afghanistan, became operational in August 2010. CRCC represents a ground-breaking, interdisciplinary approach to comprehensive musculoskeletal and concussion care in the deployed setting. As of December 1, 2011, the CRCC has seen over 2,500 patients (over 750 with concussion) with a greater than 95% return to duty rate. I am encouraged by the impact the CRCC is having in theatre by providing treatment to our service members close to the point of injury and returning them to duty upon recovery. We will continue to focus our attention on positioning our personnel and resources where they are most needed.

Post-deployment surveillance is accomplished through the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA), required for returning deployers. Navy Medicine has conducted additional post-deployment TBI surveillance on high risk units and those Marines with confirmed concussions in theatre, with a goal of improving patient outcomes and better informing leaders.

Access and quality of care for treating TBIs are being addressed through standardization of Navy Medicine's current six clinical TBI specialty programs at Naval Medical Center Portsmouth, Naval Medical Center San Diego, Naval Hospital Camp Lejeune, Naval Hospital Camp Pendleton, Naval Health Clinic New England - Branch Health Clinics Groton and Portsmouth. Additionally, we have an inpatient program at WRNMMC which focuses on moderate and severe TBI while also conducting screening for TBI on all polytrauma patients within the medical center.

The National Intrepid Center of Excellence (NICoE) is dedicated to providing cutting-edge evaluation, treatment planning, research and education for service members and their families

dealing with the complex interactions of mild traumatic brain injury and psychological health conditions. Their approach is interdisciplinary, holistic, patient and family-centered. The NICoE's primary patient population is comprised of active duty service members with TBI and PH conditions who are not responding to current therapy. The NICoE has spearheaded partnerships with many military, federal, academic and private industry partners in research and education initiatives to further the science and understanding of these invisible wounds of war. The Department of Defense (DoD) has recently accepted an offer from the Intrepid Fallen Heroes Fund to construct several NICoE Satellite centers to treat our military personnel suffering from PTSD or TBI locally. The first installations to receive these centers will be Fort Belvoir, Camp Lejeune and Fort Campbell. The Services are actively working together to determine the details regarding project timelines, building sizes, staffing, funding, and sustainability.

We need to continue to leverage the work being done by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, including the Defense and Veterans Brain Injury Center, given their key roles in the expanding our knowledge of PH and TBI within the MHS, the VA and research institutions. This collaboration is also evident in the work being conducted by the Vision Center of Excellence (VCE), established by the National Defense Authorization Act of 2008. VCE, for which Navy Medicine currently provides operational support, exemplifies this important symmetry with military medicine, the VA and research partners. They are developing a distributed and integrated organization with regional locations that link together a network of clinical, research, and teaching centers around the world. The VCE encompasses an array of national and international strategic partners, including institutions of higher learning, and public and private entities.

Family readiness supports force readiness so we must have programs of support in place for our families. We continue to see solid results from FOCUS (Families Over Coming Under Stress), our evidence-based, family-centered resilience training program that enhances understanding of combat and operational stress, psychological health and developmental outcomes for highly stressed children and families. Services are offered at 23 CONUS/OCONUS locations. As of December 2011, 270,000 families, service members, and community support members have been trained on FOCUS. Based on the program's annual report released in July 2011, we can see there has been a statistically significant decrease in issues such as depression and anxiety in service members, spouses and children who have completed the program as well as a statistically significant increase in positive family functioning for families.

For our Marine Corps and Navy reserve populations, we have developed the Reserve Psychological Health Outreach Program (PHOP). PHOP provides psychological health outreach, education/training, and resources a 24/7 information line for unit leaders or reservists and their families to obtain information about local resources for issues related to employment, finances, psychological health, family support, and child care. PHOP now includes 55 licensed mental health providers dispersed throughout the country serving on 11 teams located centrally to Navy and Marine Force Reserve commands.

Returning Warrior Workshops (RWWs) began with the Navy Reserve more than five years ago and are conducted quarterly in each Navy Reserve Region across the country. As of September 2011, over 10,000 service members and their families have participated in RWWs. RWWs assist demobilized service members and their loved ones in identifying immediate and potential issues that often arise during post-deployment reintegration.

Navy Medicine maintains a steadfast commitment to our Substance Abuse Rehabilitation Programs (SARPs). SARPs offer a broad range of services to include alcohol education, outpatient and intensive outpatient treatment, residential treatment, and medically managed care for withdrawal and/or other medical complications. We have expanded our existing care continuum to include cutting-edge residential and intensive outpatient programs that address both substance abuse and other co-occurring mental disorders directed at the complex needs of returning warriors who may suffer from substance abuse disorders and depression or PTSD. In addition, Navy Medicine has developed a new program known as MORE – My Online Recovery Experience. In conjunction with Hazelden, a civilian leader in substance abuse treatment and education, MORE is a ground-breaking web-based recovery management program available to service members 24/7 from anywhere in the world. Navy Medicine has also invested in important training opportunities on short-term interventions and dual diagnosis treatment for providers and drug and alcohol counselors, markedly improving quality and access to care.

Our Naval Center for Combat & Operational Stress Control (NCCOSC) – now in its fourth year – continues to improve the psychological health of Marines and Sailors through comprehensive programs that educate service members, build psychological resilience and promote best practices in the treatment of stress injuries. The overarching goal is to show Sailors and Marines how to recognize signs of stress before anyone is in crisis and to get help when it is needed. NCCOSC continues to make progress in advancing research for the prevention, diagnosis and treatment of combat and operational stress injuries, including PTSD. They have 50 on-going scientific projects and have doubled the number of enrolled participants from a year ago to over 7,100. Similarly, they have expanded the enrollment in their Psychological Health Pathways (PHP) pilot project to 2,248 patients - a 38% increase over last year.

Force Multipliers: Research and Development and Graduate Medical Education

Innovative research and development and vibrant medical education help ensure that we have the capabilities to deliver world-class care now and in the future. They are sound investments in sustaining our excellence to Navy Medicine to our mission of Force Health Protection.

The continuing mission of our Medical Research and Development program is to conduct health and medical research in the full spectrum of development, testing, clinical evaluation (RDT&E), and health threat detection in support of the operational readiness and performance of DoD personnel worldwide. In parallel with this primary operational research activity, our Clinical Investigation Program (CIP) continues to expand at our teaching MTFs with direct funding being provided to support the enrichment of knowledge and capability of our trainees. Where consistent with this goal, these programs are participating in the translation of knowledge and tangible products from our RDT&E activity into proof of concept and cutting edge interventions that are directly applied in benefit of our wounded warriors and our beneficiaries.

Navy Medicine's five strategic research priorities are set to meet the war fighting requirements of the Chief of Naval Operations and the Commandant of the Marine Corps. These pursuits continue with appropriate review and the application of best practices in meeting our goals. These five areas of priority include:

- Traumatic brain injury (TBI) and psychological health treatment and fitness
- Medical systems support for maritime and expeditionary operations
- Wound management throughout the continuum of care
- Hearing restoration and protection for operational maritime surface and air support personnel
- Undersea medicine, diving and submarine medicine

We continue to strengthen our medical partnerships in Southeast Asia, Africa and South America through the cooperation and support provided by our Naval Medical Research Units

and medical research operations in those geographical regions. We find that the application of medical and health care diplomacy is a firm cornerstone of successful pursuit of overarching bi-lateral relations between allies. These engagements are mutually beneficial – not only for the relationships with armed forces of engaged countries, but for generalization of health care advances to the benefit of peoples around the globe.

Graduate Medical Education (GME) is vital to the Navy's ability to train board-certified physicians and meet the requirement to maintain a tactically proficient, combat-credible medical force. Robust, innovative GME programs continue to be the hallmark of Navy Medicine. We are pleased to report that despite the challenges presented by ten years of war, GME remains strong.

Our institutions and training programs continue to perform well on periodic site visits by the Accreditation Council for Graduate Medical Education (ACGME) and most are at or near the maximum accreditation cycle length. The performance of our three major teaching hospitals, in particular, has been outstanding with all three earning the maximum five-year accreditation cycle length. Board certification is another hallmark of strong GME. The overall pass rate for Navy trainees in 2011 was 96 percent, well above the national average in most specialties. Our Navy-trained physicians continue to prove themselves exceptionally well-prepared to provide care to all members of the military family, and in all operational settings ranging from the field hospitals of the battlefield to the platforms that support disaster and humanitarian relief missions.

Overall, I am pleased with the progress we are making with our joint enlisted training efforts at the Medical Education and Training Campus (METC) in San Antonio, Texas. I had an opportunity to visit the training center earlier this year and meet with the leadership and students. We have a tremendous opportunity to train our Sailors with their Army and Air Force

counterparts in a joint environment, and I am working with my fellow Surgeons General to ensure we optimize our efforts, improve interoperability and create synergies.

Interoperability and Collaborative Engagement

Navy Medicine continues to leverage its unique relationships with the Army, Air Force, the VA, as well as other federal and civilian partners. This interoperability helps create system-wide synergies and foster best practices in care, education and training, research and technology.

Our sharing and collaboration efforts with the VA continue throughout our enterprise and Navy Medicine's most recent joint venture is a unique partnership between the Naval Health Clinic Charleston, Ralph H. Johnson Veterans Affairs Medical Center, Naval Hospital Beaufort and the Air Force's 628th Medical Group. This partnership will manage joint health care services and explore local joint opportunities for collaboration. In addition, our new replacement facility at Naval Hospital Guam, currently under construction, will continue to provide ancillary and specialty service to VA beneficiaries.

Operations continue at the Captain James A. Lovell Federal Health Care Center (FHCC) in Great Lakes, Illinois – a first-of-its-kind fully integrated partnership that links Naval Health Clinic Great Lakes and the North Chicago VA Medical Center into one health care system. This joint facility, activated in October 2010, is a five year demonstration project as mandated by the National Defense Authorization Act of FY2010. During its first year, FHCC successfully completed the Civilian Personnel Transfer of Function which realigned staff from 1,500 to more than 3,000. The USS Red Rover Recruit Clinic processed more than 38,000 U.S. Navy recruits and delivered more than 178,000 immunizations to the Navy recruits. We continue to work with DoD and the VA to leverage the full suites of information technology capabilities to support the mission and patient population.

In addition, our collaborative efforts are critical in continuing to streamline the Integrated Disability Evaluation System (IDES) in support of our transitioning Wounded, Ill and Injured service members. Within the Department of Navy (DON), we have completed IDES expansion to all 21 CONUS MTFs and we are working to implement improvements and best practices in order to streamline the IDES process to allow for timely and thorough evaluation and disposition. Further collaboration between DoD, the Services and the VA regarding information technology improvements, ability for field-level reports for case management and capability for electronic case file transfer is ongoing.

In support of DoD and VA interagency efforts, we are leveraging our information technology capabilities and building on joint priorities to support a seamless transition of medical information for our service members and veterans. This ongoing work includes the development of an integrated electronic health record and the Virtual Lifetime Electronic Record (VLER), including the Naval Medical Centers San Diego and Portsmouth participation in VLER pilot projects.

We completed the requirements associated with the Base Realignment and Closure (BRAC) in the National Capital Region (NCR) with the opening of the Walter Reed National Military Medical Center and Fort Belvoir Community Hospital. The scope of this realignment was significant and we are continuing to devote attention to ensuring that our integration efforts reduce overhead, maintain mission readiness and establish efficient systems for those providing care our patients. We have outstanding staff members comprised of Navy, Army, Air Force and civilians, who are executing their mission with skill, compassion and professionalism. The opening of these impressive facilities represented several years of hard work by the men and women of military medicine, as well as generous support from Members of Congress. I am

proud of what we accomplished and, moving forward, encouraged about the opportunities for developing a sustainable, efficient integrated health care delivery model in the NCR. I, along with my fellow Surgeons General, am committed to this goal and recognize the hard work ahead of us.

People – Our Most Important Asset

The hallmark of Navy Medicine is our professional and dedicated workforce. Our team consists of over 63,000 active component (AC) and reserve component (RC) personnel, government civilians as well as contract personnel – all working around the world to provide outstanding health care and support services to our beneficiaries. I am continually inspired by their selfless service and sharp focus on protecting the health of Sailors, Marines and their families.

Health care accessions and recruiting remain a top priority, and, overall, Navy Medicine continues to see solid results from these efforts. Attainment of our recruiting and retention goals has allowed Navy Medicine to meet all operational missions despite some critical wartime specialty shortages. In FY2011, Navy Recruiting attained 101% of active Medical Department officer goals, and 85% of reserve Medical Department officer goals. In a collaborative effort with the Chief of Navy Reserve and Commander, Navy Recruiting Command, we are working to overcome challenges in the RC medical recruiting missions. We recently held a recruiting medical stakeholders conference during which we discussed the challenges and courses of action to address them. Using a variety of initiatives such as the Health Professions Scholarship Program (HPSP), special incentive pays and selective re-enlistment bonuses, Navy Medicine is able to support and sustain accessions and retention across the Corps. We are grateful to Congress for the authorities provided to us in support of these programs.

As a whole, AC Medical Corps manning at the end of FY2011 was 100% of requirements; however, some specialty shortfalls persist including general surgery, family medicine, and psychiatry. Aggressive plans to improve specialty shortfalls include continuation of retention incentives via special pays, and an increase in psychiatry training billets. Overall AC Dental Corps manning was at 96% of requirements, despite oral and maxillofacial surgeons manning at 77%. A recent increase in incentive special pays was approved to address this shortfall. General dentist incentive pay and retention bonuses have helped increase general dentist manning to 99%, up from 88% manning a year ago. At the end of FY2011, AC Medical Service Corps manning was 94% of requirements. A staffing shortage does exist for the social work specialty, manned at 45%. This shortage is due to increased requirements and billet growth during the past three years. We anticipate that this specialty will be fully manned by the end FY2014 through increased accessions and incentive programs. Our AC Nurse Corps manning at the end of FY2011 was 94% of requirements. Undermanned low density/high demand specialties including peri-operative nurses, certified registered nurse anesthetists and critical care nurses are being addressed via incentive special pays.

Our AC Hospital Corps remains strong with manning at 96%. Critical manning shortfalls exist in several skill sets such as behavioral health technicians, surface force independent duty corpsmen, dive independent duty corpsmen, submarine independent duty corpsmen, and reconnaissance corpsmen. Program accession and retention issues are being addressed through increased special duty assignment pay, selective re-enlistment bonuses and new force shaping policies.

Reserve component Medical Corps recruiting continues to be our greatest challenge. Higher AC retention rates have resulted in a smaller pool of medical professionals leaving active duty,

and consequently, greater reliance on highly competitive Direct Commission Officer (DCO) market. RC Medical Corps manning at the end of FY2011 manning was at 71% of requirements while our Nurse Corps RC manning was 88%. To help mitigate this situation, there is an affiliation bonus of $10K or special pay of up to $25K per year based on specialty, and activated reserves are also authorized annual special incentive pays as applicable. Due to robust recruiting efforts and initiatives, the reserve component Nurse Corps exceeded recruiting goals for the second consecutive year. Dental Corps and Medical Service Corps RC manning is 100% and 99%, respectively.

Overall RC Hospital Corps manning is at 99%; however, we do have some shortfalls in surgical, x-ray and biomedical repair technicians. Affiliation bonuses are specifically targeted towards those undermanned specialties.

We are encouraged by our improving overall recruiting and retention rates. Improvements in special pays have mitigated manning shortfalls; however, it will take several years until Navy Medicine is fully manned in several critical areas. To ensure the future success of accession and retention for Medical Department officers continued funding is needed for our programs and special incentive pays. We are grateful for your support in this key area.

For our federal civilian personnel within Navy Medicine, we have successfully transitioned out of the National Security Personnel System (NSPS) and, in conjunction with the Assistant Secretary of Defense for Health Affairs and the other Services, we have begun a phased transition to introduce pay flexibilities in 32 health care occupations to ensure pay parity among health care providers in federal service. The initial phase occurred in FY 2011 when over 400 federal civilian physicians and dentists were converted to the new Defense Physician and Dentist Pay Plan. Modeled on the current VA pay system, the Defense Physician and Dentist Pay Plan

provides us with the flexibility to respond to local conditions in the health care markets. We continue to successfully hire required civilians to support our Sailors and Marines and their families - many of whom directly support our Wounded Warriors. Our success is largely attributed to the hiring and compensation flexibilities granted by Congress to the DoD's civilian health care community over the past several years.

The Navy Medicine Reintegrate, Educate and Advance Combatants in Healthcare (REACH) Program is an initiative that provides wounded warriors with career and educational guidance from career coaches, as well as hands-on training and mentoring from our hospital staff. To date, Navy Medicine has launched the REACH Program at WRNMMC, Naval Medical Centers Portsmouth and San Diego, as well as Naval Hospital Camp LeJeune. The ultimate goal of the REACH Program is to provide a career development and succession pipeline of trained disabled veterans for Federal Civil Service positions in Navy Medicine.

I am committed to building and sustaining diversity within the Navy Medicine workforce. Our focus remains creating an environment where our diversity reflects that of our patients and our Nation and where our members see themselves represented in all levels of leadership. We embrace what we learn from our unique differences with the goal of a work-life in balance with mind, body, and spirit. I believe we are more mission-ready, stronger and better shipmates because of our diversity. Navy Medicine will continue to harness the teamwork, talent, and innovation of our diverse force as we move forward into our future.

Conclusion

In summary, Navy Medicine is an agile and vibrant health care team. I am grateful to those came before us for their vision and foresight; I am inspired by those who serve with us now for commitment and bravery; and I am confident in those who will follow us because they will surely build on the strength and tradition of Navy Medicine. I have never been more proud of the men and women of Navy Medicine.

On behalf of the men and women of Navy Medicine, I want to thank the Committee for your tremendous support, confidence and leadership. It has been my pleasure to testify before you today and I look forward to your questions.

United States Air Force

Presentation before the House Armed Services Committee, Subcommittee on Military Personnel

FY 2013 Medical Programs

Statement of
Lieutenant General (Dr.) Charles B. Green
The Surgeon General of the Air Force

March 21, 2012

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) CHARLES B. GREEN

Lt. Gen. (Dr.) Charles B. Green is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Green serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Green has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 42,800 people assigned to 75 medical facilities worldwide.

General Green was commissioned through the Health Professions Scholarship Program and entered active duty in 1978 after completing his Doctorate of Medicine degree at the Medical College of Wisconsin in Milwaukee. He completed residency training in family practice at Eglin Regional Hospital, Eglin AFB, Fla., in 1981, and in aerospace medicine at Brooks AFB, Texas, in 1989. He is board certified in aerospace medicine. An expert in disaster relief operations, he planned and led humanitarian relief efforts in the Philippines after the Baguio earthquake in 1990, and in support of Operation Fiery Vigil following the 1991 eruption of Mount Pinatubo.

General Green has served as commander of three hospitals and Wilford Hall Medical Center. As command surgeon for three major commands, he planned joint medical response for operations Desert Thunder and Desert Fox, and oversaw aeromedical evacuation for operations Enduring Freedom and Iraqi Freedom. He has served as Assistant Surgeon General for Health Care Operations and Deputy Surgeon General, prior to his current assignment.

EDUCATION

1974 Bachelor of Science degree in chemistry, University of Wisconsin-Parkside, Kenosha
1978 Doctorate in Medicine and Surgery, Medical College of Wisconsin, Milwaukee
1981 Residency in family practice, Eglin Regional Hospital, Eglin AFB, Fla.
1987 Air Command and Staff College, by seminar
1988 Master's degree in public health, Harvard University, Cambridge, Mass.
1989 Residency in aerospace medicine, Brooks AFB, Texas
2000 Air War College, by correspondence

ASSIGNMENTS

1. June 1978 - July 1981, family practice resident, later, chief resident, Eglin AFB, Fla.
2. July 1981 - August 1984, flight surgeon, U.S. Air Force Hospital, Mather AFB, Calif.
3. August 1984 - September 1985, officer in charge, Family Practice Clinic, Wheeler AFB, Hawaii
4. September 1985 - August 1987, Chief of Clinic Services, Hickam AFB, Hawaii
5. September 1987 - June 1988, student, graduate aerospace medical resident, Harvard University, Cambridge, Mass.
6. June 1988 - July 1989, resident in aerospace medicine, U.S. Air Force School of Aerospace Medicine, Brooks AFB, Texas
7. July 1989 - August 1991, Chief of Aerospace Medicine, and Commander, 657th Tactical Hospital, Clark AB, Philippines
8. September 1991 - August 1993, Commander, 65th Medical Group, Lajes Field, Portugal
9. August 1993 - August 1995, Commander, 366th Medical Group, Mountain Home AFB, Idaho
10. August 1995 - January 1997, Commander, 96th Medical Group, Eglin AFB, Fla.
11. January 1997 - July 1999, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
12. July 1999 - June 2001, Command Surgeon, North American Aerospace Defense Command, U.S. Space Command and Air Force Space Command, Peterson AFB, Colo.
13. June 2001 - July 2003, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
14. July 2003 - July 2005, Commander, 59th Medical Wing, Wilford Hall Medical Center, Lackland AFB, Texas
15. July 2005 - August 2006, Assistant Surgeon General for Health Care Operations, Office of the Surgeon General, Bolling AFB, D.C.
16. August 2006 - August 2009, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, D.C.
17. August 2009 - present, Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C.

SUMMARY OF JOINT ASSIGNMENTS

1. January 1997 - July 1999, Command Surgeon, U.S. Central Command, MacDill AFB, Fla., as a colonel
2. July 1999 - June 2001, Command Surgeon, North American Aerospace Defense Command and U.S. Space Command, Peterson AFB, Colo., as a colonel
3. June 2001 - July 2003, Command Surgeon, U.S. Transportation Command, Scott AFB, Ill., as a brigadier general
4. July 2003 - July 2005, Director, DOD Region 6 (TRICARE South) Lackland AFB, Texas, as a major general

FLIGHT INFORMATION

Rating: Chief flight surgeon
Flight hours: 1,200
Aircraft flown: B-52, C-5, C-9, C-21, C-130, C-141, H-53, KC-135, T-43, F-15, F-16, P-3, T-37, T-38, UH-1 and UH-60

MAJOR AWARDS AND DECORATIONS
Distinguished Service Medal with oak leaf cluster
Defense Superior Service Medal with oak leaf cluster
Legion of Merit
Defense Meritorious Service Medal
Airman's Medal
Meritorious Service Medal with four oak leaf clusters
Joint Service Commendation Medal
Air Force Commendation Medal with two oak leaf clusters
Air Force Achievement Medal
National Defense Service Medal with bronze star
Armed Forces Expeditionary Medal
Humanitarian Service Medal with bronze star
Philippine Bronze Cross

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
American Medical Association
American College of Physician Executives
Fellow, Aerospace Medical Association
Fellow, American Academy of Family Physicians
Uniformed Services Academy of Family Physicians
Aerospace Medical Association
Society of U.S. Air Force Flight Surgeons (former President)
Air Force Association
Association of Military Surgeons of the United States

EFFECTIVE DATES OF PROMOTION
Captain June 18, 1978
Major May 26, 1984
Lieutenant Colonel May 25, 1990
Colonel May 31, 1994
Brigadier General Aug. 1, 2001
Major General Sept. 1, 2004
Lieutenant General Aug. 3, 2009

(Current as of February 2010)

Mr. Chairman and distinguished members of the Committee, thank you for inviting me to appear before you today. The men and women of the Air Force Medical Service (AFMS) have answered our nation's call and maintained a standard of excellence second to none for more than a decade of sustained combat operations. We provide service members, retirees and families the best care America has to offer. We take tremendous pride in providing "Trusted Care Anywhere" for the nation.

We support the President's budget and the proposed changes to the military health benefit. I am confident that the recommendations included in the budget reflect the proper balance and the right priorities necessary to sustain the benefit over the long term. National health care costs continue to rise at rates above general inflation and DoD is not insulated from this growth as we purchase over 60 percent of our care from private sector. DoD beneficiaries' out-of-pocket costs with the proposed changes remain far below the cost-sharing percentage they experienced in 1995. We understand we cannot ask our beneficiaries to share more of the cost for health care without seeking significant internal efficiencies. We are increasing efficiency by reducing administrative costs, improving access, recapturing care, and introducing cutting-edge technology to better connect our providers and patients.

Ready, Better Health, Better Care, and Best Value are the components of the Quadruple Aim for the Military Health Services. To meet these goals, the AFMS set priorities to transform deployable capability, build patient-centered care, and invest in education, training and research to sustain world class health care. We have made significant inroads in each of these areas over the past year.

Transform Deployable Capability

In times of war there are always significant advances in the field of medicine. Today we are applying these lessons to shape future readiness and care. We have found new ways to manage blood loss and improve blood replacement. Significant improvements in the blood program improved transfusion capability and changed the way we use fluids to resuscitate patients. Air Force trauma surgeons in deployed hospitals better control hemorrhage and treat vascular injury by designing and using new arterial shunts that have been adopted by civilian trauma surgeons. These innovations contribute to a very low case fatality rate and allow earlier transport of casualties.

Through innovative training and quick thinking, Air Force, Army and Navy medics continue to perform miracles in field hospitals. Last spring in Balad, Iraq, our critical care air transport teams (CCATT) saved the life of a soldier who had suffered blunt force trauma to his chest, causing his heart to stop. After an unknown period without a pulse, there was significant risk of brain injury. Using coolers of ice, the team undertook a rare therapeutic hypothermia procedure to lower body temperature, decreasing tissue swelling and damage to the brain. The soldier was transported to Landstuhl Medical Center in Germany where his temperature was slowly raised, bringing him back to consciousness. Within four days of injury, the soldier arrived at Brooke Army Medical Center, San Antonio, Texas, and walked out of the hospital with thankful family members. Incredible ingenuity, dedication, and teamwork continue to save lives every day.

We have an impressive legacy of building highly capable deployable hospitals over the past decade. This year we have established 10 new Expeditionary Medical Support (EMEDS)

Health Response Teams (HRT). These newly tested and proven 10-bed packages enable us to arrive in a chaotic situation, provide emergency care within 30 minutes and perform surgery within 5 hours of arrival. The entire package is transportable in a single C-17, and full base operating support for the hospital requires only one additional C-17. The HRT was used successfully in a Trinidad humanitarian mission in April and will be our standard package to provide rapid battlefield medicine and humanitarian assistance. This year we will establish intensive training with the HRT and will expand its capability with additional modular sets to respond to specialized missions such as obstetrics, pediatrics or geriatrics required for humanitarian response.

We are also pursuing initiatives to improve air evacuation capability. New advances in ventilators allow us to move patients sooner and over longer distances with less oxygen. We pursued new capabilities for heart-lung bypass support by reducing the size of extracorporeal membrane oxygenation (ECMO) equipment. ECMO has been in use for many years transporting neonatal patients, and we now have critical care teams using this advanced technology for adult patient transportation. We moved the first patient on full heart lung bypass out of Afghanistan in 2011. We are working to miniaturize and standardize ECMO equipment so it can be operated by less specialized teams. David Grant Medical Center at Travis AFB, California, recently became the first DoD recipient of the smallest ECMO device. Known as CARDIOHELP, the device is light enough to be carried by one person and compact enough for transport in a helicopter or ambulance. Researchers will utilize CARDIOHELP to evaluate the effects of tactical, high altitude and long-haul flights on patients who require the most advanced life support. We continue to advance the science of patient transport moving the sickest of the sick, as we decrease the amount of time from point of injury to definitive care in the United States.

The insertion and integration of CCATT into the air evacuation system continues to be a dominant factor in our unprecedented high survival rates. These teams speed up the patient movement process, bring advanced care closer to the point of injury, free up hospital beds for new causalities, allow us to use smaller hospitals in theater and move patients to definitive care sooner. We have improved CCATT equipment with more wireless capability aboard aircraft to simplify connection of medical equipment to critical care patients. We are continuously finding better technologies for more accurate patient assessment in flight and working to standardize equipment and supplies used by coalition teams.

We developed and fielded the Tactical Critical Care Evacuation Team in 2011. This team was built to deliver the same level of care during intra-theater transport on non-AE platforms as that provided by our CCATT teams. Our first deployed team safely transported 130 critical patients on rotary aircraft. The team is composed of an emergency physician and two nurse anesthetists that separate and fly individually with a pararescue Airman or 68W to move the sickest patients. We are now able to move critical patients between Level II and Level III facilities in theater even more expeditiously, using either rotary or fixed wing aircraft.

The Theater Medical Information Program Air Force continues to make tremendous progress supporting the war-fighting community both on the ground and in the air. We leveraged existing information management and technology services to integrate with Line of the Air Force communication groups at all deployed Air Force ground-based units. This decreased end user devices, numbers of personnel at risk, and contractor-support requirements in theater. This integration allowed us to remotely support deployed units from state-side locations for the first time and with improved timeliness. Today, AFMS units are documenting all theater-based

patient care electronically, including health records within the air evacuation system, and securely moving information throughout the DoD healthcare system.

Build patient-centered care

At home, we continue to advance Patient-Centered Medical Home (PCMH) to improve delivery of peacetime healthcare. The foundation of patient-centered care is trust, and we have enrolled 920,000 beneficiaries into team-based, patient-centered care. Continuity of care has more than doubled with patients now seeing their assigned physician 80% of the time and allowing patients to become more active participants in their health care. PCMH will be in place at all Air Force Medical Treatment Facilities (MTFs) by June of this year. The implementation of PCMH is decreasing emergency room visits and improving health indicators.

We have also implemented pediatric PCMH, focused on improving well child care, immunizations, reducing childhood obesity and better serving special needs patients. A recent American Academy of Pediatrics study analyzed the impact of medical home on children. Their report concluded, "Medical home is associated with improved health care utilization patterns, better parental assessment of child health, and increased adherence with health-promoting behavior." We anticipate completing Air Force pediatric PCMH implementation this summer through simple realignment of existing resources.

Our PCMH teams are being certified by the National Committee for Quality Assurance (NCQA). NCQA recognition of PCMH is considered the current gold standard in the medical community, with recognition levels ranging from 1-3, 3 being the highest. To date, all MTFs who completed evaluation were officially recognized by NCQA as a PCMH, with 10 sites

recognized as a level 3. This level of excellence far exceeds that seen in the nation overall. An additional 15 Air Force sites will participate in the NCQA survey in 2012.

We are enabling our family health care teams to care for more complex patients through Project ECHO (Extension for Community Healthcare Outcomes). This program started at the University of New Mexico to centralize designated specialists for consultation by local primary care providers. ECHO allows us to keep patients in the direct care system by having primary care providers "reach back" to designated specialists for consultation. For example, rather than send a diabetic patient downtown on a referral to a TRICARE network endocrinologist, the primary care team can refer the case to our diabetes expert at the 59th Medical Wing, Lackland AFB, Texas, without the patient ever departing the clinic. ECHO now includes multiple specialties, and has been so successful, the concept has been adopted by the Mayo Clinic, Johns Hopkins, Harvard, DoD, and the VA.

Our personalized medicine project, Patient Centered Precision Care (PC2), which builds on technological and evidence-based genomic association, received final Institutional Review Board approval. We enrolled the first 80 patients this year with a goal of enrolling 2,000 patients in this research. PC2 will allow us to deliver state-of-the-art, evidence-based, personalized health care incorporating all available patient information. A significant aspect of PC2 is genomic medicine research, the advancement of genome-informed personalized medicine. With a patient's permission, we analyze Deoxyribonucleic Acid (DNA) to identify health risks and then ensure follow up with the health care team. De-identified databases will allow us to advance research efforts. Research groups can determine associations or a specific area where they think there may be merit in terms of how we can change clinical practice. This research

will likely change the way we view disease and lead to much earlier integration of new treatment options.

MiCare is currently deployed to our Family Practice training programs and will be available at 26 facilities before the end of 2012. This secure messaging technology allows our patients to communicate securely with their providers via email. It also allows our patients to access their personal health record. Access to a personal health record will provide the ability to view lab test results at home, renew medications and seek advice about non-urgent symptoms. Healthcare teams will be able to reach patients via MiCare to provide appointment reminders, follow up on a condition without requiring the patient to come to the MTF, provide medical test and referral results, and forward notifications on various issues of interest to the patient. We anticipate full implementation by the end of 2013.

We are also testing incorporation of smart-phones into our clinics to link case managers directly to patients. Linking wireless and medical devices into smart phones allows the patient to transmit weight, blood pressure or glucometer readings that are in high risk parameters directly to their health team for advice and consultation. Patients with diabetes or congestive heart failure can see significant reductions in hospitalizations when interventions with the health care team are easily accessible on a regular basis. This improves quality of life for the diabetic or cardiology patient, reduces health care costs, and increases access for other patients. We have a pilot effort underway with George Washington University Hospital to use this tool in diabetes management.

Safeguarding the well-being and mental health of our people while improving resilience is a critical Air Force priority. We remain vigilant with our mental health assessments and

consistently have Post-Deployment Health Reassessment completion rates at 80 percent or higher for Active Duty, Guard and Reserve personnel. In January 2011, we implemented Section 708 of the 2010 National Defense Authorization Act for active duty Airmen, and in April 2011, for the Reserve Component. The two-phased approach requires members to complete an automated questionnaire, followed by a person-to-person dialogue with a trained privileged provider. Whenever possible, these are combined with other health assessments to maximize access and minimize inconvenience for deployers. Each deployer is screened for post-traumatic stress disorder (PTSD) four times per deployment including a person-to-person meeting with a provider.

Although Air Force PTSD rates are rising, the current rate remains low at 0.8 percent across the Air Force. Our highest risk group is explosive ordnance disposal at about 7 percent, with medical personnel, security forces, and transportation at less risk, but higher than the Air Force baseline. Our mental health providers, including those in internships and residencies, are trained in evidence-based PTSD treatments to include Prolonged Exposure, Cognitive Processing Therapy and Cognitive Behavioral Couples Therapy for PTSD. "Virtual Iraq/Afghanistan" uses computer-based virtual reality to supplement Prolonged Exposure Therapy at 10 Air Force sites. Diagnosis is still done through an interview, supported by screening tools such as the PTSD Checklist (PCL) and other psychological testing as clinically indicated.

We are working closely with Air Force leadership to inculcate healthy behaviors. Comprehensive Airmen Fitness focuses on building strength across physical, mental and social domains. Airman Resiliency Training (ART) provides a standardized approach to pre-exposure preparation training for redeploying Airmen, including tiered training that recognizes different

risk groups. Traumatic stress response teams at each base foster resiliency through preparatory education and psychological first-aid for those exposed to potentially traumatic events.

The Deployment Transition Center (DTC) at Ramstein AB, Germany, soon to be 2 years old, provides an effective reintegration program for our redeploying troops. More than 3,000 deployers have now processed through the DTC. A study of the first 800 Airmen to go through the DTC, compared with 13,000 Airmen matched to demographics, mission set, and level of combat exposure, demonstrated clear benefit from the DTC. Analyzing their PDHRAs, Airmen who attended the DTC showed positive results -- significantly fewer symptoms of Post Traumatic Stress, lower levels of alcohol use, and lower levels of conflict with family/coworkers. This study provided solid evidence that the DTC helps Airmen with reintegration back to their home environment. We are now partnering with the RAND Corporation in two other studies, looking at the overall Air Force Resilience Program and studying the effectiveness of the current ART program.

While we experienced a drop in the active duty suicide rate in 2011, we remain concerned. Guard and Reserve suicide levels have remained steady and low. The major risk factors continue to be relationship, financial and legal problems, and no deployment or history of deployment associations have been found. We strive to find new and better ways to improve suicide prevention efforts across the Total Force. By summer of this year, we will embed behavioral health providers in primary care clinics at every MTF. The Behavioral Health Optimization Program reduces stigma by providing limited behavioral health interventions outside the context of the mental health clinic, offering a first stop for those who may need counseling or treatment. The Air Reserve Components instituted on-line training tools and products that support ACE (Ask, Care, Escort), our peer-to-peer suicide prevention training. The

Air Force Reserve Command also added a new requirement for four deployment resilience assessments beginning last April.

We are increasing our mental health provider manning over the next 5 years with more psychiatrists, psychologists, social workers, psychiatric nurse practitioners, and technicians. We increased Health Professions Scholarship Program (HPSP) scholarships for psychologists, as well as psychiatry residency training billets and the psychology active duty PhD program and internship billets. To enhance social worker skills, we placed social workers in four internship programs and dedicated HPSP scholarships and Health Professions Loan Repayment Program slots for fully qualified accessions. Accession bonuses for fully qualified social workers were approved for FY12 for 3- and 4-year obligations. These actions will help us to meet mental health manning requirements for both joint deployment requirements and at home station in compliance with Section 714 in the 2010 National Defense Authorization Act. Air Force tele-mental health is now in place at 40 sites across the Air Force, and is planned for a total of 84 sites..

Like our sister Services, the Air Force continues to be concerned about, and focused on, the consequences of traumatic brain injury (TBI). We fully implemented TBI testing across the Air Force, and collected more than 90,000 ANAM assessments in the data repository. The Air Force accounts for 10-15 percent of total TBI in the military with approximately 4 percent of deployment-associated TBI. Most Air Force cases, more than 80 percent, are mild in severity. Of all our completed post-deployment health assessments and reassessments, less than 1 percent screened positive for TBI with persistent symptoms.

Despite our relatively lower incidence, the Air Force continues to work with DoD partners to better understand and mitigate the effects of TBI. In collaboration with Defense and Veterans Brain Injury Center, Air Force and Army radiologists at the San Antonio Military Medical Center (SAMMC) are working jointly to study promising neuroimaging techniques including volumetric MRI using the FDA-approved software NeuroQuant, functional MRI, spectroscopy, and diffusion tensor imaging to identify structural changes that may result from TBI. Ongoing studies will find more definitive answers to this complex diagnostic and treatment problem..

As co-chairman of the Recovering Warrior Task Force, I have come to understand all Services Wounded Warrior Programs. I have been on site visits with our committee as we seek to discern best practices to help our wounded, ill and injured members recover. The joint efforts of DoD and the Department of Veterans Affairs to streamline the Integrated Delivery Evaluation System (IDES) are paying dividends. In the Air Force, we are augmenting pre-Medical Evaluation Board (MEB) screening personnel to streamline IDES processing. Our electronic profile system gives us full visibility of those in the process and close coordination with the VA is reducing the time to complete the IDES processing.

Invest in Education, Training and Research

Providing "Trusted Care Anywhere" requires our people to have the best education and training available to succeed in our mission. We strive to find new and better ways to ensure our Airmen not only survive but thrive.

This is the goal of the Medical Education and Training Campus (METC), and it truly is a joint success story. METC has already matriculated 10,000 graduates from the Army, Navy and Air Force, and now has numerous international students enrolled. The majority of the Services' enlisted education and training programs have transferred to METC, and the remainder will transfer during the course of this year. The Institute for Credentialing Excellence (ICE) awarded METC the ICE Presidential Commendation for the pharmacy technician program and praised it as being the best program in the United States.

Air Force graduate medical education (GME) programs continue to be the bedrock for recruiting top-notch medics. Since the 1970s, many of our GME programs have been affiliated with renowned civilian universities. These partnerships are critical to broad-based training and build credibility in the U.S. and international medical communities. GME residencies in Air Force medical centers develop graduates who are trained in humanitarian assistance, disaster management, and deployment medicine. National recognition for top quality Air Force GME programs improves our ability to recruit and retain the best. First-time pass rates on specialty board exams exceeded national rates in 26 of 31 specialty areas, and stand at 92 percent overall for the past 4 years.

Over the next few years, we will transform training to support new assets in air evacuation and expeditionary medical support. Flight nurse and technician training and AE contingency operations training curriculums have been entirely rewritten to capture lessons from 10 years of war. The Centers for Sustainment of Trauma and Readiness Skills – C-STARS – in Baltimore, St. Louis and Cincinnati, have been extraordinarily successful in maintaining wartime skills. We have expanded training sites to establish sustainment of traumas skills -- Sustainment

of Trauma and Resuscitation Skills Programs (STARS-P) -- to University of California Davis, Scottsdale, University of Nevada- Las Vegas, and Tampa General Hospitals. This will include greater use of simulation at C-STARS, STARS-P, and other Air Force medical sites. We have many testimonials from deployed graduates who credit their competence and confidence in theater to C-STARS and STARS-P training. We will continue efforts to expand this training so we will have full-up trauma teams and Critical Care Air Transport teams that are always ready to go to war.

One of our most significant partners in GME and resource-sharing is the Department of Veterans Affairs. We are proud of our six joint ventures, 59 sharing agreements and 63 Joint Incentive Fund (JIF) projects, all win-wins for the military member, veteran and American taxpayer. All four Air Force JIF proposals submitted for FY 2012 were selected. These include a new CT Scan at Tyndall AFB, FL, that will also benefit the Gulf Coast VA Health Care System; establishment of an orthopedic surgery service for Mountain Home AFB, Idaho, and the Boise VAMC; funding for an additional cardiologist at Joint Base Elmendorf-Richardson and the Alaska VA Health Care System – critical to reducing the number of patients leaving our system of care; and an ophthalmology clinic at Charleston with the Naval Health Clinic Charleston and the Charleston VA Medical Center. The JIF program is extremely helpful in supporting efficiencies that make sense in the federal government, while improving access to care for our beneficiaries.

Collaboration with the VA in the DoD Hearing Center of Excellence (HCE), under Air Force lead, continues as we pursue our goals of outreach, prevention, enhanced care, information management, and research to preserve and restore hearing. Compounding hearing loss related to

noise, the effect of improvised explosive devices (IEDs) that military personnel experience in Iraq and Afghanistan expands the threat and damage to the audiovestibular system. Traumatic brain injury may damage the hearing senses and the ability to process sound efficiently and effectively. Dizziness is common, and almost half of service members with TBI complain of vertigo following blast exposure.

We are coordinating and integrating efforts with the other congressionally mandated centers of excellence to ensure the clinical care and rehabilitation of the nation's wounded, ill and injured have the highest priority. Partnering with the Defense and Veterans Eye Injury Registry has resulted in the Joint Theater Trauma Registry adding ocular and auditory injury modules to look at the effect and relation eye and ear injury has on TBI and psychological health rehabilitation. And the Vision Center of Excellence under Navy lead and HCE have contributed to the planning, patient management, and clinical guidelines with the National Intrepid Center of Excellence, the Center for the Intrepid, and within the Institute of Surgical Research.

We have expanded our research with the opening of the new School of Aerospace Medicine at Wright Patterson and our collaborative efforts with the Army in the San Antonio Military Medical Center. The 59th Medical Wing at Lackland AFB, Texas, is using laser treatment to improve range of motion and aesthetics in patients with burn scars. In the 10 subjects enrolled to date in the research, the laser treatments have resulted in an immediate reduction in scar bulk, smoothing of irregularities, and the production of scar collagen. The scars have also shown improved pliability, softness and pigmentation. This is encouraging for our wounded warriors and Service members who have received thermal or chemical burns.

Another promising laser initiative is the Tricorder Program, a collaboration effort with the University of Illinois, Chicago, designed to detect/characterize laser exposure in "real time," assisting in the development of force health protection measures, such as laser eye protection. Air Force and Navy testers evaluated the prototype laser sensors in simulated air and ground field environments. An upcoming exercise with the FBI Operational Technology Division will assess the laser sensor for forensic capability in a domestic aircraft illumination scenario.

Another collaborative effort, with the Department of Homeland Security, is the development of an environmental/medical sensor integration platform that provides real-time data collection and decision support capability for medical operators and commanders, integrating environmental and medical sensor data from the field into a hand-held platform. The sensor integration platform was demonstrated successfully several times, including its deployment for environmental monitoring capability with the Hawaii National Guard, where the platform quadrupled Hawaii's radiation monitoring capability after the tsunami in Japan. It is now the backbone of Hawaii's state civil defense system real-time environmental monitoring capability.

The U.S. Air Force School of Aerospace Medicine (USAFSAM), Wright-Patterson AFB, Ohio, developed the Cone Contrast Test (CCT) for detection of color vision deficiency. The CCT was selected as a winner of the 2012 Award for Excellence in Technology Transfer, presented annually by the Federal Laboratory Consortium to recognize laboratory employees who accomplished outstanding work in the process of transferring a technology developed by a federal laboratory to the commercial marketplace. The technology was developed by vision scientists in USAFSAM's Aerospace Medicine Department and uses computer technology to

replace the colored dot Ishihara Plates developed in the early 1900s. The CCT indicates vision deficiency type and severity, and can distinguish hereditary color vision loss from that caused by disease, trauma, medications, and environmental conditions – ensuring pilot safety while facilitating the detection and monitoring of disease.

The Way Ahead

I look back 10 years to 9/11 and marvel at how far we have come in a decade. While sustaining the best battlefield survival rate in the history of war, we have simultaneously completed complex Base Realignment and Closure projects, and enhanced our peacetime care worldwide. We changed wartime medicine by moving the sickest of the sick home to the United States within 3 days, while shifting one million enrolled patients into team based, patient centered care that improved continuity of care 100 percent. One thing has not changed…the talent, courage, and dedication of Air Force medics still inspires me every day! As I retire later this year, I know that I leave our Air Force family in exceptional hands. Air Force medics will always deliver "Trusted Care, Anywhere" for this great nation.

The AFMS will work shoulder to shoulder with our Army, Navy and DoD counterparts to be ready, and provide better health, better care, and best value to America's heroes. Together we will implement the right governance of our Military Health System. We will find efficiencies and provide even higher quality care with the resources we are given. I thank this Committee for your tremendous support to military medics. Our success, both at home and on the battlefield, would not be possible without your persistent and generous support. Thank you!

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STATEMENT OF

THE MILITARY COALITION (TMC)

before the

HOUSE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

March 21, 2012

Presented by

Colonel Steve Strobridge (USAF-Ret.)

Director of Government Relations, Military Officers Association of America
and
Co-Chairman, The Military Coalition

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning 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
Army Aviation Association of America
Association of Military Surgeons of the United States
Association of the United States Army
Association of the United States Navy
Chief Warrant 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.
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the United States of America
Marine Corps League
Marine Corps Reserve Association
Military Chaplains Association of the United States of America
Military Officers Association of America
Military Order of the Purple Heart
National Association for Uniformed Services
National Guard Association of the United States
National Military Family Association
Naval Enlisted 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
Wounded Warrior Project

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

Executive Summary

FY2013 Budget Submission on TRICARE Fees

The Coalition believes DoD's proposals for dramatic TRICARE fee hikes constitute a serious breach of faith with currently serving troops and families by cutting their future healthcare benefits. And if breaking faith with the currently serving is wrong, so is imposing a major "bait and switch" change on those who already completed 20-30 year careers, induced by promises of current benefits.

TRICARE Prime Fees: Reject any increase in TRICARE Prime fees that exceeds the COLA-based standard established in the FY2012 Defense Authorization Act.

TRICARE Standard Fees:

- The Coalition urges rejection of any TRICARE Standard enrollment fee unless and until the government provides guaranteed access to care for Standard beneficiaries
- The Coalition urges the Subcommittee to reject DoD's proposal to nearly double the TRICARE Standard deductible over the next five years.

TRICARE For Life Enrollment Fee: Sustain current law that avoids any enrollment fee for TRICARE For Life, consistent with Congress' determination in 2001 that the service and sacrifices extracted from military retirees and families over the course of their careers constituted a pre-paid premium for their TFL coverage as a Medicare supplement.

TRICARE Pharmacy Copays: Reject Administration-proposed pharmacy copayment increases that would inappropriately "civilianize" the military pharmacy benefit, dramatically raise costs for both retired and currently serving families, and deter beneficiaries from adhering to medication regimens that are essential to their long-term health as well as DoD's long-term cost containment.

TRICARE Proposals Raise New Inequities: The extremely limited categories of exemptions for survivors and disabled retirees disregard the similar or more severe situations of other survivors and disabled. The Coalition does not propose expanding the exemption, because that would imply a level of Coalition concurrence with the proposed fee hikes that does not exist. We raise this inequity issue as another reason why the proposed fee increases are grossly inappropriate for all grades and categories of beneficiaries.

TRICARE Fee "Tiering": Strongly oppose means-testing of military benefits, under which longer and more successful service would be penalized by progressive reduction of military healthcare benefits. The Coalition believes all retired servicemembers earned equal health care coverage by virtue of their service and that the proposed dramatic fee increases are inappropriate for servicemembers of all grades.

TRICARE Fee Indexing: Reject the DoD-proposed tying of annual increases in military health care fees to an index of health cost growth which would dramatically and disproportionally accelerate military healthcare fees over time.

Military Health Care Principles: The Coalition believes the law should be changed to explicitly acknowledge that:

- The healthcare benefit provided for members and families who endure to complete a military career should be among the very best available to any American;
- The decades of service and sacrifice rendered by career military personnel constitute a significant pre-paid premium toward their healthcare in retirement; and
- The large value of this pre-paid premium should be accounted for by minimizing fees payable in retirement and avoiding significant and arbitrary increases from year to year.

Leadership Accountability

The Coalition urges the Subcommittee to hold Defense leaders accountable for their own management, oversight, and efficiency failures before seeking to shift more costs to beneficiaries. Congress should direct DoD to pursue any and all options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries.

Wounded, Ill, and Injured Servicemember Issues

The Coalition urges:

- Joint hearings by the Armed Services and Veterans Affairs Committees addressing the Joint Executive Council's (JEC) effectiveness in daily oversight, management, collaboration, and coordination of the Departments' wounded, ill, and injured servicemember programs.
- Permanent funding, staffing, and accountability for congressionally mandated Defense Centers of Excellence and associated mental-behavioral health, suicide prevention, caregiver, respite, and other medical and non-medical programs.
- Continued aggressive oversight of the Integrated Disability Evaluation and legacy disability evaluations systems to ensure preservation of the 30-percent threshold for medical retirement, consistency and uniformity of policies, ratings, legal assistance, benefits, and transitional services Defense-wide.

DoD – VA Seamless Transition

The Coalition urges:

- Joint hearings by the Armed Services and Veterans Affairs Committees to assess the effectiveness of current seamless transition oversight efforts and systems and to solicit views and recommendations from DoD, VA, the military services, and non-governmental organizations concerning how joint communication, cooperation, and oversight could be improved.
- Authorizing service-disabled members and their families to receive active-duty-level TRICARE benefits, independent of availability of VA care for three years after medical retirement to help ease their transition from DoD to VA.
- Ensuring Guard and Reserve members have adequate access and treatment in the DoD and VA health systems for Post Traumatic Stress Disorder and Traumatic Brain Injury following separation from active duty service in a theatre of operations.

DoD-VA Integrated Disability Evaluation System (IDES)

The Coalition recommends:

- Preserving the statutory 30 percent disability threshold for medical retirement in order to provide lifetime TRICARE coverage for those who are injured while on active duty.
- Reforming the DoD disability retirement system to require inclusion of all unfitting conditions and accepting the VA's "service-connected" rating.
- Ensuring any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled service members.
- Eliminating distinctions between disabilities incurred in combat vs. non-combat when determining benefits eligibility for retirement.
- Revision of the VA schedule for rating disabilities (VASRD) to improve the care and treatment of those wounded, ill and injured, especially those diagnosed with PTSD and TBI.
- Barring designation of disabling conditions as "existing prior to service" for servicemembers who have been deployed to a combat zone.
- Directing DoD to re-engineer and redesign the front end of IDES to (1) better ensure medical evaluations are consistently based on a fully developed, accurate medical summary; (2) permint the servicemember's full participation; (3) afford each individual consistent, effective representation throughout the process; and (4) streamline the system by eliminating the redundancy of dual adjudication of disability.

Caregiver/Family Support Services

The Coalition recommends:

- Providing enhanced training of DoD and VA medical and support staff on the vital importance of involving and informing designated caregivers in treatment of and communication with severely ill and injured personnel.
- Providing health and respite care for non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage while the injured member remains on active duty, commensurate with what the VA authorizes for medically retired or separated members' caregivers.
- Extending eligibility for residence in on-base facilities for up to one year to medically retired or severely wounded servicemembers and their families (or until the medically retired or severely injured service member receives a VA compensation rating, whichever is longer).
-

Guard and Reserve Healthcare

The Coalition recommends:

- Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60
- Authorizing premium-based TRICARE coverage for members of the Individual Ready Reserve after being called to active service for a cumulative period of at least 12 months
- Permitting employers to pay TRS premiums for reservist-employees as a bottom-line incentive for hiring and retaining them.
- Authorizing an option for the government to subsidize continuation of a civilian employer's family coverage during periods of activation, similar to FEHBP coverage for activated Guard-Reserve employees of Federal agencies.
- Extending corrective dental care following return from a call-up to ensure G-R members meet dental readiness standards.

- Allowing eligibility in Continued Health Care Benefits Program (CHCBP) for Selected Reservists who are voluntarily separating and subject to disenrollment from TRS.
- Allowing beneficiaries of the FEHBP who are Selected Reservists the option of participating in TRICARE Reserve Select.

Additional TRICARE Prime Issues

The Coalition urges the Subcommittee to:

- Require reports from DoD and the managed care support contractors on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.
- Require increased DoD efforts to ensure consistency between both the MTFs and purchased care sectors in meeting Prime access standards.
- Ensure timely notification of and support for beneficiaries affected by elimination of Prime service areas.

Additional TRICARE Standard Issues

The Coalition urges the Subcommittee to:

- Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future.Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation to meet the threshold.
- Require a specific report on provider participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.
- Increase locator support to TRICARE Standard beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.

Overview

Mr. Chairman and distinguished members of the Subcommittee, The Military Coalition extends our thanks to you for your strong support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors.

Congress has improved retention and readiness by addressing a number of quality of life issues for the military community over the last decade including enactment of TRICARE For Life, TRICARE Senior Pharmacy coverage, and health coverage for the Guard and Reserve community, among many other important initiatives.

Now, ironically, critics decry the growth in health care spending over the last decade, ignoring that much of that cost was driven by wartime requirements and service organizational and readiness priorities rather than cost-efficient delivery of beneficiary care.

As Congress assesses how to fairly allocate necessary sacrifices among the various segments of the population, the Coalition urges that you bear in mind that:

- Assertions about personnel and health cost growth over the last decade are highly misleading, because 2001 (when nearly all older beneficiaries had been pushed out of military health coverage) is not an appropriate or reasonable baseline for comparison – 2001 was the "bottom" as far as military benefits were concerned. Congressional spending to fix that problem since then was a necessary thing, not a bad thing.

- DoD health costs remain well below the 16% share health care comprises of the national GDP.

- Assertions that cutbacks for retirees don't affect the currently serving force are a delusion. Significant benefit cutbacks for retirees reduce incentives for the currently serving to complete a career. A currently serving member who will retire next month, next year, or next decade is definitely affected by such cutbacks.

- Retired servicemembers, their families and survivors have been no stranger to sacrifice. Nearly 600,000 of today's retirees served on active duty during the current Iraq/Afghanistan wars. Hundreds of thousands more saw service in multiple hot and cold conflicts. Older retirees endured years when the government provided them no military health coverage, and those retired between 1985 and 2005 have forfeited an average 10% of earned retired pay because they retired under pay tables depressed by decades of budget-driven capping of military raises below civilian pay growth.

- Pentagon leaders' insensitivity to this situation is perfectly illustrated by Secretary Panetta's answer at a recent Senate Budget Committee hearing. When asked why the proposal focuses so much on raising fees for military retirees, he answered they would accept the changes because they're used to doing what they're told and used to a culture of sacrifice. In other words, they're used to abuse so we can – and plan – to abuse them again.

- Military members' and families' sacrifices must not be taken for granted by assuming they will continue to accept the extraordinary personal and family sacrifices inherent in a multi-decade service career regardless of significant changes in their career incentive package.

- At a time when Congress is focused on lowering payroll taxes and avoiding any tax increases for other Americans, including millionaires and billionaires, it's grossly inappropriate to impose a $1,000-$2,000 new annual tax on the one group of citizens who already have sacrificed more for their country than any other.

- The Coalition is appalled that fully 60% of the projected savings associated with the proposed TRICARE fee increases accrue from the assumption that the fee increases will be so onerous as to drive many thousands of military beneficiaries away from using their service-earned coverage. When similar assumptions were highlighted about earlier DoD TRICARE fee proposals, Congress rightly deemed it grossly inappropriate to entice members to career service with promises of care and then consciously implement plans to drive them away from using that hard-earned care. That's no less true in 2012 than it was in 2007 and 2008.

- History shows clearly that there are unacceptable retention and readiness consequences for short-sighted budget decisions that cause servicemembers to believe their steadfast commitment to protecting their nation's interests is poorly reciprocated.

FY2013 Budget Submission

The President's proposed FY2013 budget has embraced the concept put forth by the Defense Department in past years that TRICARE benefits for retired beneficiaries should "trend toward market rates" by significantly increasing fees for retired beneficiaries and family members under 65.

The proposal would shift $35 billion in costs to retired and some currently serving military families over the next 10 years through dramatic and disproportional healthcare fee increases. These fee levels are similar to those recommended by the Defense Department in past years, which the Subcommittee and Congress rejected as excessive on the basis that:

- Pentagon leaders need to demonstrate more effective cost management of their own before shifting significant additional costs to beneficiaries.

- Achieving savings by seeking to deter beneficiaries from using their service-earned benefits is inappropriate.

The budget proposes to raise beneficiary costs over the next ten years by:
- Raising annual fees by as much as $1,500 or more for retired families under age 65.
- Establishing new annual enrollment fees of up to $950 for retired couples over age 65.
- Imposing means-testing of military retiree health benefits – which no other federal employee experiences.
- Dramatically increasing pharmacy co-pays to approach or surpass the median of civilian plans.

- Tying future annual increases to an unspecified health cost index estimated to average 6.2% per year.

DoD leaders have made a great point of their intent to "keep faith with currently serving troops" by avoiding any retirement changes that would affect the current force.

But their concept of "keeping faith on retirement" doesn't extend to retirement health care benefits, as the proposed changes would affect any currently serving member who retires the day after they were implemented. This has the same effect as reducing their retired pay by up to $2,000 a year or more. Further, the pharmacy changes would affect hundreds of thousands of currently serving Guard/Reserve members and families, as well as the family members of currently serving personnel who don't have access to military pharmacies.

The Coalition believes DoD's proposals for dramatic TRICARE fee hikes constitute a serious breach of faith with currently serving troops and families by cutting their future healthcare benefits. And if breaking faith with the currently serving is wrong, so is imposing a major "bait and switch" change on those who already completed 20-30 year careers, induced by promises of current benefits.

TRICARE Prime Fees. The Administration's TRICARE Prime Fee proposal for FY2013 is a radical departure from the new fee structure the Administration proposed and Congress accepted for FY2012.

Last year, finally acknowledging Congress' long-standing concerns about the inappropriateness of dramatic increases in beneficiary fees, the Administration proposed a 13% increase in TRICARE Prime fees. In the absence of congressional objection, the increase was implemented as of October 1, 2011.

The new proposal for FY2013-2017 is a dramatic departure, proposing to triple or quadruple fees over the next five years, as indicated in the chart below.

DoD-Proposed TRICARE Prime Enrollment Fee for Retired Beneficiaries Under Age 65 (Family Rate)*

Retired Pay**	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY2017***
$0-22,589	$520	$600	$680	$760	$850	$893
$22,590-$45,178	$520	$720	$920	$1,185	$1,450	$1,523
$45,179 or more	$520	$820	$1,120	$1,535	$1,950	$2,048

*Single rate is 50% of family rate
** Retired pay thresholds to be indexed to COLA increases
*** Fees for FY18 and outyears to be indexed to health cost inflation

This proposal flies in the face of the specific language of the FY2012 Defense Authorization Act – signed into law less than three months ago – requiring that the percentage increase in TRICARE Prime fees for FY2013 and later years shall not exceed the percentage growth in military retired pay.

The logic behind the COLA cap has not changed in the last three months. Its purpose was to protect retirees against arbitrary, budget-driven initiatives to impose dramatic new fee increases.

The COLA cap was intended to help recognize that:

- Military retirees already pre-paid very large premiums for their health care in retirement through their decades of service and sacrifice in uniform, and that
- They shouldn't be subjected to a double penalty by having their fees raised dramatically after they've already rendered a career of service induced by long-standing government retirement and healthcare promises.

The Coalition urges the Subcommittee to reject any increase in TRICARE Prime fees that exceeds the COLA-based standard established in the FY2012 Defense Authorization Act.

TRICARE Standard Fees. The Administration proposes two changes to TRICARE Standard that are not authorized under current law: a new enrollment fee that would increase significantly over time, and a significant adjustment to the Standard deductible, which is set by current law at $150 for a single person and $300 for a family.

DoD-Proposed TRICARE Standard Annual Fees for Retired Beneficiaries Under Age 65 (Family Rate)*

Enrollment Fee	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY2017**
	$0	$140	$170	$200	$230	$250
Deductible	$300	$320	$400	$460	$520	$580

*Single rate is 50% of family rate

** Fees for FY18 and outyears to be indexed to health cost inflation

The Coalition strongly opposes any enrollment fee for TRICARE Standard. An enrollment fee is only appropriate when the beneficiary is guaranteed a certain level of care. While the Defense Department has specified standards for TRICARE Prime, it's definitely not the case with TRICARE Standard.

According to DoD's own surveys, there are localities where finding a provider who will accept Standard patients is very difficult. This is particularly true for some high-demand specialties such as psychiatry.

In the absence of guaranteed access to care, there should be no enrollment fee.

Establishing an explicit enrollment requirement also would change the fundamental character of this service-earned healthcare benefit by forcing a choice between military health coverage and other available coverage. Many use TRICARE as a contingent coverage that is there as a fallback if they lose their civilian job, if their civilian insurance offers limited coverage, etc. Throughout their careers, they were told they would have this coverage. The Coalition objects to a system that backs them into a situation that implies it's a reasonable decision to forfeit that earned protection because they have other insurance that may or may not endure. In other words, their military ID card is and should continue to

represent their automatic enrollment in the default military healthcare option unless they choose to enroll in Prime or age into TRICARE For Life.

The Coalition also objects strongly to the proposal to nearly double the annual Standard deductible over the next 5 years. Standard-eligible retired beneficiaries who are able to find a participating provider already are absorbing a 25% copay, and so their costs have risen as allowable charges have risen.

The Coalition urges the Subcommittee to reject any TRICARE Standard enrollment fee unless and until the government provides guaranteed access to care for Standard beneficiaries

The Coalition urges the Subcommittee to reject DoD's proposal to nearly double the TRICARE Standard deductible over the next five years.

TRICARE For Life Fees. The Administration proposes a new TRICARE For Life (TFL) enrollment fee for beneficiaries age 65 and older, with successive annual increases as indicated in the chart below:

DoD-Proposed TRICARE-for-Life Annual Enrollment Fee
(Per Individual Beneficiary Age 65+)

Retired Pay*	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY2017**
$0-22,589	$0	$35	$75	$115	$150	$158
$22,590-$45,178	$0	$75	$150	$225	$300	$317
$45,179 or more	$0	$115	$225	$335	$450	$475

** Retired pay thresholds to be indexed to COLA increases
*** Fees for FY18 and outyears to be indexed to health cost inflation

Again, the Coalition believes strongly that an enrollment fee is only appropriate when there is a guarantee of timely access to quality healthcare. While that is the case with TRICARE Prime, there is no such guarantee for TFL beneficiaries.

Because TFL is available only if the beneficiary enrolls in Medicare Part B and acts as second-payer to Medicare, it provides coverage only in the case of providers who accept Medicare patients.

In many localities around the country, more and more providers are limiting the number of Medicare patients they serve. In some localities, providers are refusing to accept any new Medicare patients.

In the event a provider refuses to accept Medicare, the beneficiary must absorb the full cost of the care, as Medicare will not reimburse the beneficiary for any share of the charges.

The reality is that Medicare patients already pay significantly more for their care than beneficiaries under 65 do because of the statutory requirement to enroll in Medicare Part B to be eligible for TFL. This means a TFL-eligible couple already is paying premiums of at least $2,400 per year in 2012. Couples in higher income brackets may pay up to $7,680 per year in Part B premiums alone.

Further, large numbers of these retired members already suffer severe and permanent financial penalties as a result of past government budget crises that caused depression of their annual pay raises while on active duty. Depression of military pay over time caused military pay scales to lag up to 13.5% behind private sector pay. Members who retired under those depressed pay scales already are being made to forfeit thousands of dollars per year, and those penalties will last through their lifetimes. Adding a TFL enrollment fee would add further financial insult to that grievous injury.

TFL was enacted in 2001 to rectify the previous decade's disenfranchisement of older military beneficiaries from virtually all military healthcare coverage in the wake of the BRAC-driven closure and downsizing of hundreds of military hospitals and clinics.

When Congress enacted TFL, it did so with the explicit acknowledgement that an enrollment fee for this program is inappropriate.

In passing the new law, Congress acknowledged that the premium for this Medicare-supplemental coverage already had been paid in full through decades of service and sacrifice.

The Coalition believes strongly that the experience of the last decade – during which the military community has been required to bear 100% of the nation's wartime sacrifice – only reinforces the rightness of Congress' 2001 acknowledgement that imposing an enrollment fee for TFL is inappropriate.

The Coalition urges strongly against imposing any enrollment fee for TRICARE For Life.

Proposed Fees Raise New Series of Inequities

The Coalition appreciates that some modest effort was made to accommodate human concerns by exempting medical (Chapter 61) retirees and survivors of members who died on active duty.

However, these very restricted exemptions create a whole new series of inequities that demonstrate a gross lack of appreciation for the circumstances of various beneficiary populations.

Limiting survivor exemption to cases of deaths on active duty ignores that other categories of survivors, most of whom are older, typically have far less resources than survivors of recent active duty deaths. Thousands of these older survivors have no income at all from the military or the VA, and received dramatically lower Servicemen's Group Life Insurance settlements than are available today -- yet they would be subjected to the higher TRICARE fees.

Among retirees, the sole exemption of chapter 61 (medical retirement) cases similarly ignores the realities of the disabled retiree population.

Medical retirees include not only the severely disabled, but also many with disability ratings of 30% (or lower in some cases, since members with 20+ years of service can be medically retired under chapter 61 with disability ratings as low as zero).

As the Subcommittee is only too well aware in the wake of multiple recent reviews and commissions in recent years, far larger numbers with significant disabilities were denied medical retirement under service policies and told to "see the VA for any disability issues."

So a 20-year retiree with a zero-to-30% medical retirement would be exempted from the higher TRICARE fees that would be imposed on a similar 20-year non-medical retiree who is immediately acknowledged by the VA as 100% disabled.

The Coalition does not raise these inequity issues in order to propose expanding the exemption, because that would imply a level of Coalition concurrence with the proposed fee hikes that does not exist. We raise them as another reason why the proposed fee increases are grossly inappropriate for all grades and categories of beneficiaries.

Pharmacy Co-Payments. The Administration proposes dramatic increases in retail and other pharmacy copays, as shown in the chart below.

DoD-Proposed Pharmacy Co-Payments
(For All Retirees, Survivors, Guard/Reserve and Active Duty Family Members)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY2017
Retail (1 mo fill)						
Generic	$5	$5	$6	$7	$8	$9
Brand	$12	$26	$28	$30	$32	$34
Non-Formulary*	$25	N/A	N/A	N/A	N/A	N/A

Mail-Order (3 mo fill)	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY2017
Generic	$0	$0	$0	$0	$0	$9
Brand	$9	$26	$28	$30	$32	$34
Non-Formulary	$25	$51	$54	$58	$62	$66

* Non-Formulary pharmaceuticals will have limited availability in retail pharmacies

Again, these are dramatic increases from the copayment rates the Administration proposed for FY2012, and implemented on Oct 1, 2011 in the absence of congressional objection.

For FY2012, the Administration imposed increases of $2 to $3 (e.g., from $9 to $12 for retail brand-name drugs and from $3 to $5 for retail generics.)

Now, only a year later, the proposal would more than double the new retail rates and triple the mail-order rates for brand-name medications.

In subsequent years, copays would rise for generics in the retail venue, and the copay the Administration just eliminated for mail-order generic drugs last year would not only be restored, but tripled.

These purely budget-driven proposals are inappropriate on several levels.

- The current $5 retail generic copay already exceeds the $4 generic copay widely available to any civilian who walks through the door at dozens of retail pharmacies. Proposed further increases in the outyears only exacerbate the relative disadvantage for military beneficiaries.

- The proposed brand-name and non-formulary copays would make the TRICARE pharmacy benefit little or no better than the median of civilian employer plans. In 2011, for example, 56% of civilian plans provide brand-name medications for a copay of $25 or less, compared to the DoD-proposed $26.

- Contrary to DoD assertions about exempting currently serving personnel from fee hikes, the pharmacy copay increases would apply to hundreds of thousands of drilling Guard and Reserve personnel, as well as to active duty, Guard and Reserve family members who don't have access to military pharmacies.

- DoD has expended relatively little substantive effort to increase use of the mail order system other than seeking to impose an ever-bigger "stick" of higher fees on those who use other venues. The Coalition has urged DoD to create positive incentives such as eliminating copays for maintenance medications (see next paragraph) and work with the Coalition to develop better communication materials to address real-world concerns that deter beneficiaries from mail-order use, and will continue to do so even with higher copays. These initiatives could save DoD hundreds of millions a year, but Coalition offers to partner on such efforts have been rebuffed.

- Such dramatic pharmacy copay increases will only discourage adherence to medication regimens for chronic conditions like asthma, diabetes, and more. Studies show that even modest copayment increases deter use of maintenance medications that are essential to preserving wellness and holding down far more expensive care when the conditions deteriorate. The Coalition has endorsed reducing or eliminating copays for maintenance medications to hold down long-term costs. This new proposal would fly in the face of that objective, sacrificing long-term beneficiary health for short-term cost savings.

The Coalition believes strongly that the TRICARE pharmacy benefit should be a top-tier benefit, not merely one that approaches the median of plans offered by civilian employers, and that it should enhance wellness goals rather than posing a new impediment to them.

The Coalition urges the Subcommittee to reject Administration-proposed pharmacy copayment increases that would inappropriately "civilianize" the military pharmacy benefit, dramatically raise costs for both retired and currently serving families, and deter beneficiaries from adhering to medication regimens that are essential to their long-term health as well as DoD's long-term cost containment.

Means-Testing Plan Discriminates Against Military Retirees. The Administration proposal envisions establishing graduated enrollment fees for TRICARE Prime and TFL, based on the amount of the retired servicemember's retired pay, as indicated in the charts previously shown.

This proposal would impose blatant and dramatic discrimination against military retirees.

No other federal employee or retiree pays income-based fees for service-earned health coverage. The President, the Secretary of Defense, and the Speaker of the House pay the same premiums as the lowest-paid federal civilian retiree.

Means-tested fees also are rare in the private sector. This is because healthcare has long been recognized as a service-earned benefit.

Means-testing healthcare as DoD proposes would turn the concept of service-based benefits on its head, so that the longer and more productive the service, the less the earned benefit.

This need-based mentality may be appropriate for social welfare programs, but its application to benefits that are earned by service and sacrifice is inappropriate and counterproductive.

The proposal also discriminates against the military by failing to apply the same protections provided to VA healthcare programs and beneficiaries.

No such fee increases are envisioned for VA care, and Congress expressly exempted VA healthcare and other programs from any reduction under sequestration.

In past years, Congress has strongly rejected far smaller VA fee increases proposed for non-disabled veterans who had served as few as two years.

In those contexts, imposing fee hikes of up to $2,000 a year for those who have served and sacrificed for two or three decades is grossly inconsistent and inappropriate.

The Coalition urges the Subcommittee to oppose means-testing of military benefits, under which longer and more successful service would be penalized by progressive reduction of military healthcare benefits. The Coalition believes all retired servicemembers earned equal health care coverage by virtue of their service and that the proposed dramatic fee increases are inappropriate for servicemembers of all grades.

Indexing of TRICARE Fees. The Administration's FY2013 budget request proposes to index, either immediately or following some transition period, a variety of TRICARE fees to a health care cost index.

The specifics of how that cost index would be calculated, what beneficiary population it would account for, and who would be responsible for calculating it, have not yet been revealed to us.

Last year, DoD sources indicated an expectation that such an index would yield annual adjustments on the order of 6.2% per year.

The Coalition objects strongly to tying TRICARE fee growth for military beneficiaries to any measure of healthcare cost changes.

Indexing fees to healthcare cost growth would far outstrip annual retired pay increases and greatly erode retired compensation value.

During congressional debate on this topic last year, Congress rejected the health cost growth index and capped year-to-year percentage increases in TRICARE Prime fees at the percentage growth in military retired pay, reflecting the belief that the latter measure was fairer considering the very large, up-front premium already extracted from career military personnel over decades of service and sacrifice.

The chart below shows how DoD-proposed increases in TRICARE Prime enrollment fees, tied in the outyears to the proposed health cost index, would vastly exceed the COLA-based standard approved by Congress last year, imposing large beneficiary losses that would continue and accelerate with each passing year.

Monetary Impact of DoD-Proposed Fee Adjustment Methodology

Year	Cap at Retired Pay COLA* Percentage	DoD Proposal (tied to HC inflation)**	Difference (loss of purchasing power)	Year	Cap at Retired Pay COLA* Percentage	DoD Proposal (tied to HC inflation)**	Difference (loss of purchasing power)
2012	$520	$520	$0	2029	$859	$3,135	$2,275
2013	$536	$720	$184	2030	$885	$3,329	$2,444
2014	$552	$920	$368	2031	$912	$3,535	$2,624
2015	$568	$1,185	$617	2032	$939	$3,755	$2,815
2016	$585	$1,450	$865	2033	$967	$3,987	$3,020
2017	$603	$1,523	$920	2034	$996	$4,235	$3,238
2018	$621	$1,617	$997	2035	$1,026	$4,497	$3,471
2019	$640	$1,718	$1,078	2036	$1,057	$4,776	$3,719
2020	$659	$1,824	$1,165	2037	$1,089	$5,072	$3,983
2021	$678	$1,937	$1,259	2038	$1,121	$5,387	$4,265
2022	$699	$2,057	$1,359	2039	$1,155	$5,721	$4,565
2023	$720	$2,185	$1,465	2040	$1,190	$6,075	$4,886
2024	$741	$2,320	$1,579	2041	$1,225	$6,452	$5,226
2025	$764	$2,464	$1,701	2042	$1,262	$6,852	$5,590
2026	$787	$2,617	$1,831	2043	$1,300	$7,277	$5,977

2027	$810	$2,779	$1,969	2044	$1,339	$7,728	$6,389
2028	$834	$2,952	$2,117	2045	$1,379	$8,207	$6,828

* Uses DoD actuaries' 3% long-term COLA assumption for military retirement trust fund
**DoD proposal assumes a 6.2% annual health cost inflation factor

The Coalition urges the Subcommittee to reject the DoD proposal to index military health care fees to an index of health cost growth.

Annual Financial Impact of Fee Hikes on Military Families

The following chart highlights how the cumulative impact of the DoD-proposed fee changes would roughly double or triple annual health costs for the bulk of the affected force (grades E-7 to O-4). Cost growth would be significantly larger for grades W-4 and O-5 and above.

This chart assumes average use of medications. Many older families and those with disabled or otherwise at-risk children require significantly more medications, and the proposed doubling and tripling of pharmacy copays would increase those families' annual expenses substantially above those shown in the chart.

The chart also highlights what many overlook – that Medicare-eligibles already are required to pay significant Medicare Part B premiums in addition to the proposed new TFL and pharmacy fees.

Impact of DoD-Proposed FY2013 TRICARE Fees on Military Families (E-7 to O-4)
(Recommended by DoD in the President's Budget)

E-7 / O-4 Retiree* Under Age 65, Family of Three

TRICARE Prime**	Current	FY 2013 Proposed	FY 2017
Enrollment Fee	$520	$720	$1,523
Doctor Visit Copays	$60	$60	$60
Rx Cost Shares***	$408	$744	$1,032
Yearly Cost	***$988***	***$ 1,524***	***$2,615***

Retiree Under Age 65, Family of Three

TRICARE Standard	Current	FY 2013 Proposed	FY 2017
Enrollment Fee	$0	$140	$250
Deductible	$300	$320	$580
Rx Cost Shares***	$408	$744	$1,032
Yearly Cost	***$708***	***$1,204***	***$1,862***

* Enrolled in 2nd Retirement Income Tier (W-4s, O-5s and higher grades would pay even more)

**Enrolled to the network and assumes 5 doctor visits per year.
***Assumes 2 generic and 2 brand name prescriptions per month in retail pharmacy

E-7 / O-4 Retiree* Over Age 65 and Spouse

TRICARE For Life**	Current	FY 13 Proposed	FY 2017
Medicare Part B	$2,398	$2,494****	$2,917****
Enrollment Fee*	$0	$150	$634
Rx Cost Shares***	$756	$1,428	$1,956
Yearly Cost	***$3,154***	***$4,072***	***$5,507***

*Enrolled in 2nd Retirement Income Tier (W-4s, O-5s and higher grades would pay even more)
**Assumes lowest tier Medicare Part B premium for new enrollee in 2012.
***3 generic and 4 brand name prescriptions per month purchased at retail pharmacy
****Assumes Part B increases of 4% per year

Currently Serving Family of Four

TRICARE Standard*	Current	FY 13 Proposed	FY 2017
Enrollment Fee	$0	$0	$0
Deductible	$300	$300	$300
Rx Cost Shares**	$264	$432	$624
Yearly Cost	***$564***	***$732***	***$924***

* Spouse and 2 children use Standard.
**Assumes 2 generic and 1 brand name prescriptions per month at retail pharmacy.

Military vs. Civilian Cash Fees Is "Apple to Orange" Comparison

The Coalition continues to object strongly to simple comparisons of military vs. civilian cash fees. Such "apple to orange" comparisons ignore most of the very great price career military members and families pay for their coverage in retirement.

The unique package of military retirement benefits – of which a key component is a superior health care benefit – is the primary offset provided 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 a grateful Nation provides to the small fraction of the population who agree to subordinate their personal and family lives to protecting our national interests for so many years.

For all practical purposes, those who wear the uniform of their country are enrolled in a 20- to 30-year pre-payment plan that must be completed to earn lifetime health coverage. Once that pre-payment is already rendered, the government cannot simply ignore it and focus only on post-service cash payments – as if the past service, sacrifice, and commitments had no value.

DoD 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.

The Coalition believes the TRICARE fee controversy is caused in part by the lack of any statutory record of the purpose of military health care benefits and the specific benefit levels earned by a career of service in uniform.

Current law gives the Secretary of Defense broad latitude to adjust fees for TRICARE Prime and the pharmacy systems. Absent congressional intervention, the Secretary can choose not to increase fees for years at a time or to triple or quadruple fees, as in this year's budget proposal.

Until a few years ago, this was not a particular matter of concern, as no Secretary had previously proposed dramatic fee increases.

The experience of the recent past – during which several Secretaries proposed no increases and then a new Secretary proposed doubling, tripling, and quadrupling various fees – has convinced the Coalition that current law leaves military beneficiaries excessively vulnerable to the varying budgetary inclinations of the incumbent Secretary of Defense.

It's true that many private sector employers are choosing to shift more healthcare costs to their employees and retirees, and that's causing many still-working military retirees to fall back on their service-earned TRICARE coverage. Fallout from the recession has reinforced this trend.

Efforts to paint this in a negative light (i.e., implying that working-age military retirees with access to civilian employer plans should be expected to use those instead of military coverage) belie both the service-earned nature of the military coverage and the long-standing healthcare promises the government aggressively employed to induce their career service.

The Coalition believes the law should be changed to explicitly acknowledge that:

- ***The healthcare benefit provided for members and families who complete a military career should be among the very best available to any American;***
- ***The decades of service and sacrifice rendered by career military personnel constitute a significant pre-paid premium toward their healthcare in retirement; and***
- ***The large value of this pre-paid premium should be accounted for by minimizing fees payable in retirement and avoiding significant and arbitrary increases from year to year.***

DoD Should Fix Inefficiencies, Not Punish Beneficiaries

Unlike civilian healthcare systems, the military health system is built mainly to meet military readiness requirements rather than to deliver needed care efficiently to beneficiaries.

Each Service maintains its unique facilities and systems to meet its unique needs, and its primary mission is to sustain readiness by keeping a healthy force and sustaining capacity to treat casualties from military actions. That model is built neither for cost efficiency nor beneficiary welfare.

When military forces deploy, the military medical force goes with them, and that forces families, retirees and survivors to use the more expensive civilian health care system in the absence of so many uniformed health care providers. This shift in the venue of care and the associated costs are completely out of beneficiary control.

These military-unique requirements have significantly increased readiness costs. But those added costs were incurred for the convenience of the military, not for any beneficiary consideration, and beneficiaries should not be expected to bear any share of military-driven costs – particularly in wartime.

The Coalition strongly rejects Defense leaders' efforts to seek dramatic beneficiary cost increases as a first cost-containment option rather than meeting their own responsibilities to manage military healthcare programs in a more cost-effective manner.

Instead of imposing higher fees on beneficiaries as the first budget option, DoD leaders should be held accountable for fixing their own management and oversight failures that add billions to defense health costs.

- Decades of GAO and other reports demonstrate DoD cost accounting systems are broken and unauditable.
- More than a dozen reports have recommended consolidated oversight of three separate service medical systems, four major contractors, and innumerable subcontractors that now compete for budget share in counterproductive ways.
- DoD-sponsored reviews indicate more efficient organization could cut health costs 30% without affecting care or beneficiary costs
- DoD's inexplicable refusal to partner with associations to expand mail-order pharmacy above the current low level has cost hundreds of millions per year (each prescription switched from retail to mail saves DoD $125).
- Improve and expand focus on management of chronic diseases.
- Reduce inappropriate and costly emergency room use by expanding clinic hours, urgent care venues, open access appointing, and phone/web-based access to providers after hours.
- Reform the TRICARE contracting and acquisition process.
- Base incentives to providers on quality-driven clinical outcomes that reward efficiency and value.
- Eliminate referral requirements that add complexity and inhibit timely delivery of needed care.
- Fix broken appointing system that inhibits beneficiary access to care.

These are only some of the examples demonstrating that more effective management, oversight and reorganization of military healthcare delivery could dramatically reduce defense health costs without affecting care or costs for beneficiaries.

The Coalition urges the Subcommittee to hold Defense leaders accountable for their own management, oversight, and efficiency failures before seeking to shift more costs to beneficiaries. Congress should direct DoD to pursue any and all options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries.

Wounded, Ill, and Injured Servicemember Care

Though the war in Iraq has officially ended and the country seeks an exit strategy in Afghanistan, the Coalition has great and continuing concerns about the longer-term stability and viability of the policies, programs, and services intended to care and support our wounded, ill, and injured and their families-caregivers.

As the Pentagon marks a decade at war, seamless transition between the Departments of Defense (DoD) and Veterans Affairs (VA) continues to be problematic in many cases for our wounded, ill, and injured troops; disabled veterans; and their family caregivers.

Since 2007, every National Defense Authorization Act has built upon institutionalizing a seamless and unified approach to caring and supporting America's wounded, ill, and injured and their families-caregivers.

TMC acknowledges the significant progress that has been made in caring for our nation's heroes and thanks the Subcommittee for its leadership and oversight on these pressing issues, particularly in the last four years since the Walter Reed scandal that brought to light the flaws and inadequacies of both DoD and VA health care and benefits systems.

But complex challenges remain in overseeing and validating massive policy and program changes among the military services; the DoD; the VA; several Centers of Excellence; a multitude of civilian contractors and non-governmental agencies; and at least six congressional oversight committees.

The Coalition looks forward to continued work with the Subcommittee to address the remaining issues and fully establish systems of seamless care and benefits that support our transitioning wounded warriors and family members.

TMC strongly urges:

- ***Joint hearings by the Armed Services and Veterans Affairs Committees addressing the Joint Executive Council's (JEC) effectiveness in daily oversight, management, collaboration, and coordination of the Departments' wounded warrior programs.***
- ***Permanent funding, staffing, and accountability for congressionally mandated Defense Centers of Excellence and associated mental-behavioral health, suicide prevention, caregiver, respite, and other medical and non-medical programs.***
- ***Continued aggressive oversight of the Integrated Disability Evaluation and legacy disability evaluations systems to ensure preservation of the 30-percent threshold for medical retirement, consistency and uniformity of policies, ratings, legal assistance, benefits, and transitional services Defense-wide.***

DoD – VA Seamless Transition

Institutional Oversight – While many legislative changes have improved the care and support of our wounded, ill, and injured servicemembers, the Coalition is concerned that the sunset in law of the DoD-VA Senior Oversight Committee (SOC) poses significant risks for effective day-to-day leadership and coordination of DoD and VA seamless transition efforts. While an informal SOC exists, the Pentagon has relegated responsibility and authority to lower levels of the agency, making it difficult for senior official involvement and oversight on these matters and limiting the Department's ability to fully establish a synchronized, uniform and seamless approach to care and services.

Previously, the Coalition has expressed concern that the change of Administration posed a significant challenge to the two departments' continuity of joint effort, as senior leaders whose personal

involvement had put interdepartmental efforts back on track left their positions and were replaced by new appointees who had no experience with past problems and no personal stake in ongoing initiatives.

Unfortunately, those concerns were realized, as many appointive positions in both departments went unfilled for long periods, requiring reorganization of responsibilities and entry of new people with little or no background or authority to engage systems and continue to move forward.

While many well-meaning and hard working military and civilians are doing their best to keep pushing progress forward, leadership, organization, and mission changes have left many leaders frustrated with the process.

The Coalition urges joint hearings by the Armed Services and Veterans Affairs Committees to assess the effectiveness of current seamless transition oversight efforts and systems and to solicit views and recommendations from DoD, VA, the military services, and non-governmental organizations concerning how joint communication, cooperation, and oversight could be improved.

In addition, the hearings should focus on implementation progress concerning:

- ***Single separation physical;***
- ***Single, integrated disability evaluation system;***
- ***Bi-directional electronic medical and personnel records data transfer;***
- ***Medical centers of excellence responsibilities vs. authority, operations, and research projects;***
- ***Coordination of care and treatment, including DoD-VA federal/recovery care coordinator clinical and non-clinical services and case management programs; and***
- ***Consolidated government agency support services, programs, and benefits.***

Continuity of Health Care – Transitioning between DoD and VA health care systems remains challenging and confusing to those trying to navigate and use these systems. Systemic, cultural, and bureaucratic barriers often prevent the service member or veteran from receiving the continuity of care they need to heal and have productive and a high level of quality of life they so desperately need and desire.

Service members and their families repeatedly tell us that DoD has done much to address trauma care, acute rehabilitation, and basic short-term rehabilitation. They are less satisfied with their transition from the military health care systems to longer-term care and support in military and VA medical systems.

We hear regularly from members who have experienced significant disruptions of care upon separation or medical retirement from service.

One is in the area of cognitive therapy, which is available to retired members under TRICARE only if it is not available through the VA. Unfortunately, members are caught in the middle because of differences between DoD and VA authorities on what constitutes cognitive therapy and the degree to which effective, evidenced-based therapy is available.

Action is needed to further protect the wounded, ill, injured, and disabled. The Subcommittee has acted previously to authorize three years of active-duty-level TRICARE coverage for the family members of

those who die on active duty. The Coalition believes we owe equal transition care continuity to those whose service-caused illnesses or injuries force their retirement from service.

The Coalition recommends:

- ***Authorizing service-disabled members and their families to receive active-duty-level TRICARE benefits, independent of availability of VA care for three years after medical retirement to help ease their transition from DoD to VA.***

- ***Ensuring Guard and Reserve members have adequate access and treatment in the DoD and VA health systems for Post Traumatic Stress Disorder and Traumatic Brain Injury following separation from active duty service in a theatre of operations.***

DoD-VA Integrated Disability Evaluation System (IDES) – One of the most emotional issues that emerged from the Walter Reed scandal was the finding that services were "low-balling" disabled servicemembers' disability ratings, with the result that many significantly disabled members were being separated and turned over to the VA rather than being medically retired (which requires a 30% or higher disability rating)—a trend that continues today, especially for those in the Guard and Reserves.

Congress has taken positive steps to address this situation, including establishment of the Physical Disability Board of Review (PDBR) to give previously separated servicemembers an opportunity to appeal too-low disability ratings.

A jointly executed DoD-VA IDES pilot has been implemented and expanded, but experience under IDES has shown that the fundamental goals it was to achieve – to be more streamlined, faster, less complex, and non-adversarial -- have for the most part yet to be realized. The service member, typically without effective assistance, must navigate a still-complex adversarial system that is compromised by incomplete medical evaluations, overlooked conditions, and examinations omitting diagnoses – resulting in gaps in care, delays in decision-making, and lack of timely adjudication.

TMC was further encouraged that wounded, ill, and injured members would benefit from the Dec. 19, 2007 Under Secretary of Defense (Personnel and Readiness) Directive Type Memorandum (DTM) which added "deployability" as a consideration in the DES decision process – permitting medical separation/retirement based on a medical condition that renders a member non-deployable.

Unfortunately, several cases surfaced indicating the Services failed to incorporate the DTM in their DES process. In this regard, many members found "fit" by the PEB have been deemed by the service to be "unsuitable" for continued service – and administratively separated – because the member's medical condition prevents them from being able to deploy or maintain their current occupational skill. The Coalition is grateful to the subcommittee for including provisions in both the FY2011 and FY2012 Defense Authorization Act prohibiting this practice.

Unfortunately, some services still use other loopholes, such as designating disorders as "existing prior to service" – even though the VA rated the condition as "service-connected" and the member was deemed fit enough to serve in a combat zone. The Coalition believes strongly that once we have sent a soldier,

sailor, airman or marine to war, the member should be given the benefit of the doubt that any condition subsequently found should not be considered as existing prior to service.

The Coalition believes strongly that all unfitting "service-connected" conditions as rated by the VA should be included in the DoD disability rating, and any member determined by the parent service to be 30 percent or more disabled should continue to be eligible for a military disability retirement with all attendant benefits, including lifetime TRICARE eligibility for the member and his/her family. We do not support efforts to disconnect health care eligibility from disability retired pay eligibility.

The Coalition also agrees with the opinion expressed by former Secretary Gates that a member forced from service for wartime injuries should not be separated, but should be awarded a high enough rating to be retired for disability.

The Coalition recommends:

- ***Preserving the statutory 30 percent disability threshold for medical retirement in order to provide lifetime TRICARE coverage for those who are injured while on active duty.***
- ***Reforming the DoD disability retirement system to require inclusion of all unfitting conditions and accepting the VA's "service-connected" rating.***
- ***Ensuring any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled service members.***
- ***Eliminating distinctions between disabilities incurred in combat vs. non-combat when determining benefits eligibility for retirement.***
- ***Revision of the VA schedule for rating disabilities (VASRD) to improve the care and treatment of those wounded, ill, and injured, especially those diagnosed with PTSD and TBI.***
- ***Barring designation of disabling conditions as "existing prior to service" for servicemembers who have been deployed to a combat zone.***
- ***Directing DoD to re-engineer and redesign the front end of IDES to (1) better ensure medical evaluations are consistently based on a fully developed, accurate medical summary; (2) permint the servicemember's full participation; (3) afford each individual consistent, effective representation throughout the process; and (4) streamline the system by eliminating the redundancy of dual adjudication of disability.***

Caregiver/Family Support Services – The sad reality is that, for the most severely injured servicemembers, family members or other loved ones are often required to become full-time caregivers. Many have lost their jobs, homes, and savings in order to meet caregiver needs of a servicemember who has become incapacitated due to service-caused wounds, injuries or illness.

The Coalition believes the government has an obligation to provide reasonable compensation and training for such caregivers, who never dreamed that their own well-being, careers, and futures would be devastated by military-caused injuries to their servicemembers.

In 2009, the Subcommittee authorized a special payment to an active duty servicemember to allow compensation of a family member or professional caregiver. The authorized payment was in the same amount authorized by the VA for veterans' aid-and-attendance needs, reflecting the Subcommittee's thinking that caregiver compensation should be seamless when the member transitions from active duty to VA care, as long as the caregiver requirements remain the same.

The Coalition appreciates the Subcommittee's effort to sustain that principle in the FY2011 Defense Authorization Act in terms of caregiver support, and urges additional steps to ensure that non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage are provided health and respite care while the injured member remains on active duty, commensurate with what the VA authorizes for caregivers of wounded, ill, and injured veterans.

In a similar vein, many wounded or otherwise-disabled members experience significant difficulty transitioning to medical retirement status. To assist in this process, consideration should be given to authorizing medically retired members and their families to remain in on-base housing for up to one year after retirement, in the same way that families are allowed to do when a member dies on active duty.

Another important care continuity issue for the severely wounded, ill and injured is the failure to keep caregivers of these personnel involved in every step of the care and follow-up process. Again and again, we are told of clinicians and administrative people who seek to exclude caregiver participation and talk only to the injured member – despite the reality that the injured member may not be capable of remembering instructions or managing their appointments and courses of care. In many cases, this occurs even when the caregiver has a medical power of attorney and other authorities documented in the member's records.

Congress, DoD and the VA have worked to get essential information to the wounded, ill, and injured and their caregivers. Similar efforts are urgently needed to educate medical providers and administrative staff at all levels that the final responsibility for ensuring execution of prescribed regimens of care for severely wounded, ill and injured servicemembers typically rests with the caregivers, who must be kept involved and informed on all aspects of these members' treatment, appointments, and medical evaluations.

The Coalition recommends:

- ***Providing enhanced training of DoD and VA medical and support staff on the vital importance of involving and informing designated caregivers in treatment of and communication with severely wounded, ill, and injured personnel.***

- ***Providing health and respite care for non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage while the injured member remains on active duty, commensurate with what the VA authorizes for eligible caregivers of medically retired or separated members.***

- ***Extending eligibility for residence in on-base facilities for up to one year to medically retired or severely wounded, ill, and injured servicemembers and their families (or until the servicemember receives a VA compensation rating, whichever is longer).***

Guard and Reserve Health Care issues – The Coalition is very grateful for sustained progress in providing reservists' families a continuum of government-sponsored health care coverage options throughout their military careers into retirement, but key gaps remain.

For years, TMC has recommended continuous government health care coverage options for Guard and Reserve (G-R) families. Operational reserve policy during two protracted wars has only magnified that need.

DoD took the first step in the 1990s by establishing a policy to pay the Federal Health Benefits Program (FEHB) premiums for G-R employees of the Department during periods of their active duty service.

Thanks to this subcommittee's efforts, considerable additional progress has been made in subsequent years to provide at least some form of military health coverage at each stage of a Reserve Component member's life, including TRICARE Reserve Select for actively drilling Guard/Reserve families and TRICARE Retired Reserve for "gray area" retirees.

But some deserving segments of the Guard and Reserve population remain without needed coverage, including post-deployed members of the Individual Ready Reserve and early Reserve retirees who are in receipt of non-regular retired pay before age 60.

In other cases, the Coalition believes it would serve Guard/Reserve members' and DoD's common interests to explore additional options for delivery of care to Guard and Reserve families. As deployment rates decline, for example, it would be cost-effective to establish an option under which DoD would subsidize continuation of employer coverage for family members during (hopefully less-frequent) periods of activation rather than funding year-round TRS coverage.

TMC continues to support closing the remaining gaps to establish a continuum of health coverage for operational reserve families.

The Coalition recommends:

- ***Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60***
- ***Authorizing premium-based TRICARE coverage for members of the Individual Ready Reserve after being called to active service for a cumulative period of at least 12 months***
- ***Permitting employers to pay TRS premiums for reservist-employees as a bottom-line incentive for hiring and retaining them.***

- ***Authorizing an option for the government to subsidize continuation of a civilian employer's family coverage during periods of activation, similar to FEHBP coverage for activated Guard-Reserve employees of Federal agencies.***

- ***Extending corrective dental care following return from a call-up to ensure G-R members meet dental readiness standards.***

- ***Allowing eligibility in Continued Health Care Benefits Program (CHCBP) for Selected Reservists who are voluntarily separating and subject to disenrollment from TRS.***

- ***Allowing beneficiaries of the FEHBP who are Selected Reservists the option of participating in TRICARE Reserve Select.***

Additional TRICARE Prime Issues – The Coalition is very concerned about growing dissatisfaction among TRICARE Prime enrollees – which is actually higher among active duty families than among retired families. The dissatisfaction arises from increasing difficulties experienced by beneficiaries in getting appointments, referrals to specialists, and sustaining continuity of care from specific providers.

Increasingly, beneficiaries with a primary care manager in a military treatment facility find they are unable to get appointments because so many providers have deployed, have been gone PCS, or are otherwise understaffed or unavailable.

The Coalition supports implementation of a pilot study by TMA in each of the three TRICARE Regions to study the efficacy of revitalizing the resource sharing program used prior to the implementation of the TRICARE-Third Generation (T-3) contracts under the current Managed Care Support contract program.

The Coalition strongly advocates the transparency of healthcare information via the patient electronic record between both the MTF provider and network providers. Additionally, institutional and provider healthcare quality information should be available to all beneficiaries so that they can make better informed decisions.

We are concerned about the impact on beneficiaries of the elimination of some Prime service areas under the new contract. This will entail a substantive change in health care delivery for thousands of beneficiaries, may require many to find new providers, and will change the support system for beneficiaries who have difficulty accessing care.

To date, largely because of the delay in award of the new contracts, beneficiaries who live in the areas where Prime service will be terminated have not received any information on this and how it may affect them.

The Military Coalition urges the Subcommittee to:

- ***Require reports from DoD and the managed care support contractors on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.***

- ***Require increased DoD efforts to ensure consistency between both the MTFs and purchased care sectors in meeting Prime access standards.***

- ***Ensure timely notification of and support for beneficiaries affected by elimination of Prime service areas.***

Additional TRICARE Standard Issues – The Coalition appreciates the Subcommittee's continuing interest in the specific problems unique to TRICARE Standard beneficiaries. TRICARE Standard beneficiaries need assistance in finding participating providers within a reasonable time and distance from their home. This is particularly important with the expansion of TRICARE Reserve Select and the upcoming change in the Prime Service Areas, which will place thousands more beneficiaries into TRICARE Standard.

The Coalition is grateful that the FY2012 Defense Authorization Act extended through 2015 the requirement for DoD to survey participation of providers in TRICARE Standard.

However, we are concerned that DoD has not yet established benchmarks for adequacy of provider participation, as required by section 711(a)(2) of the FY2008 NDAA. Participation by half of the providers in a locality may suffice if there is not a large Standard beneficiary population, but could severely constrain access in other areas with higher beneficiary density.

The Coalition hopes to see an objective participation standard (perhaps based on the 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 intervention.

Further, the Coalition believes the Department should be required to take action to increase provider participation in localities where participation falls short of the standard.

A source of continuing concern is the TRICARE Standard inpatient copay for retired members, which now stands at $708 per day or 25% of billed charges. The Coalition believes this amount already is excessive, and should be capped at that rate for the foreseeable future.

The Coalition urges the Subcommittee to:

- ***Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future.***

- ***Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation to meet the threshold.***

- ***Require a specific report on provider participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.***

- ***Increase locator support to TRICARE Standard beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.***

Colonel Steve Strobridge (USAF-Ret)
Director, Government Relations, Military Officers Association of America (MOAA); and
Co-Chairman, The Military Coalition

Steve 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 33 military and veterans associations.

DOCUMENTS SUBMITTED FOR THE RECORD

MARCH 21, 2012

Written Testimony on Health Care

Reserve Officers Association of the United States
And
Reserve Enlisted Association

for the

House Armed Services Committee
Subcommittee on Military Personnel

March 21, 2012

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RESERVE STRENGTH. RESERVE LIFE.

The Reserve Officers Association of the United States (ROA) is a professional association of commissioned and warrant officers of our nation's seven uniformed services, and their spouses. ROA was founded in 1922 during the drawdown years following the end of World War I. It was formed as a permanent institution dedicated to National Defense, with a goal to teach America about the dangers of unpreparedness. When chartered by Congress in 1950, the act established the objective of ROA to: "...support and promote the development and execution of a military policy for the United States that will provide adequate National Security." The mission of ROA is to advocate strong Reserve Components and national security, and to support Reserve officers in their military and civilian lives.

The Association's 58,000 members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on Active Duty to meet critical needs of the uniformed services and their families. ROA's membership also includes officers from the U.S. Public Health Service and the National Oceanic and Atmospheric Administration who often are first responders during national disasters and help prepare for homeland security. ROA is represented in each state plus departments in Latin America, the District of Columbia, Europe, the Far East, and Puerto Rico. Each department has several chapters throughout the state. ROA has more than 450 chapters worldwide.

ROA is a member of The Military Coalition where it co-chairs the Tax and Social Security Committee. ROA is also a member of the National Military/Veterans Alliance. Overall, ROA works with 75 military, veterans and family support organizations.

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The Reserve Enlisted Association (REA) is an advocate for the enlisted men and women of the United States Military Reserve Components in support of National Security and Homeland Defense, with emphasis on the readiness, training, and quality of life issues affecting their welfare and that of their families and survivors. REA is the only Joint Reserve association representing enlisted reservists – all ranks from all five branches of the military.

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DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers and Reserve Enlisted Associations are member-supported organizations. Neither ROA nor REA have received grants, sub-grants, contracts, or subcontracts from the federal government in the past three years. All other activities and services of the associations are accomplished free of any direct federal funding.

RESERVE STRENGTH. RESERVE LIFE.

INTRODUCTION

The Reserve Officers Association and the Reserve Enlisted Association thank the Military Personnel subcommittee for the chance to present testimony on behalf of the 1.1 million Ready Reservists affected by medical readiness, and for the retirees of the National Guard and Reserve who continue to be entitled to health care. The Associations also thank the House Armed Services committee as a whole for limiting adjustments to TRICARE Prime enrollment to only an increase at the same percentage as the retiree's cost-of-living (COLA) rate.

Yet, the Department of Defense (DoD) was not satisfied with last year's increase to TRICARE, and has revisited this topic by proposing further increases. The challenge this year is reviewing these increases to TRICARE fees, prescription co-payments and the catastrophic caps, and the establishment of new enrollment structures for TRICARE Standard, and TRICARE for Life.

Both ROA and REA are disappointed that the Pentagon continues to make these recommendations unilaterally and to neither discuss cost sharing with the beneficiary associations, nor heed the sense of Congress as to what direction to take in making adjustments.

We commend your committee on proactively working these health care issues ahead of proposed DoD language. Open communication is key to reducing the angst felt by the beneficiaries that would be directly affected. Further, the serving force is watching how the retirees are being treated to see how this or any administration "keeps the faith" with those who serve.

ROA and REA also appreciate the reassurances that the serving members of the Reserve and National Guard who are TRICARE Reserve Select beneficiaries are excluded from any fee increases being considered just the same as active duty members and their families.

EXECUTIVE SUMMARY

Increasing the cost-share of DoD health care beneficiaries is admittedly an emotional issue. The nation and the Department of Defense are faced with ever increasing health care costs, but this is not simply a budgeting exercise. Because of the dynamics involved, this is an issue that should be resolved by involving all those who are concerned. Here is a summary of the key points as seen by the Reserve Officers Association (ROA) and the Reserve Enlisted Association (REA).

Congress must maintain an oversight over DoD health care, preventing capricious fee increases to beneficiaries.

TRICARE:

- Do not change the Catastrophic Cap of $3000.
    - o If indexed, at no more than COLA adjustments.

TRICARE Prime:

- Continue any adjustment to Prime enrollment based on COLA rates.
- Independently verify the current total cost of DoD health care benefits. Such an audit will permit Congress to validate proposals based on cost-sharing percentages.
- Do not link annual increases to the market-driven national health costs inflation rate, nor Federal Employee Health Benefits Plan (FEHBP).

On Pharmacy Co-payments:

- Any higher retail pharmacy co-payment should not apply on initial prescriptions, but on maintenance refills only.
- To keep co-payments lower, ROA and REA support a mandatory mail-order prescription refill, if an opt-out is permitted.

TRICARE Standard:

- No annual enrollment fee for DoD beneficiaries.
    - Should an enrollment fee be instituted - limit such an enrollment to only a one-time nominal administrative fee.
- No increase to Standard deductible.
    - Higher cost share is already being made by automatic increases to TRICARE Standard through the 25 % copayment as health care costs increase.
    - For individuals or families relying on Standard for medical treatment, it is a more expensive health plan than TRICARE Prime.
    - Should the Standard deductible be increased, by no more than COLA.
- Do not link annual increases to the market-driven national health costs inflation rate, nor Federal Employee Health Benefits Plan (FEHBP).
- Decouple changes to TRICARE Standard deductible from TRS as Reservists pay more upfront.

Reserve Health Care Initiatives:

- Improve continuity of health care for all drilling Reservists and their families by:
    - Permitting active members in the Individual Ready Reserve (IRR) to buy-into TRICARE Reserve Select.
    - Allowing demobilized Retirees and Reservists involuntarily returning to IRR to qualify for subsidized TRS coverage.
    - Providing TRS coverage to mobilization ready IRR members; levels of subsidy would vary for different levels of readiness.
    - Improving post deployment medical and mental health evaluations and access to care for returning Reserve Component members.
    - Providing an option for Reservists where DoD pays a stipend to employers.
- Extend military coverage for restorative dental care following deployment to 90 days.
- Permit beneficiaries of Federal Employee Health Benefit plan the option of subscribing to TRICARE Reserve Select.

TRICARE Retired Reserve (TRR)

- Premiums are too high; to keep TRR viable, premiums must be reduced.
- GAO should audit the assumptions used for TRICARE Retired Reserve premiums.

TRICARE for Life:

- Implement no enrollment fee.
- Do not link annual increases to the market-driven national health costs inflation rate, nor Federal Employee Health Benefits Plan (FEHBP).

TFL beneficiaries are already paying Medicare Part "B", which adds up to more than any other TRICARE beneficiary pays (except for gray area Reservists). In addition, there is means testing, which increase the expense for a number of retirees over age 65.

DISCUSSION

MILITARY HEALTH CARE – a shaky foundation.

For a number of years, the Pentagon has spoken out about the rising costs of health care and the need for reform. This can be noted by statements illustrating that military health costs have increased such as "DoD medical costs have shot up from $19 billion in FY 2001 to $52.5 billion in FY 2012," as made by Deputy Secretary of Defense William J. Lynn, III at a Senate Budget hearing last year.

Health care costs now consume about nine percent of the DoD budget. Yet comparisons of health care costs are distorted by beginning with a peacetime starting point followed by a decade of war. Still judging from what has been said to both Congress and the press, it would seem that many in the Pentagon are attributing the increases in military health care to its retirees, especially those working second careers. A break out of beneficiary medical expense totals have not been provided by the Pentagon.

This is why DoD needs to publish a breakdown of its OCO and baseline health care costs. The department has said it will cost a billion dollars to perform such an audit and won't have anything before 2014.

Congress needs to continue to ask the Pentagon for a financial breakdown. An independent audit by the Government Accountability Office (GAO) or another agency would allow Congress an opportunity to validate proposals based on financial benchmarks rather than DoD speculation.

DoD officials continue to tout that "working-age retirees" (those younger than 65) should use their employer's health care. The Congressional Budget Office predicts that if TRICARE fees go up, 60 percent of the beneficiaries would leave TRICARE, providing the Pentagon with long sought after savings. There is fallacy in this argument. Recent changes to the TRICARE structure have only driven beneficiaries to TRICARE Prime which is more expensive for the Government.

The Pentagon's public campaign for health care reform has undercut its credibility with serving members, retirees and beneficiary associations in what has been said, what has been budgeted, and what still might be planned.

The Reserve Officers Association was among the first associations to be open to a relook on cost sharing for TRICARE beneficiaries. Unfortunately, ROA's position has grown less flexible as DoD demands have grown more costly to beneficiaries.

HEALTH CARE COST DISCUSSION

The Reserve Officers Association and the Reserve Enlisted Association would like to thank Congress for its continued involvement on DoD health care issues and hope it remain a leading partner on these issues.

ROA and REA applaud the efforts by Congress to address the issue of increasing Department of Defense health care costs and its interest to initiate dialogue and work with both the Pentagon and the beneficiary associations to find the best solution. The time has come to examine the cost of TRICARE and the level of beneficiary contribution.

It is important to sustain the DoD health care as a deferred benefit for our serving Active and Reserve Component members and their families. While retired, these beneficiaries have accepted risks and made sacrifices in their earlier military careers that have not been asked of the remaining 99 percent of the nation's population. TRICARE fulfills an on-going promise by the government for continued health care to those who have served or are serving.

ROA and REA are committed to our membership to sustain this health care benefit. DoD, Congress and the beneficiary associations need to work together to find a fair and equitable solution that protects our beneficiaries and ensures the financial viability of the military health care system for the future. ROA and REA remain open to discussions on cost-sharing.

Of concern is a proposal to index future increases. DoD suggests that cost indexing be based on the national health costs inflation rate. Military retirees face different health issues than the national average. Twenty to thirty years of physical training requirements makes it a healthier population than the nation as a whole.

ROA and other associations are advocating that no change be made to the adjustments of the annual TRICARE Prime enrollment fee, allowing only an increase at the same percentage as the retiree's cost-of-living (COLA). Cost of living is actually rising higher than what COLA adjusts for.

The actual inflation rate is higher than how COLA is calculated. While COLA adjustment increased by 3.6 percent, everyday prices rose 7.2 percent in past year, according to the American Institute for Economic Research.

ROA and REA share the concern that any process used should be a fair and equitable approach where retiree's won't be overburdened.

RESERVE COMPONENT HEALTH CARE DISCUSSION

The Pentagon views TRICARE as a health care plan, and Reserve TRICARE as a health care insurance. Because words create paradigm, Reserve health care is treated by DoD entirely different than active duty health care. The differences are easily noted: Active duty members enroll in a benefit with deductibles and co-payments; Guard and Reserve members "purchase" a premium based health plan. The following are suggested improvements.

1. ROA and REA still hold concerns over the implementation of TRICARE for gray area retirees. Because DoD treated Reserve gray area retirees as a separate health care risk group,

health care premiums proved higher than expected. Because of the expense, enrollment is low. It is likely just being used by those with health care problems, who can't afford health care from other sources. If the program is not changed it will have a similar success to mobilization insurance.

ROA and REA hope that the committee will request a Government Accountability Office review of the process that determined the published premium levels.

2. Seamless Transition. Service members should not have to navigate through bureaucracy to receive care or benefits. Every time a Reserve Component member transitions into a new category of health care, he or she is required to reenroll in the new program. Even those who are beneficiaries of TRICARE Reserve Select (TRS) need to do an administrative transition between TRS, TRICARE once mobilized, into Transitional Assistance Management Program (TAMP) and back onto TRS. And once retired, there is additional transition into TRICARE Retired Reserve, and the latter TRICARE retiree health care. Add to this the additional health care provided by the Department of Veteran Affairs, and there are gaps in health care as a Reserve Component or family member moves between programs.

3. Employer health care option: DoD could pay a stipend to employers of deployed Guard and Reserve members to continue employer health care during deployment. G-R family members are eligible for TRICARE if the members' orders to Active Duty are for more than 30 days; but some families would prefer to preserve the continuity of their own health insurance. Being dropped from private sector coverage as a consequence of extended activation adversely affects family morale and military readiness and discourages some from reenlisting. Many G-R families live in locations where it is difficult or impossible to find providers who will accept new TRICARE patients. This stipend would be equal to DoD's contribution to Active Duty TRICARE.

ROA and REA continue to support an option for individual Reservists where DoD pays a stipend to employers

4. Dental Readiness. Currently, dental readiness has one of the largest impacts on mobilization. The action by Congress in the FY-2010 NDAA was a good step forward, but still more needs to be done.

The services require a minimum of Class 2 (where treatment is needed, however no dental emergency is likely within six months) for deployment. Current policy relies on voluntary dental care by the Guard or Reserve member. Once alerted, dental treatment can be done by the military, but often there isn't adequate time for proper restorative remedy.

ROA and REA continues to suggest that the services are responsible to restore a demobilized Guard or Reserve member to a Class 2 status to ensure the member maintains deployment eligibility.

Because there are inadequate dental assets at Military Treatment Facilities for active members, active families, and reservists, **ROA and REA further recommend that dental restoration be included as part of the six month TAMP period following demobilization**. DoD should cover full costs for restoration, but it could be tied into the TRICARE Dental program for cost and quality assurance.

5. IRR Access to TRS: Not everyone who drills is eligible for TRS. All services offer drilling for points without pay. These members are in the IRR. The Navy has Voluntary Training Units

that drill monthly. The Air Force and Army have non-paid Individual Mobilization Augmentees (IMA). The Army also has a group within the IRR body that has agreed to mobilization during their first two years.

The Army, the Marine Corps and the Navy have mobilized Reservists out of the Individual Ready Reserve. Under current law, unless these RC members are given an opportunity to join the Selected Reserve, they are not eligible to purchase TRS.

ROA and REA feel that IRR members should be eligible for TRS (not TRR.) They could qualify if they sign an agreement of continued service and complete a satisfactory year of training and satisfy physical standards. A satisfactory year could be defined either by points or by training requirements, as defined by each Reserve Chief.

ROA and REA recommend legislation to allow IRR buy-in to TRICARE Reserve Select.

CONCLUSION

ROA an REA reiterate their profound gratitude to the subcommittee for addressing the health care issues. The process that we develop and what we decide upon this year for TRICARE fees and sustained benefits reflects not only our recognition of retired members for their service to the nation, but is a dedication to the warriors of the future.

Service members deserve the best medical care that the nation can offer. Health care services are vital to keeping the nation's military force strong and ready. As a deferred benefit, it serves as a recruiting as well as a retention tool, as the willingness of the young to serve will depend on how they perceive the treatment and appreciation given to earlier veterans.

When a nation puts members of its military at physical risk from disease and traumatic injury it absolutely owes them health care not health insurance.

ROA and REA strongly urge that when all cost-sharing is finally taken into account, our beneficiaries must receive the DoD provided health care for which they are entitled.

Statement for the Record

of the

NATIONAL MILITARY FAMILY ASSOCIATION

Before the

Subcommittee on
Military Personnel

of the

UNITED STATES HOUSE OF REPRESENTATIVES
ARMED SERVICES COMMITTEE

March 21, 2012

Not for Publication
Until Released by
The Committee

The National Military Family Association is the leading nonprofit organization committed to strengthening and protecting military families. Our over 40 years of accomplishments have made us a trusted resource for families and the Nation's leaders. We have been at the vanguard of promoting an appropriate quality of life for active duty, National Guard, Reserve, retired service members, their families and survivors from the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

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

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

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

Chairman Wilson, Ranking Member Davis, and Distinguished Members of the Subcommittee, the National Military Family Association thanks you for the opportunity to present testimony for the record concerning the quality of life of military families – the Nation's families. After almost 11 years of war, we continue to see the impact of repeated deployments and separations on our service members and their families. We appreciate your recognition of the service and sacrifice of these families. Your response through legislation to the increased and ever-changing need for support has resulted in programs and policies that have helped sustain our families through these difficult times.

We recognize the emphasis the Administration is placing on supporting military families. The work of Mrs. Obama and Dr. Biden in raising awareness of the sacrifices military families make has been well-received by the Nation and appreciated by our families. The *Joining Forces* initiative calls the American people to action in supporting military service members and their families. It is helping more Americans understand how 1 percent of our population in the United States is being called upon to bear 100 percent of the burden of defending our Nation, giving up years of family life together, and how they need the support of the other 99 percent of Americans to continue carrying that burden. But all Americans must also understand that military service members and their families are still serving, in Afghanistan, in contingency operations throughout the world, and by maintaining readiness for unknown contingencies in the future.

We endorse the recommendations contained in the statement submitted by The Military Coalition on personnel issues and health care.

Our Nation's military is facing challenges after 11 years of war. As some of the troops come home, many will find realigning the work/ life balance as a family may not be easy. Military families worry that budget cuts will affect the service member and erode the foundation of support they have relied on. Our Association believes that the Federal government has an inherent responsibility to provide support for military families and to ensure the readiness of the service member.

To address the challenges facing our Nation and its military families this year, our Association has identified critical priorities and will address them in the first pages of this statement. We also feel we have an obligation, as the only organization that speaks for the families of all components, retirees and survivors, to bring to your attention other issues of concern and, in some cases, let you know how legislation you have championed in the past has made an impact on their lives. We know our statement is lengthy. Military families love to share their stories. We want to share their stories with you.

Family Readiness

We remain a Nation at war. The readiness of service members and the families that support them needs to be at the forefront. Families rely on a foundation of support: accessible quality health care, responsive behavioral health support, spouse employment options, quality children's education, comprehensive child care, a secure retirement, and unwavering support when wounded, widowed, or orphaned. Military families should be able to access some level of this support no matter where they live – in the United States or overseas.

With the change in mission and expected reduction of forces, some families will be forced to make unexpected transitions. Some may enter a world filled with uncertainties, especially in the area of employment. Those who make the military a career also face uncertainties as they perceive threats to their retirement benefits. A review of the military retirement system must be made within the context of the entire military compensation package. It should recognize the service of those who don't or can't make the military a career.

Our Nation's warriors are returning to their families after multiple deployments and frequent separations. Our research shows children are especially affected by repeated separations from their mom or dad, and by how well their parent/ caregiver has handled deployments. We cannot begin to anticipate the long-term impact on our families. The ability to achieve and maintain a work/ life balance needs to include time for reintegration for all families, including those of the wounded, ill, and injured.

Reintegration Support

Military families have been living a revolving door existence for the past 11 years. They have experienced repeated deployments, each the same with the strains of separation, but unique with the dynamic of their family at that moment in time. They have had repeated reunions, honeymoons followed by the hard work of rebuilding their family. As they rebuilt, nagging in the back of their mind was the

thought that soon their family would be doing this again. Family members of single service members can find themselves experiencing reintegration with their families long distance.

The Services have addressed reintegration needs by providing service members with resilience training through programs like the Army Comprehensive Soldier Fitness program, presently being adopted by the Air Force as well. The establishment of resilience centers on installation serves as a one-stop shop for access to counseling, chaplains and other wellness programs. The Army and Air Force are encouraging spouses to participate in the online evaluation and training sessions and have master trainers available at Family Support Centers. This may prove to be a good tool for the long term.

Reintegration programs become a key ingredient in the family's success. Our Association believes we need to focus on treating the whole family with programs offering readjustment information, education on identifying stress, substance abuse, suicide, and traumatic brain injury, and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties. We appreciate the inclusion in the National Defense Authorization Act Fiscal Year 2010 (NDAA FY10) for education programs targeting pain management and substance abuse for families, especially as the Department of Defense (DoD) reports an increase in medication-related deaths and prescription-related substance use. We recommend Congress request DoD report on its outreach and the effectiveness of its educational programs in addressing this issue.

Successful reintegration programs will require attention over the long term, as well as a strong partnership at all levels between the various mental health arms of DoD, Veterans Affairs (VA), and State agencies. DoD and VA need to provide family and individual counseling to address these unique issues. Opportunities for the entire family, and for the couple to reconnect and bond must also be provided. Our Association has recognized this need and established family retreats under our *Operation Purple*® program in the National Parks, promoting family reintegration following deployment.

Expand and support strong and effective reintegration programs for families of all Services and Components.

Recommend Congress request DoD report on its outreach and the effectiveness of its educational programs in addressing readjustment information and services.

National Guard and Reserve

During the past 11 years of war, our Nation has relied on the services of the National Guard and Reserve more than ever before. Our Association appreciates the great strides made by both Congress and the Services to help support our Reserve Component families. We believe sustaining effective support programs for our "Citizen Soldiers" and their families is essential at every stage of deployment. We ask Congress to provide funding for preventive and follow-up counseling and behavioral health services for mobilized Reserve Component members and their families.

Our Association also appreciates Congress authorizing travel and transportation for Uniformed Services members and up to three designees to attend Yellow Ribbon events. We appreciate the provision enhancing the Yellow Ribbon Program by authorizing Service and state-based programs to provide access to all service members and their families. We ask you continue funding this quality of life program for Reserve Component families.

Our Association has long recognized the unique challenges our National Guard and Reserve families face. They are geographically dispersed, live in rural areas, and have service members deployed as individual augmentees. Although family support programs have been strengthened, these programs may not be close enough to access. These families need more education on leveraging community resources with available military resources.

Provide funding for preventive and follow-up counseling and behavioral health services for mobilized Reserve Component members and their families.

Continue funding the Yellow Ribbon program and stress the need for greater coordination of resources supporting our Reserve Component families.

Behavioral Health Care

Our Nation must help returning service members and their families cope with the aftermath of war. DoD, VA, and State agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs, especially during transition from active duty to

veteran status (voluntary or involuntary) and Permanent Change of Station (PCS) moves. Partnering will also capture the National Guard and Reserve member population, who often straddle these agencies' health care systems.

Full Spectrum of Care

As the war continues, the call from families who need a full spectrum of behavioral health services—from preventative care and stress reduction techniques, to counseling and medical managed behavioral health services—is growing louder. The military offers a variety of psychological health services, both preventative and treatment, across Services, agencies, and a variety of programs. However, as service members and families experience numerous lengthy and dangerous deployments, we believe the need for confidential, preventative, and psychological health services will continue to rise. More importantly, this need will remain high even after military operations scale down.

Our Association applauds DoD and Senior leadership initiatives in addressing stigma around seeking behavioral health services for service members, Guardsmen, and Reserves. However, stigma still exists for spouses and their children. At a recent military spouse symposium, several spouses described their concerns with seeking treatment. They feared it would negatively impact their service member's promotion. Two spouses stated the Command was called by the counselor after they sought care at their Service's family support center. Spouses frequently tell us they don't know what is out there for help even though there are so many available programs. It is hard to find support when military families are having emotional difficulties or substance abuse issues because they live so far away from their loved ones who can assist with interventions. Stigma about seeking treatment is not openly discussed, but it exists and DoD needs to address it.

In the research they conducted for us, RAND found military children reported higher anxiety signs and symptoms than their civilian counterparts. A recent study by Gorman, et. al (2010), *Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints,* found an 11 percent increase in outpatient mental health and behavioral health visits for children from the ages of 3-8 during 2006-2007. Researchers found an 18 percent increase in pediatric behavioral health visits and a 19 percent increase in stress disorders when a parent was deployed. Additional research has found an increase in mental health services by non-deployed spouses during deployment. A study of TRICARE claims data from 2003-2006 published last year by the *New England Journal of Medicine* showed an increase in mental health diagnoses among Army spouses, especially for those whose service members had deployed for more than one year.

Our research also found the mental health of the caregiver directly affects the overall well-being of the children. Therefore, we need to treat the family as a unit as well as individuals. Communication is key in maintaining family unit balance. Our study also found a direct correlation between decreased communication and an increase in child and/ or caregiver issues during deployment. Research is beginning to validate the high level of stress and mental strain our military families are experiencing. The answer is making sure our families have access to behavioral health providers.

Recommend an extended outreach program to service members, veterans, and their families of available psychological health resources, such as DoD, VA, and State agencies.

Encourage DoD to include families in its Psychological Health Support survey and perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members).

Suicide

Our Association recognizes the action being taken by the Services and the VA to address the rising number of suicides in active duty, National Guard and Reserve members, and veterans. We appreciate the Army's suicide report and the *DoD Suicide Prevention Task Force* report. However, we are concerned that military and veteran families were not included when examining suicides. We have no data showing whether families are also experiencing a rise in suicides and outpacing their civilian counterparts. Therefore, we recommend Congress require a DoD report on the number of family members who committed suicide, made a suicide attempt, or reported suicidal thoughts.

We encourage Congress to direct DoD to include a brief mental health assessment of military families each time they visit their primary health care provider. Providers should inquire about whether or not the family is experiencing a loved one's deployment. We also recommend DoD offer a type of pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members).

Recommend Congress require a DoD report on the number of family members who have committed or attempted suicide.

Downsizing

While we are aware that the downsizing of the force has already begun, we want to highlight the effect on service members and their families whether they leave the service or stay. The editors of the March 19th editions of the various *Military Times* newspapers emphasized the toll these 11 years of war have taken on families. Quoting from their most recent *Military Times* Poll, active duty troops who say they are satisfied with their marriages, dropped 9 points since 2011 to 85%. The editorial also stated

> *The Marine Corps is shedding 20,000 people and fanning out to more deployment locations in the Pacific. The Navy is moving to longer sea tours. Places like the Philippines and Africa loom a new deployment destinations.*
> *To their credit, military leaders are trying to address dwell times between deployments and the need for stronger family support programs. ....**A shrinking force will be a busier force – and that could prove tough on families.***

Our Association agrees. It is another reminder that family support programs need to be sustained to support readiness. As the Army takes on a more expeditionary role to Europe and Korea, families left behind will need to rely on Family Readiness Groups (FRGs) and other support services. While service members will not be at war, they will be away from their families. The need for support programs will remain.

And what of those who are being asked to leave? While DoD and the Services talk about an upgraded Transition Assistance Program (TAP), more emphasis should be placed on attendance by the spouse of the separating service member at these sessions. Military spouses should be encouraged to take advantage of programs like the Military Spouse Employment Partnership to help with their employment planning. We hope that an appropriate lead time will be given to separating service members to help with planning. We also recommend that transitional compensation and health care coverage be made available to help ease the cross over to civilian life.

Provide compensation and transitional health care coverage for service members who are being released from service due to downsizing.

Encourage the Services to make TAPS training more accessible for military spouses.

TRICARE Cost Saving Strategies in the 2013 Budget

DoD's proposed TRICARE changes include a change in enrollment fees for TRICARE Prime for under age 65 retirees and the implementation of a first-ever enrollment requirement along with a fee for TRICARE Standard/ Extra and TRICARE for Life (TFL). DoD also proposed additional changes to pharmacy co-pays and limited access to non-formulary retail medications. DoD states it will incur savings through better management of health care costs, but also highlights the "savings" it will gain through beneficiary fee increases. We believe, however, that the dramatic fee increases proposed for TRICARE Prime and the new fees for TRICARE Standard/ Extra and TFL are not real "savings" at all, but simply a cost shifting to beneficiaries.

Moreover, as evidenced by last year's GAO Report *"Prohibition on Financial Incentives That May Influence Health Insurance Choices for Retirees and Their Dependents under Age 65"* (GAO-11-160R, Feb 16, 2011) and a February 22, 2012 report from the Congressional Budget Office, DoD has no clear indicator of what drives beneficiaries away from using their TRICARE benefit and choosing other insurance. When faced with increased costs to their employee health care and an ineligibility to use TRICARE standard as a second payer, both reports infer that many under age 65 retirees migrated to TRICARE Prime, resulting in higher costs to DoD. A TRICARE Standard enrollment fee combined with the cost of employer provided care or private TRICARE supplemental insurance and no managed care or guaranteed access to care, may drive more beneficiaries in this age category to Prime.

Our Association has always supported a mechanism to provide for modest increases to TRICARE Prime enrollment fee for retirees under age 65. TRICARE Prime, the managed care option for military beneficiaries, provides guaranteed access, low out of pocket costs, additional coverage, and more continuity of care than the basic military health benefit of TRICARE Standard/ Extra and TFL. We have never supported an enrollment fee for TRICARE Standard/ Extra or TFL because these programs lack the

same guarantees attached to TRICARE Prime. There is no added benefit to the beneficiary, just an added cost. It appears this is strictly a financial decision in order to bring in more revenue.

We oppose DoD's is proposed tiered enrollment fees for TRICARE Prime and TFL based on retiree income. Civilian health care plans offer a variety of options at different premium levels. However in the civilian market, higher premium fees are tied to added benefits or coverage. DoD's proposal calls for TRICARE beneficiaries to pay a higher enrollment fee tied to their retirement income for identical TRICARE coverage. Again, it appears DoD's proposed tiered fees are simply a financial decision.

We appreciate that DoD did not propose any changes to the TRICARE benefit for active duty members, did not include a TRICARE enrollment fee for active duty family members, and ensures FY13 TRICARE enrollment fee changes will not apply to medically retired service members and survivors of active duty service member deaths.

While we have always supported a mechanism for modest TRICARE Prime increases, we have concerns regarding DoD's selection of a civilian-based index in determining TRICARE enrollment fee increases after October 2012. We object to DoD's proposed use of a civilian index because we believe health care experts cannot agree on an accurate index on which to base civilian health care yearly cost increases. Our Association has always supported the use of Cost of Living Allowance (COLA) as a yearly index tied to TRICARE Prime retiree enrollment fee increases. We believe if DoD thought the rate of $230 for individual and $460 for family was appropriate in 1995, then yearly increases tied to COLA would maintain that same principle. If DoD had used COLA from the beginning to increase TRICARE Prime enrollment fee for retirees and their families, it would have been $339 for individual and $678 for family in 2012, more than DoD's proposed Tier 1 fee. We applaud the Congressional mandate in NDAA FY11 to tie TRICARE Prime fees to COLA. We believe increases tied to COLA are the most fair to beneficiaries and predictable for DoD.

Recommend future increases to TRICARE Prime enrollment fees for working age retirees be indexed to retired pay cost of living adjustments as it is currently required by law.

Oppose an enrollment fee for TRICARE Standard/Extra for working age retirees and Medicare eligible TFL beneficiaries.

Recommend that Medicare-eligible beneficiaries using the USFHP be allowed to remain in the program.

Include consideration of health care cost adjustments as part of a larger study of overall military compensation.

Other Cost Saving Proposals

We ask Congress to establish better oversight for DoD's accountability in becoming more cost-efficient. We recommend:

- Require the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality health care in a cost-effective manner
- Create a committee, similar in nature to the Medicare Payment Advisory Commission, to provide oversight of the DoD Military Health System (MHS) and make annual recommendations to Congress. *The Task Force on the Future of Military Health Care* often stated it was unable to address certain issues not within their charter or within the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.
- Reform the Governance Structure of MHS. The Defense Health Board in 2006 and 2009 and the U.S. House Armed Service Committee's NDAA FY11 and FY12 proposed the establishment of a Unified "Joint" Medical Command, which our Association has supported as well.

Our Association believes right-sizing to optimize MTF capabilities through innovative staffing methods; adopting coordination of care models, such as medical home; timely replacement of medical facilities utilizing "world class" and "unified construction standards;" and increased funding allocations would allow more beneficiaries to be cared for in the MTFs. This would be a win-win situation because it increases MTF capabilities, which DoD asserts is the most cost effective. It also allows more families, who state they want to receive care within the MTF, the opportunity to do so. We support the *Task Force on the Future of Military Health Care* recommendations to make the DoD MHS more cost-efficient. They conclude the MHS must be appropriately sized, resourced, stabilized, and make changes in its business and health

care practices. We encourage Congress to include the recommendations of the Task Force in the year NDAA FY13. These include:

- Restructure TMA to place greater emphasis on its acquisition role
- Examine and implement strategies to ensure compliance with the principles of value-driven health care
- Incorporate health information technology systems and implement transparency of quality measures and pricing information throughout the MHS (This is also a civilian health care requirement in the recently passed *Patient Protection and Affordable Care Act*.)
- Reassess requirements for purchased care contracts to determine whether more cost effective strategies can be implemented

We support TMA's movement toward a medical home model of patient and family-centered care within the direct and purchase care systems. An integrated health care model, where beneficiaries will be seen by the same health care team focused on well-being and prevention, is a well-known cost saver for health care expenditures. Our concern is with the individual Services' interpretation of the medical home model and its ability to truly function as designed. Our MTFs are still undergoing frequent provider deployments; therefore, the model must be staffed well enough to absorb unexpected deployments to theater, normal staff rotation, and still maintain continuity of providers within the medical home.

We support DoD's interest to reform the governance structure of MHS. The establishment of a Defense Health Agency and its ability to provide efficiencies is still being evaluated by the Government Accountability Office. However, we have some concerns with the governance reform chosen by DoD. We believe it has not gone far enough to include all of the needed changes to capture maximum efficiencies across the MHS. We look forward to discussing potential options with Members of Congress.

Military Compensation

In their recent testimony before the House Appropriations Committee's Military Construction, Veterans Affairs and Related Agencies Subcommittee, the Senior Enlisted Advisors of all Services spoke of a recent phenomenon they had all experienced. The Defense Business Board's presentation on *Modernizing the Military Retirement System* had prompted concerns among all levels of the enlisted and non-commissioned officer ranks. What they heard was "what's going on with my retirement?" They heard it everywhere they traveled. The Senior Enlisted Advisors passed that concern on to the members of the Subcommittee, stressing that the force did not need the added distraction in the field about whether the retirement system would be there for them after 11 years of war.

The Defense Business Board, which advises the Secretary of Defense, recommends eliminating the current retirement system that awards half of base pay for life to a service member who retires after 20 years of active service. Instead, the Board recommends a new defined-contribution plan for currently-serving and future service members, which would require service member and DoD contributions to the Federal Thrift Savings Plan (TSP). DoD contributions per service member could vary, with the prospect of larger contributions for personnel in risky assignments, on hardship tours, or in critical specialties. Under the Board's proposal, service members would be vested in the plan after 3 to 5 years and could take their TSP savings with them when leaving the military. But they would not be able to receive payouts from the TSP until age 60 or 65. Current retirees would not be affected by this proposal.

In an environment of defense budget cuts, military families wonder how soon this plan might be implemented and how they might be affected given their service member's time in the military. Among the most worried are the currently-serving members who've built their retirement planning on expectations about the existing system. We've heard several references to "promises broken" from members of the military community.

This reaction underlines the need for a broad review of the military retirement system. Our Association believes retirement is only one part of what must be a complex and comprehensive review of the military compensation system. That system and the benefits it provides must reflect the demands of service on service members and their families and enable DoD to recruit and retain the highly-skilled, dedicated people it needs to fight our Nation's wars and protect our security. We appreciate the Defense Business Board's recognition that most service members do not stay long enough to retire. Service members who have served five, ten, or 15 years should be able to leave service with some kind of start on their retirement savings, especially in times like the past 11 years of war with repeated deployments. With the plans to downsize, personnel who may want to stay to retirement may not be able to do so. Having a flexible compensation system that includes the option to provide retirement savings to people

forced out because of periodic force strength reductions may provide a welcome retirement nest egg to these former service members and their families who must start over in another job.

This review will be complex. We disagree with the proposed BRAC-like legislative process proposed by the Administration. This would not allow the opportunity for thorough consideration by the Armed Services Committees.

Call for a comprehensive review of the military compensation system, including health care benefits.

Family Readiness and Support

Family Support

During deployments and often between deployments, military spouses have come to rely on the support from Family Support Centers. They've come to understand and make better use of benefits when they attend family support programs. In talking with the Services, we have heard of cuts in child care for volunteers, reduced curriculum materials for marriage enrichment programs, and significant reductions to chapel program budgets. We hear of other ways that family programs are being short-changed. Installation commanders may try to make up for budget shortfalls, either because of the Continuing Budget Resolutions of last year or in anticipation of cuts for FY13. Staff members have been cut from family service centers, causing reduction in services. Family members who have been trained and participate in family support programs have better experiences with deployment and have fewer problems. DoD and the Services talk of eliminating the programs that are redundant and keeping the ones that work. Without a staff to run them, how will families access any of them?

Cuts to installation budgets affect the quality of life of service members and families in other ways. We are hearing from families and program staff that some families who have been waiting on housing lists for months must now pay for their own moving expenses when their turn finally comes up. This type of move had previously been provided through installation funds. Living an hour away from the installation, with added expenses for a short while, seemed a good trade-off for the opportunity to live in installation housing for the majority of their tour. The cost of moving may make it prohibitive to make the move to the installation. Will those families fall behind financially?

Installation commanders need to make the difficult choice of reducing hours or closing valued services such as libraries and gyms. These are services that consistently show up as highly valued by service members and their families.

Senior leadership recognizes family support is extremely important but continually reminds families of the need to "tighten our belts". Families do not feel valued when their programs are cut. We know it will take time to fine tune the right mix of programs and the expectations of the families. We ask for funding to sustain effective family support programs critical to family readiness.

Fund family support programs to address the changing needs of military families.

Child Care

Our Association appreciates the efforts of Congress and the Department of Defense (DoD) to ensure that military families have access to high quality child care. Child care concerns used to be the number one complaint we heard from families. This is no longer true. Our military families enjoy a plethora of choices including drop-in and 24-hour care, and choose between care in Child Development Centers or in Family Care homes. We also have several services available to help us find child care in our local communities through the National Association of Child Care Resource and Referral Agencies (NACCRRA) and SitterCity. The Department of Defense (DoD) and the Services continue to take innovative steps to address concerns as they arise.

The Department of Defense is running a pilot initiative in thirteen states aimed at improving the quality of child care within communities. This investment translates into increased child care capacity for military families living in geographically dispersed areas. DoD is contracting with SitterCity.com to help military families find caregivers and military subsidized child care providers. The military Services and NACCRRA continue to partner to provide subsidized child care to families who cannot access installation based child development centers.

In February, the GAO released the report required by the National Defense Authorization Act (NDAA) Fiscal Year 2010 (FY10) on financial assistance provided for child care costs across the Services and Components to support the families of service members deployed in support of a contingency operation. The report details the steps DoD and the Services are taking to address family concerns with regards to accessibility and quality.

The Mental Health Needs of Military Children

Our Association is concerned about the impact of deployment and/ or the injury of the service member is having on our most vulnerable population, children of our military service members and veterans. Our study on the impact of the war on caregivers and children found deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not "rock the boat." They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve members face unique challenges since most do not live near a military installation. Our research finds they have more difficulty with deployments and reintegration than their active duty counterpart.

Our study respondents stated their communities did not understand what it was like to be military, and youth reported feeling misunderstood by people in their schools. We hear that school systems are generally unaware of this change in focus within these family units and are ill prepared to spot potential problems caused by these deployments or when an injury occurs. The National Guard and Reserve must partner with their deployed families' schools and educate them about available services and programs.

We appreciate the inclusion of a study on the mental health needs of military children in the NDAA FY10. However, we are still waiting for the study's findings.

Prompt DoD to release the study on the mental health needs of military children called for in NDAA FY10.

Education of Military Children

We strongly urge Congress to ensure appropriate and timely funding of Impact Aid through the Department of Education. We also ask that you allow school districts experiencing high levels of growth, to apply for Impact Aid funds using current student enrollment numbers rather than the previous year. In addition, we thank Congress for authorizing and funding DoD Impact Aid annually. We ask you to authorize $50 million for schools educating large numbers of military connected students. These funds help local school districts to meet the education needs of our military children in an era of declining state budgets. Our Association has long believed that both Impact Aid programs are critical to ensuring school districts can provide quality education for our military children.

Our Association wishes to thank Congress for providing additional funding to civilian school districts educating military children through DoDEA's Educational Partnership Grant Program. We are very pleased the *National Defense Authorization Act for Fiscal Year 2012* provided a three-year extension to the DoD authority that was set to expire in 2013. Since 2008, DoDEA has awarded 146 grants, totaling $167 million to school districts, for more than 900 schools. We believe DoDEA's expanded authority to provide grant assistance to local education agencies is an important step in strengthening education for all of the 1.2 million school-aged children.

We also thank Congress for appropriating additional funding to construct, renovate, repair, or expand elementary and secondary public schools on military installations. We appreciate that schools with the most serious capacity or facility condition deficiencies will be given priority consideration.

Ensure appropriate and timely funding of Impact Aid through the Department of Education.

Allow school districts experiencing high growth to apply for Impact Aid funds using current student enrollment numbers.

Authorize and appropriate $50 million in DoD Impact Aid funding for schools educating large numbers of military connected students.

Support for Special Needs Families

The Office of Community Support for Military Families with Special Needs (OSN) was created in the NDAA FY10 to enhance and improve DoD support around the world for military families with special needs, whether medical or educational. Last year our Association expressed concern that the needs of our special needs families were not being addressed in a holistic manner. Our Association is pleased OSN is now regularly meeting with the Department of Defense Office of Health Affairs to address the medical resources our special needs families require. We are also pleased the OSN has twice convened the Advisory Panel on Community Support for Military Families with Special Needs created in the NDAA FY 11 to get input from families on the medical, educational, relocation, and family support resources our special needs families require. Progress has been made, but our Association still has some concerns.

Case management for military beneficiaries with special needs is not consistent across the Services or the TRICARE Regions because the coordination of care for the military family is being done by a non-synergistic health care system. Beneficiaries try to obtain an appointment and then find themselves getting partial health care within the MTF, while other health care is referred out into the purchased care network. Thus, military families end up managing their own care. Incongruence in the case management process becomes more apparent when military family members transfer from one TRICARE Region to another and when transferring within the same TRICARE Region. This incongruence is further exacerbated when a special needs family member requires not only medical intervention, but non-medical care as well. Each TRICARE Managed Care Support Contractor (MCSC) has created different case management processes. Families need a seamless transition and a warm hand-off between and within TRICARE Regions and a universal case management process across the MHS. TRICARE leaders must work closely with their family support counterparts through the Office of Community Support for Military Families with Special Needs to develop a coordinated case management system that takes into account other military and community resources, as well as health care.

We applaud the attention Congress and DoD have given to our special needs family members in the past three years and their desire to create robust health care, educational, and family support services for special needs family members. But, these robust services do not follow them when they retire. We encourage the Services to allow these military families the opportunity to have their final duty station be in an area of their choice, preferably in the same state in which they plan to live after the service member retires, to enable them to begin the process of becoming eligible for state and local services while still on active duty. We also suggest the Extended Care Health Option (ECHO) be extended for one year after retirement for those family members already enrolled in ECHO prior to retirement. More importantly, our Association recommends if the ECHO program is extended, it must be for all who are eligible for the program because we should not create a different benefit simply based on medical diagnosis.

The Office of Community Support is studying Medicaid availability for special needs military family members. Our Association is anxiously awaiting this study's findings. We will be especially interested in the types of value-added services individual State Medicaid waivers offer their enrollees and whether state budget difficulties are making it more difficult for military families to qualify for and participate in waiver programs. This information will provide yet another avenue to identify additional services ECHO may include in order to help address our families' frequent moves and their inability to often qualify for these additional value-added benefits in a timely manner.

There has been discussion over the past several years by Congress and military families regarding the ECHO program. The ECHO program was originally designed to allow military families with special needs to receive additional services to offset their lack of eligibility for state or federally provided services due to frequent moves. We suggest that, before making any more adjustments to the ECHO program, Congress should request a GAO report to determine if the ECHO program is working as it was originally designed and if it has been effective in addressing the needs of the population it was intended to serve. We also hear from our ECHO eligible families that they could benefit from additional programs and health care services to address their special needs. We request a DoD pilot study to identify what additional services, if any, our special needs families need to improve their quality of life, such as cooling vests, diapers, and some nutritional supplements. We recommend families in the pilot have access to $3,000 above what is provided by ECHO to purchase self-selected items, programs, and/ or services not already covered by ECHO. DoD would be required to authorize each purchase to verify the requested item, program, or service is appropriate. This pilot study could identify gaps in coverage and provide DoD and Congress with a list of possible extra ECHO benefits for special needs families. More information is needed so the correct solutions can be applied to meet the needs of these families. Our Association believes the Medicaid waiver report, the GAO report, along with the pilot study will provide DoD and Congress with the valuable information needed to determine if the ECHO program

needs to be modified in order to provide the right level of extra coverage for our special needs families. We also recommend a report examining the impact of the war on special needs military families.

The Reserve Component (RC) has unique challenges with their special needs family members. They only qualify for ECHO when they are on active duty status. The population is relatively small, but our Association is concerned with the coordination of care and seamless transition of services as the special needs family member becomes eligible to receive ECHO benefits and then losses them when the member is deactivated. We request Congress ask GAO to examine ECHO benefits during the activation and deactivation cycle, and its impact on the RC family and the special needs family member.

Require GAO reports to determine if the ECHO program is working as it was originally designed, and to examine the impact of almost 11 years of war on our special needs families.

Create a DoD pilot study to identify what additional service(s), if any, our special needs families need to improve their quality of life.

Ask GAO to examine the impact of ECHO benefits during the activation and deactivation cycle on the RC family and the special needs family member and if it has been effective in addressing the needs of this population.

Spouse Education and Employment

In February 2012, the First Lady and Dr. Biden urged state action to support military spouses with state licenses by unveiling the joint report from the Departments of Defense and Treasury. *Supporting our Military Families: Best Practices for Streaming Occupational Licensing Across State Lines* outlines best practices that states can adopt to support military spouse employment and license portability. We believe Congress can also support military spouse license portability. We recommend Congress pass the *Military Spouse Job Continuity Act*, (H.R. 3046 or S. 697) or similar legislation. This legislation provides a tax credit to a military spouse to offset the cost of a new state-required license after a government ordered move.

Military spouses who require a state license for their profession are financially disadvantaged by Permanent Change of Station (PCS) orders. Many military spouses maintain career licenses in multiple states, costing hundreds of dollars. For example, a pharmacist can only reciprocate to another state from their original license, which requires a military spouse pharmacist to maintain a license in more than one state. State legislation can expedite the employment process and Congress can alleviate the financial burden with a tax credit.

To further spouse employment opportunities, we recommend an expansion to the Work Opportunity Tax Credit for employers who hire spouses of active duty and reserve component service members as proposed through the *Military Spouse Employment Act, H.R. 687*. This employer tax credit is one way to encourage corporate America to hire military spouses.

We thank you for your strong support of military spouse education by continuing to fund the Military Spouse Career Advance Account (MyCAA) program. We are disappointed DoD has not reopened the program to all military spouses. Many military spouses delay their education to support the service member's career. Since 2004, our Association has been fortunate to sponsor our Joanne Holbrook Patton Military Spouse Scholarship Program. Of particular interest, 33.5 percent of applicants from our 2011 scholarship applicant pool stated their education was interrupted because of the military lifestyle (frequent moves, TDYs, moving expenses, etc.) and 12.2 percent of those directly attributed the interruption to deployment of the service member. In 2012, there were nearly 9,000 applicants and 40 percent were not eligible for the MyCAA program. Military spouses remain committed to their education and need assistance from Congress to fulfill their educational pursuits.

In FY11, DoD did not use all of the funds allocated for the MyCAA program. We ask Congress to push DoD to reinstate the MyCAA program to include all military spouses, regardless of their service member's rank. We also ask Congress to work with the appropriate Service Secretaries to extend the MyCAA program to spouses of the Coast Guard, the Commissioned Corps of NOAA, and the U.S. Public Health Service.

We look forward to the military spouse employment report required by the NDAA FY12. This report will complement the Congressional mandated military spouse education report released in 2011.

Recognize the value of military spouses with a tax credit to offset state license and credential fees (H.R. 3046/S. 697) and expand the Work Opportunity tax credit (H.R. 687).

Fully fund the My CAA program for all military spouses.

Commissary and Exchange

Our Association is committed to protecting the Commissary and Exchange benefits vital to the quality of life of our military families. This past year, our Association worked tirelessly to defeat attacks to the Commissary and Exchange benefits:

- The Senate Veterans' Affairs Committee voted to eliminate the federal subsidy for military commissaries and recommended the Department of Defense (DoD) consolidate the operations of the commissaries and exchanges in order to pay for the *Caring for Camp Lejeune Veterans Act of 2011* (S.277).
- An amendment proposed to the NDAA FY12 to consolidate commissaries and exchanges and increase prices.
- Senator Tom Coburn's (R-OK) "Back to Black" report recommended consolidation of commissaries and exchanges into a single, nonsubsidized retail system over five years.
- The Congressional Budget Office continues to recommend consolidation of commissaries and exchanges, price increases, and commercially redeemable vouchers for only certain commissary patrons.

Our Association is very pleased that the DoD FY13 Budget does not call for additional reductions to the Defense Commissary Agency (DeCA). We believe the commissary benefit is a vital part of the compensation package for service members and retirees, and is valued by them, their families, and survivors. Military families consistently tell us that they consider the commissary one of their most important benefits. Here are just a few of the many comments we received:

- "The commissary is a great benefit that helps us stretch our paycheck while helping us put food on the table. I was in shock recently when I went to a grocery store and saw the prices! I know that it would be much harder to feed my family within our budget if there wasn't a commissary."
- "Making it on junior enlisted pay means we have a strict budget and there isn't a lot left over. Every penny counts and living in an overseas location makes things even tighter. One of the ways we are able to make ends meet is shopping at the commissary. We simply cannot afford to shop off post. Taking away the savings we get at the commissary would catastrophically hurt our standard of living."
- "Our family chooses to shop at the commissary and the PX because so many of the items are less expensive than retail. It is hard to feed a family of 4 boys on retail rates. My husband and I figured out we save approx. $300.00 a month. The other reason why we shop at the PX and the Commissary is that the money that is made is put back into military programs via MWR..."

Commissaries provide an average savings of more than 32 percent over local supermarkets. They also employ military family members. According to the Honorable Jo Ann Rooney, Acting Under Secretary of Defense for Personnel and Readiness, in her statement before the House Armed Services Committee Military Personnel Subcommittee, "Last fiscal year, 39 percent of DeCA employees in the United States were military spouses or other family members; and the total rises to 63 percent when including military retirees, other veterans, and members of the Guard and Reserve."

Commissaries also provide military families a sense of community. Commissary shoppers gain an opportunity to connect with other military families and are provided with information on installation programs and activities. Commissary patrons also receive nutritional information through commissary promotions and campaigns, as well as the opportunity for educational scholarships for their children.

In addition to commissary benefits, military families also save over 20 percent by shopping in the Exchanges. The $300 million in annual dividends are used to support essential Moral, Welfare and Recreation (MWR) programs that support service members and their families. Our Association strongly believes that every effort must be made to ensure this important benefit and MWR revenue is preserved, especially as facilities are down-sized or closed overseas.

According to this year's American Customer Satisfaction Index (ACSI) survey, the Exchange scored higher than ever before as its operations equaled the industry of excellence. The Exchange also relies on a Customer Service Index (CSI) to provide feedback on how well facilities improve the value of support

provided to Soldiers, Airmen, and their families. The CSI score for 2011 was a 77, another all-time high score for the Exchange. These customer satisfaction indexes prove that military families value the benefit of the Exchange more than ever.

Protect the Commissary and Exchange benefits from future budget cutting measures.

Military Housing

Privatized housing expands the opportunity for families to live on the installation and is a value for military families. With more joint basing, the Services must work together to create consistent policies not only within their Service, but across the Services. Pet policies, deposit requirements, and utility policies are some examples of differences across installations and across Services. How will Commanders address these variances under joint basing? Military families face many transitions when they move, and navigating the various policies and requirements of each contractor is frustrating and confusing. It's time for the Services to increase their oversight and work on creating seamless transitions by creating consistent policies across the Services. We ask Congress to push the Services to develop joint basing policies.

The Government Accountability Office (GAO) report, *Military Housing: Enhancements Needed to Housing Allowance Process and Information Sharing among the Services* identified four key areas of improvement. Our Association is especially concerned with the lack of available housing at growth installations. As service members return from deployments and families move back to installations, we will have a housing shortage. According to the GAO Military Housing report there is a housing shortage at DoD installations impacted by growth. Further, installation officials expect such housing challenges to continue or worsen.

Congress must look for solutions to provide housing to growth impacted installations. The Services need flexibility to enter into housing partnerships in local communities and to adjust allowances for families who may need to live in temporary housing for longer periods of time as they wait for housing to become available.

Adopt the recommendations from the GAO Military Housing report.

Find additional flexible solutions for housing needs at growth installations.

Voting Support for Military Service Members and their Families

The passage of the *Military and Overseas Voter Empowerment (MOVE) Act of 2009* was a significant step toward alleviating many of the voting issues faced by military service members and their families. Our Association greatly appreciates Congress passing this important legislation and holding subsequent hearings to evaluate its effectiveness. Many improvements have been made to strengthen the absentee voting process for military families. However, according to DoD's 2010 Post Election Survey Report to Congress, 29 percent of military voters still did not receive their ballots in the 2010 election. In light of this fact, we urge you to continue your oversight of the MOVE Act implementation.

Our Association is proud of the role we played in helping to pass the MOVE Act. We work with the DoD State Liaison Office to support the passage of the *Uniform Military and Overseas Voters Act* (UMOVA). This legislation would assist states in meeting the statutory mandates of the MOVE Act and expand these important protections and benefits to cover state and local elections. To date, forty-seven states and the District of Columbia have passed state-specific laws resulting in better protection for military and overseas voters. Our Association remains committed to advocating for military families' right to vote wherever they are stationed, and to have their vote counted.

Continue oversight of the MOVE Act implementation to improve voting rights for military service members and their families.

Financial Readiness

We applaud the efforts of the DoD Financial Readiness Campaign and recommend it continue. Ongoing financial literacy and education is critically important for today's military families. Military families are not a static population; new service members join the military daily. For many, this may be

their first job with a consistent paycheck. The youthfulness and inexperience of junior service members makes them easy targets for financial predators. Financial readiness is a crucial component of family readiness.

The DoD financial literacy program should be expanded to transitioning service members and their families. The program currently focuses on new and junior service members. Transitioning families must be financial prepared for life outside the military and the financial literacy program is the right resource to provide this training.

Our Association is pleased the Office of Servicemember Affairs (OSMA) within the Consumer Financial Protection Bureau (CFPB) elevated financial concerns of military families and connected government and nongovernment organizations. We look forward to the further development of the complaint process.

We remain concerned about the impact of the housing crisis on military families. The funds from the expanded Homeowners Assistance Program (HAP) are gone and other solutions are limited. In September 2011, Members of Congress sent letters to Departments of Treasury and Housing and Urban Development, the Federal Housing Finance Agency, and the Securities and Exchange Commission, after hearing concerns from service members about the difficulties they face when receiving Permanent Change of Station (PCS) orders and attempting to qualify for home foreclosure prevention programs. Service members and their families are often unable to sell their homes quickly at prices that will enable them to pay off their mortgages, and they cannot generate enough rental income to cover their mortgage payments or retain their homes until housing prices return to normal values.

The Department of Treasury responded by providing updated guidance to its Home Affordable Foreclosure Alternatives (HAFA) Program. Under the new guidance, service members who cite a Permanent Change of Station (PCS) order as a basis for their financial hardship under HAFA are now eligible even if their income has not decreased. Unfortunately, the new guidance does not address a military homeowner who is a landlord and is underwater. Government agencies must continue to provide solutions to assist underwater military homeowners. Service members must relocate where ordered and cannot ride out the housing market.

We remain a Nation at war and must continue to support the families of our forward deployed war fighters. The Family Separation Allowance (FSA) has not increased in more than ten years. We ask that the Family Separation Allowance be indexed to the Cost of Living Allowance (COLA) to better reflect rising costs for services.

Press federal agencies to formulate solutions to assist underwater military homeowners.

Increase the Family Separation Allowance by indexing it to COLA.

Flexible Spending Accounts

Congress has provided the Armed Forces with the authority to establish Flexible Spending Accounts (FSA), yet the Service Secretaries have not established these important tax savings accounts for service members. We are pleased H.R. 791 and S. 387 have been introduced to press each of the seven Service Secretaries to create a plan to implement FSAs for uniformed service members. FSAs were highlighted as a key issue presented to the Army Family Action Plan at their 2011 Department of the Army level conference. FSAs would be especially helpful for families with out-of-pocket dependent care and health care expenses. Civilians who work for the Department of Defense have access to FSAs, it is time for service members to have access to a similar benefit.

It is imperative that FSAs for uniformed service members take into account the unique aspects of the military lifestyle, such as Permanent Change of Station (PCS) moves and deployments, which are not compatible with traditional FSAs. We ask that the flexibility of a rollover or transfer of funds to the next year be considered.

Require DoD to create Flexible Spending Accounts for uniformed service members that account for the unique aspects of military life including deployments and Permanent Change of Station moves.

Healthcare

When considering changes to the health care benefit, our Association urges policymakers to recognize the unique conditions of service and the extraordinary sacrifices demanded of military members and families. Repeated deployments, caring for the wounded, ill, and injured, and the stress of

uncertainty create a need for greater access to professional behavioral health care for all military family members.

Family readiness calls for access to quality health care and mental health services. Families need to be assured the various elements of their military health system are coordinated and working as a synergistic system. The direct care system of MTFs and the purchased care segment of civilian providers under the TRICARE contracts must work in tandem to meet military readiness requirements and ensure they meet access standards for all military beneficiaries.

Improving Access to Care

Our Association continues to monitor the experience of military families with accessing care within both the direct care and purchased care segments of the MHS. We are concerned our MTFs are stressed from 11 years of provider deployments, which directly affects the quality, access, and cost of health care. We consistently hear from families that their greatest health care challenge is getting timely care in both the direct and the purchased care systems. Their main challenges with the direct care system are:

- access to their Primary Care Managers (PCM)
- availability of after-hours and weekend routine care
- availability of urgent care and additional same-day appointments
- having appointments available in MTFs for next day or week, along with 60, 90, or 120-day follow-ups recommended by their providers

Beneficiaries' main challenges with the purchased care system, according to TRICARE's *Health Care Survey of DoD Beneficiaries 2009 Annual Report,* are difficulty in accessing personal doctors and specialty care.

Our Association hears frequent complaints by families regarding the referral process. Families are often unfamiliar with the process at their MTF and in their TRICARE region. They frequently report difficulties in obtaining an appointment within access standards. Families often find that a provider on the TRICARE Managed Care Support Contractor's (MCSC) list is no longer taking TRICARE or taking new patients. The difficulties sometimes cause the beneficiary to give up on the referral process and never obtain the specialty appointment their PCM believes they need. Our Association is concerned with the impact these delays or the lack of even getting the referral is having on the quality of care and beneficiary outcome. We cannot stress enough how continuity of care is important to maintain our families' quality of care. We recommend Congress require a DoD report on the management of the referral process—both within the direct care system and between the direct care and purchased care sectors—and the impact on beneficiaries' access to care.

We see even more issues ahead that could affect beneficiary access. The TRICARE Management Activity (TMA) has rolled out the new TRICARE Third Generation (T3) contract in the TRICARE North Region and will be rolling out T3 in the TRICARE South Region beginning April 2011. At that time, the remaining TRICARE West Region will still be operating under the existing TRICARE Next Generation (T-Nex) contract. Full T3 implementation will remain in a holding pattern, preventing contractors' renegotiation with approximately 33 percent of our civilian TRICARE providers. With the demands and uncertainties to providers in regards to health care reform's added requirements and expenses along with looming Medicare reimbursement rate changes, we are beginning to hear from providers their lack of a long-term willingness to remain in the TRICARE network and impact TRICARE MCSCs' ability to recruit new providers. Thus, the combination of factors may result in a decreased access to care for military families, especially mental health.

We applaud DoD building "world class" MTFs that utilize evidence-based design. Ft. Belvoir Community Hospital and the National Military Medical Center Bethesda are two examples. Ten more MTFs are being built using similar design concepts. Our Association wants to make sure that the inner workings of the hospital are also "world class." Reasonable pharmacy wait times, professional attitudes with a customer focus, medical home designed clinics, quality care, and access standards met for all appointments are hallmarks of a "world class" system. Given the recent discussion of high health care costs and budget concerns, beneficiaries are going to wonder why DoD spent so much money on facilities that look great, but conduct business as usual. Congress needs to make sure that DoD's new facilities meet "world class" definitions both in brick and mortar and in customer services and policies and procedures.

Require a DoD report on the impact on beneficiaries of the MHS referral process.

National Guard and Reserve Member Family Access to Care

We remain especially concerned about access to care for National Guard and Reserve families. These families also need increased education about the multiple types of TRICARE health care benefits in which they are eligible to participate. We recommend Congress request a report to assess the coordination and continuity of health care services for National Guard and Reserve families as they frequently move from activated TRICARE Prime coverage to non-activated status and TRICARE Reserve Select (TRS) or their employer civilian health care insurance plans. We continue to believe that paying a stipend to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan while the service member is mobilized may work out better for many families in areas where the TRICARE network may not be robust. This will hold true as well when the beneficiary population in remote areas decreases as mobilizations decline with the end of conflicts.

Require a report assessing the coordination and continuity of health care services for National Guard and Reserve families as they transition from one TRICARE status to another.

Allow reserve component families to be given the choice of a stipend to continue their employer-provided care during the deployment of the service member.

TRICARE Reimbursement

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. We are pleased Congress passed the *Temporary Payroll Tax Cut Continuation Act of 2011* (P.L.112-78), which provided a one-year extension of current Medicare physician payment rates until December 31, 2012. When Congress takes up Medicare legislation this year, we ask you to consider how this legislation will impact military health care. We are especially concerned about our most vulnerable population, military families living in rural communities and those needing access to mental health services.

While we have been impressed with the strides TMA and the TRICARE MCSCs are making in adding providers, especially mental health providers, to the networks, we believe more must be done to persuade health care and mental health care providers to participate and remain in the TRICARE network, even if that means DoD must raise reimbursement rates. We still hear from providers they will not participate in TRICARE because of their belief in time-consuming requirements and low reimbursement rates. National provider shortages in the mental health field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates and TRICARE rules. Military-unique geographic challenges, such as large military beneficiary populations in rural or traditionally-underserved areas, also contribute to providers' unwillingness to accept TRICARE low reimbursement rates. Many mental health providers are willing to see military beneficiaries on a voluntary status; therefore, we need to do more to attract these providers to join the TRICARE network. Increasing TRICARE reimbursement rates is just one way of enticing them.

Pharmacy

For several years, our Association has cautioned about DoD generalizing findings of certain civilian pharmacy plans changing beneficiary behaviors and automatically applying them to the military population. As part of the President's FY13 Budget proposal, DoD recently announced it would adjust certain pharmacy co-payments. DoD's intent is to drive beneficiaries away from retail pharmacies and toward TRICARE Mail Order Pharmacy (TMOP) utilization, which should lower government costs and increase DoD savings. Our Association long championed a zero co-payment for generic Tier 1 medications in TMOP and we applaud DoD's proposal and Congressional approval to implement this measure as one of their cost-saving measures.

The rationale behind DoD's recent proposed pharmacy changes is concerning. The proposed increase in co-payments and the loss of access to retail non-formulary medications starting in 2013 will have the biggest impact on beneficiaries who have no choice but to rely on the retail pharmacy for urgent formulary and non-formulary non-maintenance medications. For example, young families of deployed National Guard, Reserve members and recruiters usually do not live close to an MTF pharmacy. When their child needs an antibiotic for an urgent medical condition, such as pneumonia, they have no other option than the retail pharmacy. Beneficiaries who need certain medications not suited for TMOP, such as a narcotic or a chemical compound not suitable for home delivery, would find themselves paying more or not able to even fill the non-formulary prescription without first acquiring a Prior Authorization (PA) or Medical Necessity (MN) from their provider. We fear this requirement of a PA or MN will become so confusing and difficult to achieve by everyone involved (beneficiary, provider, and pharmacist), the beneficiary will simply walk out without the needed medications. The end result will impact beneficiary compliance and decrease desired quality outcomes. If this is implemented, DoD will need to educate the

beneficiary and TRICARE network providers on the PA and MN requirement process to ensure the process is seamless and successful.

We are also concerned about the effect of the proposed co-pay changes and access to non-formulary medication at retail will have on our wounded, ill, and injured service members and those already medically retired. This population may be adversely affected because of the frequent alteration to their medication protocols by their health care providers in order to achieve optimum medical benefits for their often-changing medical conditions. Their medications may appear to be maintenance drugs, but are actually intended to be used only for short-term relief. Sending them to TMOP for a 90-day supply just because the co-payment is less may in fact cost the beneficiary and the government more because of frequent changes in doses. Many of the prescriptions needed by the wounded, ill, and injured are for newly FDA-approved medications, which will most likely place them in non-Formulary Tier 3 status. This may place an unfair financial burden and lack of access to these medications on this population because they tend to utilize a higher number of formulary and non-formulary medications.

Beneficiaries who have no choice in where they must obtain their medications should not be subjected to co-payment increases and barriers to non-formulary retail access simply aimed at changing the behavior of those who do have choices. DoD must consider the possible effects of its co-payment changes and access barriers as it plans for implementation and may need to devise alternative co-payment adjustments to protect beneficiaries during these situations. We look forward to discussing potential options with Members of Congress and DoD.

We believe there are additional ways DoD could experience increased pharmacy savings. These include:

- Provide medications treating chronic conditions, such as asthma, diabetes, and hypertension, at the lowest level of co-payment regardless of brand or generic status
- Implement *The Task Force on the Future of Military Health Care* recommendation to include over-the-counter (OTC) drugs as a covered pharmacy benefit, thus eliminating the need for more costly pharmaceuticals that have the same efficacy as over-the-counter options
- Make all newly FDA approved medications non-formulary status until reviewed by DoD's Pharmacy and Therapeutics Committee's (P&T Committee) within 9 months of approval.

The new T3 contract will provide TRICARE MCSCs and the pharmacy contractor with the ability to link pharmacy data with disease management. This will allow for better case management, increase adherence/ compliance, and decrease cost, especially for beneficiaries suffering from chronic illness, co-morbidities, and multiple conditions. However, this valuable tool is only available starting April of this year in the TRICARE North and South Regions because the T3 contract still remains under protest in the remaining TRICARE West Region.

Require DoD to report on how proposed pharmacy changes may impact beneficiary behavior and health care quality outcomes.

U.S. Family Health Plan (USFHP)

We remain opposed to last year's change to the U.S. Family Health Plan (USFHP) eligibility, requiring newly enrolled beneficiaries to transition from USFHP once they become Medicare/ TFL eligible. Our Association believes USFHP is already providing TMA's medical home model of care, maintaining efficiencies, capturing savings, and improving patient outcomes. USFHP also meets the *Patient Protection and Accountability Care Act*'s definition of an Accountable Care Organization. They certainly have the model of care desired by civilian health care experts and should be used by DoD as a method to test best-practices that can be implemented within the direct care system. Every dollar spent in preventative medicine is captured later when the onset of beneficiary co-morbid and chronic diseases are delayed. It is difficult to quantify the long-term savings not only in actual cost to the health care plan—and thus to the government—but to the improvement in the quality of life for the beneficiary. Removing beneficiaries from USFHP at a time when they and DoD will benefit the most from their preventative and disease management programs will greatly impact the continuity and quality of care to our beneficiaries and only shift the cost of their care from one government agency to another. Almost all USFHP enrollees already purchase Medicare Part B in case they decide to leave the plan or spend long periods of time in warmer parts of the country. There must be another mechanism in which beneficiaries would be allowed to continue in this patient-centered program after becoming Medicare eligible.

Recommend that Medicare-eligible beneficiaries using the USFHP be allowed to remain in the program.

National Health Care Reform

Our Association is cautious about the changes contained in the *Patient Protection and Affordable Care Act* (P.L. 111-148) and their potential impact on TRICARE and CHAMPVA. We thank Congress for including a provision in the NDAA FY11 to allow TRICARE Standard/ Extra and Prime coverage for TRICARE eligible young adult beneficiaries up to the age of 26. Military families had been asking for this added benefit. However, we still need Congressional action to allow CHAMPVA coverage for eligible young adults up to the age of 26. This lack of coverage for eligible survivor dependents is causing an unnecessary financial burden on a population already economically challenged.

Provide health care coverage to young adults, up to the age of 26, who are eligible for CHAMPVA.

Access to Behavioral Health Care

The body of research focusing on the increased levels of anxiety and utilization of mental health services and medication causes our Association to be even more concerned about the overall shortage of mental health providers in TRICARE's direct and purchased care network.

While TMA reports significant progress by the TRICARE contractors in adding to the numbers of mental health providers in the networks, these numbers do not automatically translate into a corresponding increase in access. A recently published report in the March 2011 issue of *Military Medicine*, "Access to Mental Health Services for active duty and National Guard TRICARE Enrollees in Indiana," found that only 25 percent of mental health providers listed in the TRICARE contractor's provider list were accepting new TRICARE beneficiaries. Researchers stated the number one barrier to active duty and reserve component service members and their families, in obtaining mental health care in Indiana, was the accuracy of the TRICARE mental health provider list. Our Association hears from families about the number of times they contact network providers using the TRICARE provider list only to find the providers cannot meet access standards, are no longer taking TRICARE, or are not taking new TRICARE patients. Provider lists must be up-to-date in order to handle real time demands by military families.

While families are pleased more military mental health providers are available in theater to assist their service members, they are disappointed with the resulting limited access to providers at home. Families report they are being turned away from obtaining appointments at their MTFs and clinics and told to seek services elsewhere. The military fuels the shortage by deploying its mental health providers, even its child and adolescent psychology providers, to combat zones.

Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. We recommend an extended outreach program to service members, veterans, and their families of available mental health resources through DoD and VA with providers who inherently understand military culture. We appreciate the VA allowing family member access to Vet Centers; however, we encourage them to develop more family-oriented programs and offer internet based chat and Skype grouped meetings. DoD must also look beyond its own resources to increase mental health access by working with other government agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), especially SAMHSA's Military Families Strategic Initiative and Service member, veteran, and family Policy Academy States and Territories, and encourage State agencies to provide their already established services and programs to service members, veterans, and family members. Our Association has been actively working with SAMHSA, providing valuable input on military families and military culture to these initiatives. DoD must also educate these other agencies about military culture to make the providers more effective in their support.

Frequent and lengthy deployments create a sharp need in mental health services by family members and service members as they get ready to deploy and after they return. There is also an increase in demand in the wake of natural disasters, such as hurricanes and fires. Embedding mental health providers in medical home modeled clinics will allow easier access for our families. DoD must maintain a flexible pool of mental health providers that can increase or decrease rapidly in numbers depending on demand on the MHS side. Currently, Military Family Life Consultants (MFLC) and Military OneSource counseling are providing this type of preventative and entry-level service for military families. The web-based TRICARE Assistance Program (TRIAP) has been offering another vehicle for non-medical counseling, especially for those who live far from counselors. The TRIAP program will be absorbed by Military OneSource beginning 30 March. Project FOCUS (Families Over Coming Under Stress) is a family psychological health and resiliency building program to help families deal with deployment(s) and high-operational tempo. The military Services, along with military family members, need to be more aware of resources along the continuum of mental health support. Families need the flexibility of support in both

the MHS and Service family support arenas, as well as coordination of support between these two entities.

There are other barriers to access for some in our population. Many already live in rural areas, such as our National Guard and Reserve members, or they will choose to relocate to rural areas lacking available mental health providers. We need to address the distance issues families face in finding mental health resources and obtaining appropriate care. Isolated service members, National Guard and Reserve, veterans, and their families do not have the benefit of the safety net of services and programs provided by MTFs, military installation based support programs, VA facilities, Community-Based Outpatient Centers, and Vet Centers. The National Guard Bureau's Psychological Health Services (PHS) has been established to address mental health issues. We applaud the provision in NDAA FY11 promoting the use of telemental health and removing geographic practice barriers that prevent mental health providers from participating in telemental health services. Our Association looks forward to working with DoD on implementation of this new policy. However, we encourage Congress to do more by: increasing mental health reimbursement rates for rural areas; developing a standardized military culture curriculum; and educating civilian network mental health providers about our military culture.

The Defense Centers of Excellence (DCoE) is providing a transition benefit for mental health services for active duty service members, called *inTransition*. Our Association recommends this program be expanded to provide the same benefit to active duty spouses and their children. Families often complain about the lack of seamless transition of care when they PCS. This program will not only provide a warm hand-off between mental health providers when moving between and within TRICARE Regions, but more importantly enable mental health services to begin during the move, when families are between duty stations and most venerable.

Recommend the "inTransition" program be expanded to provide the same benefit to active duty family members.

Recommend the use of alternative treatment methods, such as increasing mental health reimbursement rates for rural areas; developing a standardized curriculum; and educating civilian network mental health providers about our military culture.

TRICARE Policy Barriers to Behavioral Health Care

TRICARE's policies contribute to a lack of adequate access to behavioral health care. TRICARE is not part of the Mental Health Parity and Addiction Equity Act of 2008 (P.L.110-343); therefore, our families have a yearly cap on how many days they can receive inpatient behavioral health services. Some families try to enroll their child into Medicaid in order to continue receiving treatment. TRICARE should meet the provisions of the Mental Health Parity law. TRICARE requires Partial Hospitalization Programs (PHP) and Substance Use Disorder Rehabilitation Facilities (SUDRFs) to become a National Quality Monitoring contractor (NQMC). There is no incentive for PHP and SUDRFs to comply since it is not required by commercial programs. TRICARE's policy excludes the utilization of Intensive Outpatient Program (IOP), which is considered a best clinical and business practice that allows for the continuum of care. Also, DoD needs to incorporate clinical best practices across the Services.

Caregiver Burnout

Many health care and behavioral health providers have just returned home after completing a combat tour, only to be overwhelmed by treating active duty members, retirees, and their families. It can lead to provider compassion fatigue and create burnout. Our Association would like to be assured DoD is allowing these providers adequate dwell time and time to reintegrate with their families before returning to work. Beneficiaries rely heavily on MTF providers for their care, especially mental health, and need them to be fully ready to care for them. Providers must also be provided the opportunity to sharpen their practice skills, which may have not been used while serving in a combat zone. If they are not adequately addressed, this situation has the potential to negatively impact both the provider's ability to provide quality care and the beneficiary to receive quality care. We recommend Congress ask for a study to examine the impact the war is having on our MHS active duty providers and their families.

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Educating Those Who Care for Service Members and Families

The families of service members and veterans must be educated about the effects of Traumatic Brain Injury (TBI), Post-Traumatic Stress (PTS), Post-Traumatic Stress Disorder (PTSD), and suicide in

order to help accurately diagnose and treat the service member/ veteran's condition. These families are on the "pointy end of the spear" and are more likely to pick up on changes attributed to either condition and relay this information to their health care providers. Programs are being developed by each Service. However, they are narrow in focus, targeting line leaders and health care providers, but not broad enough to capture our military family members and the communities they live in. As Services roll out suicide prevention programs, we need to include our families, communities, and support personnel.

The DoD, VA, and State agencies must educate their health care and mental health professionals of the effects of mild Traumatic Brain Injury (mTBI) in order to help accurately diagnose and treat the service member's condition. They must be able to deal with polytrauma—PTS and PTSD in combination with mTBI and multiple physical injuries.

DoD, working with the TRICARE Managed Care Support Contractors (MCSC) and Service medical leadership, must reach out to educate civilian health care providers on how to identify signs and symptoms of mTBI, PTS, and PTSD. They must also educate them about our military culture. We recommend a course on military culture be required in all health care and behavioral health care college curriculums and to offer a standardized DoD approved military culture Continuing Education Unit (CEU) for providers who have already graduated. TMA should incentivize providers to take these courses.

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Transition

Families on the Move

Travel allowances and reimbursement rates have not kept pace with the out-of-pocket costs associated with today's moves. In a recent PCS survey conducted by our Association, more than 50% of survey respondents identified uncovered expenses related to the move as their top moving challenge. Military families are authorized 10 days for a house hunting trip, but the cost for the trip is the responsibility of the service member. Families with two vehicles may ship one vehicle and travel together in the second vehicle. The vehicle will be shipped at the service member's expense and then the service member will be reimbursed funds not used to drive the second vehicle to help offset the cost of shipping it. Or, families may drive both vehicles and receive reimbursement provided by the Monetary Allowance in Lieu of Transportation (MALT) rate. MALT is not intended to reimburse for all costs of operating a car but is payment in lieu of transportation on a commercial carrier. Yet, a TDY mileage rate considers the fixed and variable costs to operate a vehicle. Travel allowances and reimbursement rates should be brought in line with the actual out-of-pocket costs borne by military families.

Our Association supports the *Service Members Permanent Change of Station Relief Act*, S. 472, and believes it will reduce some of the additional moving expenses incurred by many military families.

Address the out-of-pocket expenses military families bear for government ordered moves.

Wounded Service Members Have Wounded Families

Our Association asserts that behind every wounded service member and veteran is a wounded family. It is our belief the government, especially DoD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded, ill, and injured service member must also consider the needs of the spouse, children, parents of single service members and their siblings, and the caregivers. DoD and VA need to think proactively as a team and one system, rather than separately, and address problems and implementing initiatives upstream while the service member is still on active duty status.

DoD and VA are working together on the Integrated Disability Evaluation System (IDES). Our Association applauds this cooperation. Many of our wounded, ill, and injured are members of the Reserve Component. They often do not reside where the IDES is taking place. We recommend DoD and VA pilot the IDES using a Community Based Warrior Transition Unit (CBWTU). This would allow the wounded, ill, and injured Guardsman or Reservist to be home with their family while going through the IDES process. Currently, they are held at the demobilization site, assigned to the MTF, and proceed through the IDES. This recommendation is also supported by the National Guard Association of the United States (NGAUS), The Retired Enlisted Association (TREA), and Association of United States Navy (AUSN).

Reintegration programs become a key ingredient in the family's success. For the past three years, we have held our *Operation Purple® Healing Adventures* camp to help wounded, ill, and injured service members and their families learn to play again as a family. We hear from the families who participate in this camp that many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/ lover with an injury/ illness. Each member needs to understand the unique aspects the injury/ illness brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes everyone must focus on treating the whole family, with DoD and VA programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process. DoD, the VA, and non-governmental organizations must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

DoD and the VA must do more to work together both during the treatment phase and the wounded service member's transition to ease the family's burden. They must break down regulatory barriers to care and expand support through the Vet Centers, the VA medical centers, and the community-based outpatient clinics (CBOCs). We recommend DoD partner with the VA to allow military families access to mental health services throughout the VA's entire network of care using the TRICARE benefit. Before expanding support services to families, however, VA facilities must establish a holistic, family-centered approach to care when providing mental health counseling and programs to the wounded, ill, and injured service member or veteran. Family members are a key component to a service member's psychological well-being. They must be included in mental health counseling and treatment programs for service members, reserve component, and veterans.

We remain concerned about the transition of wounded, injured, and ill service members and their families from active duty status to that of the medically-retired. While we are grateful DoD has proposed to exempt medically-retired service members, survivors of active duty service members, and their families from the TRICARE Prime enrollment fee increases, we believe wounded service members need even more assistance in their transition. We continue to recommend that a legislative change be made to create a three-year transition period in which medically-retired service members and their families would be treated as active duty family members in terms of TRICARE fees, benefits, and MTF access. This transition period would mirror that currently offered to surviving spouses and would allow the medically-retired time to adjust to their new status without having to adjust to a different level of TRICARE support and financial requirement.

Wounded, ill, and injured service members and their families should be allowed to remain enrolled in their MTF when they are medically retired. Our Association has been hearing from families that this is not always the case. The family may be re-enrolled, but the medically retired service member is not and told to enroll in the VA health system of care instead. Many are having difficulty obtaining timely specialty care for service connected disability medical conditions, such as PTS. Medical retirees are using their TRICARE benefit to receive their care, paying co-pays, and having to navigate the TRICARE purchased care network for specialty providers without the assistance of a case manager. This can be a daunting task for a medically retired service member with a mild to moderate Traumatic Brain Injury and PTSD. We request Congress ask the GAO to design and conduct a study to determine the accessibility and timelessness of VA primary and specialty care, particularly for those conditions most prevalent among returning veterans. The study should take into account of such factors as waiting times relative to patient acuity, travel times, barriers to provisions of fee basis care and variability among VA networks; should identify what alternative treatment avenues veterans/ medically retirees are using when confronting barriers at VA; and should provide not only a quantitative analysis but an analysis of other factors that account for or contribute to lack of access and timeless, where it exists. This Congressional request is also supported by Iraq and Afghanistan Veterans of America (IAVA), Wounded Warrior Project (WWP), AMVETS, and Veterans of Foreign Wars (VFW).

Allow medically-retired service members and their families to maintain the active duty family TRICARE benefit for a transition period of three years following the date of medical retirement, comparable to the benefit for surviving spouses.

Allow service members medically discharged from service and their family members to continue for one year as active duty for TRICARE and then start the Continued Health Care Benefit Program (CHCBP) if needed.

Case Management

Our Association still finds families trying to navigate a variety of complex health care systems alone, trying to find the right combination of care. Our most seriously wounded, ill, and injured service members, veterans, and their families are often assigned multiple case managers. Families often wonder which one is the "right" case manager. We believe DoD and the VA must look at whether the multiple, layered case managers have streamlined the process or have only aggravated it. We know the goal is for a seamless transition of care between DoD and the VA. However, we continue to hear from families whose service members are still on active duty and meet the Federal Recovery Coordinator (FRC) requirement, who have not been told FRCs exist or that they qualify for one. The GAO FRC report found there were many areas of concern, one being limitations on sharing of information between the Services' case managers and the VA's FRCs, which impacts care coordination. The Congressionally mandated Recovering Warrior Task Force (RWTF) has also been looking into the issue around case management. We look forward to their report to determine how case management is working within each Service and government agency caring for our wounded, ill, and injured service members, veterans, and their families.

Caregivers of the Wounded

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded service members and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DoD and VA health care providers because they tend to the needs of the service members and the veterans on a regular basis. Their daily involvement saves DoD, VA, and State agency health care dollars in the long run. Their long-term psychological care needs must be addressed. Caregivers of the severely wounded, ill, and injured service members who are now veterans have a long road ahead of them. In order to perform their job well, they will require access to mental health services.

We have observed from our own *Healing Adventure Camps* the lack of support and assistance to the spouse/ caregiver of our wounded, ill, and injured. Many feel frustrated with not being considered part of the care team and not included in long-term care decisions. The level of frustration displayed by the spouses/ caregivers at our recent *Healing Adventure Camp* at Ft. Carson about lack of information and support was disturbing. Even the RWTF discovered the same level of frustration during their site visit and raised their concerns to the MTF and Warrior Transition Unit (WTU) Commanders. DoD needs to make sure the spouse/ caregiver and the family are also cared for and provided them the support they need to perform their role as a caregiver and provide them with the tools to care for themselves as well. WTU Commanders need to establish spouse/ caregiver support groups and mentoring opportunities. Spouses/ caregivers need a platform where they can voice their concerns without the fear of retribution. Evoking HIPAA (*Health Insurance Portability and Accountability Act of 1996*) privacy is not an excuse to limit spouses/ caregivers from receiving health care information about their loved one. Wounded warrior commands must remember that they are an integral part of the health care team and their input is invaluable.

The VA has made a strong effort in supporting veterans' caregivers. Our Association still has several concerns with the VA's interpretation of P.L.111-163. The VA's eligibility definition does not include illness, which means it does not align with DoD's *Special Compensation for Service*. We believe the VA is waiting too long to provide valuable resources to caregivers of our wounded, ill, and injured service members and veterans who served in Operation Iraqi Freedom/ Operation Enduring Freedom/ Operation New Dawn (OIF/ OEF/ OND). The intent of the law was to allow caregivers to receive value-added benefits in a timely manner in order to improve the caregiver's overall quality of life and train them to provide quality of care to their service member and veteran. Another area of immediate concern is the potential gap in financial compensation when the service member transitions to veteran status. The VA's application process and caregiver validation process appear to be very time intensive. The DoD Special Compensation benefit expires at 90 days following separation from active duty. We recommend DoD's remove the 90-day limit and allow the Special Compensation benefit to be extended until the VA's caregiver benefit is instituted.

The VA's decision to delay access to valuable training may force each Service to begin its own caregiver training program. Thus, each Service's training program will vary in its scope and practice and may not meet VA's training objectives. This disconnect could force the caregiver to undergo two different training programs in order to provide care and receive benefits.

Our Association also believes the current laws do not go far enough. Compensation of caregivers should be a priority for DoD and the Secretary of Homeland Security. Non-medical care should be

factored into DoD's compensation to service members. The goal is to create a seamless transition of caregiver benefit between DoD and the VA. We ask Congress to assist in meeting that responsibility.

The VA piloted eight caregiver assistance programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. DoD should evaluate these pilot programs to determine whether to adopt them for caregivers of service members still on active duty. Caregivers' responsibilities start while the service member is still on active duty.

Spouses/ caregivers of the wounded, ill, and injured Reserve Component face unique challenges. They are often not located where their loved one is assigned by their Services' wounded warrior commands. They must travel using their own money to visit them while they are receiving medical treatment for service connected conditions or going through the Medical Evaluation Board process. DoD should pay for their travel and lodging during this timeframe. If the family decides to relocate in order to be closer to their loved ones treatment at the MTF, DoD should pay for their move. Services should allow wounded, ill, and injured Reserve Component the opportunity to receive treatment as close to home as possible. When they receive care in TRICARE's purchase care network for service connected conditions, TRICARE MCSC should case manage their treatment.

Encourage DoD to establish spouse/caregiver support groups and mentoring opportunities.

Recommend DoD remove the 90-day limit and allow the Special Compensation benefit to be extended until the VA's caregiver benefit is instituted.

Relocation Allowance and Housing for Medically-Retired Single Service Members

Active Duty service members and their spouses qualify through the DoD for military orders to move their household goods when they leave the military service. Medically retired service members are given a final PCS move. Medically retired married service members are allowed to move their family; however, medically retired single service members only qualify for moving their own personal goods.

Our Association suggests that legislation be passed to allow medically retired single service members the opportunity to have their caregiver's household goods moved as a part of the medical retired single service member's PCS move. This should be allowed for the qualified caregiver of the wounded, ill, and injured service member and the caregiver's family (if warranted), such as a sibling who is married with children, or mom and dad. This would allow for the entire caregiver's family to move, not just the caregiver. The reason for the move is to allow the medically retired single service member the opportunity to relocate with their caregiver to an area offering the best medical care, rather than the current option that only allows for the medically retired single service member to move their belongings to where the caregiver currently resides. The current option may not be ideal because the area in which the caregiver lives may not be able to provide all the health care services required for treating and caring for the medically retired service member. Instead of trying to create the services in the area, a better solution may be to allow the medically retired service member, their caregiver, and the caregiver's family to relocate to an area where services already exist.

The decision on where to relocate for optimum care should be made with the assistance of their FRC (case manager), the service member's medical physician, the service member, and the caregiver. All aspects of care for the medically retired service member and their caregiver shall be considered. These include a holistic examination of the medically retired service member, the caregiver, and the caregiver's family for, but not limited to, their needs and opportunities for health care, employment, transportation, and education. The priority for the relocation should be where the best quality of services is readily available for the medically retired service member and his/ her caregiver.

The consideration for a temporary partial shipment of caregiver's household goods may also be allowed if deemed necessary by the care management team.

Authorize medically retired single service members to have their caregiver's household goods moved as a part of their final PCS move.

Medical Power of Attorney

We have heard from caregivers of the difficult decisions they have to make over their loved one's bedside following an injury. We support the *Traumatic Brain Injury Task Force* recommendation for DoD to require each deploying service member to execute a Medical Power of Attorney and a Living Will.

Require each deploying service member to execute a Medical Power of Attorney and a Living Will.

Senior Oversight Committee

The Recovering Warrior Task Force report recommended the Senior Oversight Committee functions be consolidated into the Joint Executive Council (JEC). Even though the Services have stated to the RWTF that SOC initiatives are progressing, there are still frequent instances where processes are working at cross-purposes, resulting in misaligned DoD and VA benefits and programs. The JEC has a history of not getting things done, which is why the SOC was created in the first place. Pushing responsibilities of creating seamless transition of benefits and programs back onto the JEC in our minds is moving the process backward rather than forward. DoD and VA senior leaders must play an active role, which means meeting on a regular basis, developing goals, and implementing strategies to address issues at every meeting. We request Congress hold DoD and VA Secretaries accountable for getting the job done right.

Office of Wounded Warrior Care and Transition Policy

DoD established the Office of Wounded Warrior Care and Transition Policy to take over responsibility for three SOC Line of Action items for wounded ill, and ill service members. The Office has seen frequent leadership and staff changes and a narrowing of its mission. We urge Congress to put a mechanism in place to continue to monitor this Office for its responsibilities in maintaining DoD and VA's partnership and making sure the Office creates a seamless transition of services and benefits for our wounded, ill, and injured service members, veterans, their families, and caregivers.

Defense Centers of Excellence

A recent GAO report found the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury has been challenged by a mission that lacked clarity and by time-consuming hiring practices. Other Centers of Excellence have experienced a lack of adequate funding, hampering their ability to hire adequate staff and begin to provide care for the patient population as they were created to address. These include the Vision Center of Excellence, Hearing Center of Excellence, and the Traumatic Extremity Injury and Amputation Center of Excellence. We recommend Congress immediately fund these Centers and require DoD to provide resources to effectively establish these Centers and meet DoD's definition of "world class" facilities.

Encourage all Congressional Committees with jurisdiction over military personnel and veterans matters to talk on these important issues. Congress, DoD, and VA can no longer continue to create policies in a vacuum and focus on each agency separately because our wounded, ill, and injured service members and their families need seamless, coordinated support from each.

Survivors

The Services continue to improve their outreach to surviving families. In particular, the Army's SOS (Survivor Outreach Services) program makes an effort to remind these families they are not forgotten. We appreciate the special consideration, sensitivity, and outreach to the families whose service members have committed suicide. We do have some concerns about the effect federal civilian employee downsizing will have on this program when certain expectations for survivors have been established. We would like to acknowledge the work of the Tragedy Assistance Program for Survivors (TAPS) in this area as well. They have developed unique outreach to these families and hold support conferences to help surviving family members navigate what is a very difficult time with many unanswered questions. DoD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need through all of VA's venues. We believe Congress must grant authority to allow coverage of bereavement or grief counseling under the TRICARE behavioral health benefit. The goal is the right care at the right time for optimum treatment effect.

We are grateful the extended TRICARE Active Duty Dental benefit for survivors has finally been implemented. We were disappointed that TRICARE chose to use the date of implementation instead of the date the legislation was passed as the effective date for these families.

The need for designated bereavement leave has been brought to our attention. Service members, especially those married to other service members, many times are not allowed the administrative leave necessary to finalize paperwork and other operations that may be required after the loss of a loved one, never mind the need to grieve. While this should seem to be straightforward, the recent introduction of non-chargeable adoption and paternity leave demonstrates the gentle nudge that some commanders need to allow their service members the time to complete administrative tasks. The service member may then return to duty without the distraction of important tasks left undone. This leave would be at the discretion of the commander, as are the other two designated leaves.

Recommend that grief counseling be more readily available to survivors as a TRICARE benefit.

Establish a designated bereavement leave policy to allow the surviving service member to complete required administrative tasks in a timely manner and fully return to duty more quickly.

Our Association still believes the benefit change that will provide the most significant long-term advantage to the financial security of all surviving families would be to end the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP). Ending this offset would correct an inequity that has existed for many years. Each payment serves a different purpose. The DIC is a special indemnity (compensation or insurance) payment paid by the VA to the survivor when the service member's service causes his or her death. The SBP annuity, paid by DoD, reflects the longevity of the service of the military member. It is ordinarily calculated at 55 percent of retired pay. Military retirees who elect SBP pay a portion of their retired pay to ensure that their family has a guaranteed income should the retiree die. If that retiree dies due to a service-connected disability, their survivor becomes eligible for DIC.

Surviving active duty spouses can make several choices, dependent upon their circumstances and the ages of their children. Because SBP is offset by the DIC payment, the spouse may choose to waive this benefit and select the "child only" option. In this scenario, the spouse would receive the DIC payment and the children would receive the full SBP amount until each child turns 18 (23 if in college), as well as the individual child DIC until each child turns 18 (23 if in college). Once the children have left the house, this choice currently leaves the spouse with an annual income of $13,848, a significant drop in income from what the family had been earning while the service member was alive and on active duty. The percentage of loss is even greater for survivors whose service members served longer. Those who give their lives for their country deserve more fair compensation for their surviving spouses.

We believe several other adjustments could be made to the Survivor Benefit Plan. Allowing payment of the SBP benefits into a Special Needs Trust in cases of disabled beneficiaries will preserve their eligibility for income based support programs. The government should be able to switch SBP payments to children if a surviving spouse is convicted of complicity in the member's death.

We believe there needs to be DIC equity with other federal survivor benefits. Currently, DIC is set at $1,195 monthly (43 percent of the Disabled Retirees Compensation). Survivors of federal workers have their annuity set at 55 percent of their Disabled Retirees Compensation. Military survivors should receive 55% of VA Disability Compensation. We are pleased that the requirement for a report to assess the adequacy of DIC payments was included in the NDAA FY09. We are awaiting the overdue report. We support raising DIC payments to 55% of VA Disability Compensation. When changes are made, we ask Congress to ensure that DIC eligibles under the old system receive an equivalent increase.

Imagine that you have just experienced the death of your spouse, a retired service member. In your grief, you navigate all the gates you must, fill out paperwork, notify all the offices required. Then, the overdrawn notices start showing up in your mailbox. Bills that you thought had been paid at the beginning of the month suddenly appear with "overdue" on them. Retirees are paid proactively, that is, they receive retired pay for the upcoming month, i.e. on May 31st, a retiree receives retired pay for the month of June. Presently, the government has the authority to take back the full month's pay from the retiree's checking account when that retiree dies. Payment for the number of days the retiree was alive in the month is subsequently returned to the surviving spouse. The VA, on the other hand, allows the surviving spouse to keep the last month of disability pay. We support H.R. 493, which would allow the surviving spouse or family to keep the last month of retired pay to avoid financial penalties caused by the decrease of funds in a checking account.

Eliminate the DIC offset to SBP to recognize the length of commitment and service of the career service member and spouse. We support H.R. 178 and S. 260, which both provide for that elimination.

Allow SBP benefits to be paid to a Special Needs Trust in cases of disabled family members.

Increase DIC to 55 percent of VA Disability Compensation.

Provide for forgiveness of overpayments of retired pay paid to deceased retired members of the Armed Forces following their death. We support H.R. 493, "The Military Retiree Survivor Comfort Act," which provides for that forgiveness.

Former Spouses, Abandoned Spouses

On September 10, 2001, DoD released a report containing recommendations for improvements to the Uniformed Services Former Spouse Protection Act (USFSPA). While Congress has addressed one or two of the recommendations from the report in the ensuing 11 years, none of them have been passed. We endorse the TMC recommendation for a hearing on this important issue.

We have also heard from a number of spouses who have been abandoned physically and financially. There can be many reasons for this, some related to behavioral health, some to inability of the families to reintegrate after many deployments. We intend to pursue this issue with DoD and the Services since it appears not to need a legislative fix. However, we do feel it is important enough to mention as a symptom of how our families and marriages are suffering after 11 years of war.

Our Association recommends that legislative action be taken to implement recommendations of the DoD Report on the Uniformed Services Former Spouse Protection Act including:

- ***Base the award amount to the former spouse on the grade and years of service of the member at time of divorce (not time of retirement);***
- ***Prohibit the award of imputed income while on active duty, which effectively forces active duty members into retirement;***
- ***Extend 20/20/20 benefits to 20/20/15 former spouses;***
- ***Permit the designation of multiple Survivor Benefit Plan (SBP) beneficiaries with the presumption that SBP benefits must be proportionate to the allocation of retired pay;***
- ***Eliminate the "10-year Rule" for the direct payment of retired pay allocations by the Defense Finance and Accounting Service (DFAS);***
- ***Permit SBP premiums to be withheld from the former spouse's share of retired pay if directed by court order;***
- ***Permit a former spouse to waive SBP coverage;***
- ***Repeal the one-year deemed election requirement for SBP; and***

Assist DoD and the Services with greater outreach and expanded awareness to members and former spouses of their rights, responsibilities, and benefits upon divorce.

Implementation of the Repeal of "Don't Ask, Don't Tell"

We are very pleased with the implementation of the repeal of "Don't Ask, Don't Tell". We have heard from many gay and lesbian service members and their families about how accepted and welcomed they have felt by the military community. They are participating in support activities and accessing resources where they can. Our Association is pleased at the ongoing efforts by the DoD and the Services to monitor the implementation. We were heartened to read in the recent statement by Dr. Jo Ann Rooney, Acting Under Secretary of Defense for Personnel and Readiness about the formal monitoring process and the feedback they continue to get back from all service members. We are pleased DoD is engaged in a comprehensive review of the possibility of extending eligibility for additional benefits, when legally permitted, to same-sex partners. The success of this implementation underlines the importance of careful planning and training when instituting controversial new policies. We congratulate DoD and the Services on its success.

Military Families – Our Nation's Families

Bringing the troops home does not end our military's mission or the necessity to support military families, especially their children, dealing with the long-term effects of more than a decade at war. Downsizing and budget cuts will present new challenges. The government should ensure military families have the tools to remain ready. Effective support for military families must involve a broad network of government agencies, community groups, businesses, and concerned citizens.

Our Nation must continue to fund what works to support military families, protect the most vulnerable, and, above all, value their service.

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STATEMENT OF

THE MILITARY COALITION (TMC)

before the

HOUSE ARMED SERVICES
SUBCOMMITTEE ON PERSONNEL

March 06, 2012

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning issues affecting the uniformed services community. This statement for the record 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
AMVETS (American Veterans)
Army Aviation Association of America
Association of Military Surgeons of the United States
Association of the United States Army
Association of the United States Navy
Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
Commissioned Officers Association of the U.S. Public Health Service, Inc.
Fleet Reserve Association
Gold Star Wives of America, Inc.
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the United States of America
Marine Corps League
Marine Corps Reserve Association
Military Chaplains Association of the United States of America
Military Officers Association of America
Military Order of the Purple Heart
National Association for Uniformed Services
National Guard Association of the United States
National Military Family Association
Naval Enlisted 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
Wounded Warrior Project

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

Executive Summary

Force Levels

Over the past several years, Congress has addressed the greater than anticipated requirements and resources to support the operational requirements and the resulting negative impact on the quality of life of uniformed servicemembers by boosting the Services' end strength resulting in increasing dwell time.

TMC remains concerned about the adequacy of strength levels in light of stress indicators including increased divorces, alarming suicide rates, and other symptoms.

Therefore, the Coalition urges the Subcommittee to:

- Ensure that the drawdown does not proceed at a rate which would adversely impact the required dwell time for the troops; that is, sustain force levels which are consistent with the mission.
- Ensure that the Services maximize the use of voluntary drawdown tools (including the temporary early retirement authority included in the FY2012 National Defense Authorization Act) before resorting to involuntary measures.
- Sustain adequate recruiting and retention resources to enable the uniformed services to sustain their continuing needs for top-quality personnel.
- Support a defense budget that funds both people and weapons needs.

Military Retirement

The purpose of the unique military retirement package is to offset the extraordinary demands and sacrifices inherent in a service career. These benefits provide a powerful incentive for top-quality people to serve 20-30 years in uniform.

The Administration's budget submission calls for a BRAC-like study to review the retirement system which has proven to be so critical to sustaining long-term retention and readiness. The program must not be subject to a short-circuited legislative process that denies due diligence and leaves this crucial program subject to the whims of a small group tasked to meet a political deadline.

The Coalition urges the Subcommittee to:

- Oppose initiatives that would "civilianize" the military retirement system, ignore the lessons of the ill-fated REDUX initiative, and inadequately recognize the unique and extraordinary demands and sacrifices inherent in a military career.
- Oppose a BRAC-like legislative process for military retirement reform that would short-circuit the opportunity for thorough Armed Services Committee deliberation.

Currently Serving Issues

Compensation – Congress has made great strides to restore military pay comparability over the past 12 years, including a statutory change that explicitly ties military pay raises to Employment Cost Index (ECI) growth.

Despite significant progress and retention problems associated with the "erosion of pay and benefits" abated, there are renewed calls to cut back on military raises, create a new comparability standard or substitute more bonuses for pay raises in the interests of deficit reduction.

The Coalition believes such proposals are exceptionally short-sighted in view of the extensive negative experience with military pay raise caps.

The Coalition urges the Subcommittee to sustain fully-comparable annual military pay raises based on the Employment Cost Index as specified in current law.

Wounded, Ill, and Injured Servicemember Compensation – Complex challenges remain in overseeing and validating massive policy and program changes among the military services; the DoD; the VA; several Centers of Excellence; a multitude of civilian contractors and non-governmental agencies; and at least six congressional oversight committees.

The Coalition urges the Subcommittee to:
- Ensure any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled servicemembers.
- Oppose distinguishing between disabilities incurred in combat versus non-combat service when determining benefits eligibility for retirement.
- Support extending eligibility for residence in on-base facilities for up to one year to medically retired, severely wounded servicemembers and their families.

DoD Resale Operations – TMC strongly believes military commissary, exchange and Morale Welfare and Recreation (MWR) programs contribute significantly to a strong national defense by sustaining morale and quality of life for military beneficiaries both within the United States and around the globe.

The Coalition urges the Subcommittee to resist initiatives to civilianize or consolidate DoD resale systems in ways that would reduce their value to patrons.

Family Readiness and Support – A fully funded, robust family readiness program is crucial to military readiness, especially given the continuing demands of deployments and the uncertainty of the legacy of the effects of 10 years of war on servicemembers and their families.

The Coalition urges the Subcommittee to:
- Continue much-needed supplemental funding authority to schools impacted by large populations of military students.
- Direct DoD to report on MWR category programs.
- Fully fund effective programs.
- Ensure all National Guard and Reserve Yellow Ribbon Programs meet a standard level of family support within each State.
- Continue support for child care needs of the highly deployable, operational total force community.
- Encourage greater military spouse educational and career opportunities, and ensure existing programs are accessible and effective.
- Continue pressing the Defense Department to implement flexible spending accounts to enable military families to pay health care and child care expenses with pre-tax dollars.

Base Realignment and Closure (BRAC) Rounds – The Administration's budget calls for two additional rounds of BRAC in order to garner savings. The Coalition is very concerned that these decisions are driven solely to save money.

The Coalition urges the subcommittee to proceed cautiously with additional BRAC rounds and verify DoD has accounted for all the implementing costs of their proposals.

National Guard and Reserve Issues

Operational Reserve Retention and Retirement Reform – The current law that credits only active service since January 28, 2008 disenfranchises and devalues the service of hundreds of thousands of Guard/Reserve members who served combat tours (multiple tours, in thousands of cases) between 2001 and 2008.

The Coalition urges the Subcommittee to:
- Eliminate the fiscal year limitation which effectively denies full early retirement credit for active duty tours that span the October 1 start date of a fiscal year.
- Modernize the reserve retirement system to incentivize continued service beyond 20 years and provide fair recognition of increased requirements for active duty service.
- Authorize early retirement credit for all Guard and Reserve members who have served on active duty tours of at least 90 days retroactive to September 11, 2001.

Yellow Ribbon Reintegration Program – Congress has provided increased resources to support the transition of warrior-citizens back into the community; however, program execution remains spotty from state to state and falls short for returning Federal Reserve warriors in widely dispersed regional commands.

The Military Coalition urges Congress to hold oversight hearings and direct additional improvements in coordination, collaboration and consistency of Yellow Ribbon services between States.

Reserve Compensation System – Related to this are demands on qualifications, mental skills, physical fitness, and training in conjunction with national security missions at home and abroad. The compensation system needs to be improved to attract and retain individuals into the Guard/Reserve.

The Coalition recommends Congress authorize:
- Credit for all inactive duty training points earned annually toward reserve retirement.
- Parity in special incentive pay for career enlisted/officer special aviation incentive pay, diving special duty pay, and pro-pay for reserve component medical professionals.
- Recalculation of retirement points after one year of activation. A recent law change allowed certain flag and general officers to recalculate retirement pay after one year of active duty. TMC believes this opportunity should be made available to all ranks.

Guard/Reserve GI Bill – Benefits for joining the Selected Reserve were not upgraded or integrated in the Post-9/11 GI Bill as TMC has long recommended. However, the Budget request proposes to reduce contributions into the DoD Educational Benefit Trust Fund.

The Coalition recommends the Subcommittee:

- Restore basic reserve MGIB benefits for initially joining the Selected Reserve to the historic benchmark of 47-50% of active duty benefits.
- Integrate reserve and active duty MGIB laws in Title 38.
- Enact academic protections for mobilized Guard and Reserve students, including refund guarantees and exemption of Federal student loan payments during activation.

Guard/Reserve Family Support Programs – We have seen considerable progress in outreach programs and services for returning Guard and Reserve warriors and their families. Family support programs promote better communication with servicemembers. Specialized support and training for geographically separated Guard and Reserve families and volunteers are needed.

The Coalition urges the Subcommittee to:

- Ensure programs are in place to meet the special information and support needs of families of individual augmentees or those who are geographically dispersed.
- Fund joint programs among military and community leaders to support servicemembers and families during all phases of deployments.
- Provide preventive counseling services for servicemembers and families.
- Authorize child care, respite care, family readiness group meetings and drill time.
- Improve the joint family readiness program to facilitate understanding and sharing of information between all family members.

Retiree Issues

Cost-of-Living Adjustments (COLAs) – COLAs are particularly important to military retirees, disabled retirees, and survivors because they start drawing their annuities at younger ages than most other COLA-eligibles and thus experience the compounding effects over a greater number of years. To the extent that COLAs fail to keep up with living costs, real purchasing power declines dramatically as long the longer a retiree lives.

The Coalition urges the Subcommittee to ensure continued fulfillment of congressional COLA intent, as expressed in House National Security (HNSC) Committee Print of Title 37, USC: "to provide every military retired member the same purchasing power of the retired pay to which he was entitled at the time of retirement [and ensure it is] not, at any time in the future...eroded by subsequent increases in consumer prices."

Concurrent Receipt – The Coalition strongly believes that career military members earn their retired pay by service alone, and that those who suffer a service-caused disability in the process should have any VA disability compensation from the VA added to, not subtracted from, their service-earned military retired pay and this remains a key goal in 2012.

The Coalition urges the Subcommittee to continue to seek options to:

- Expand Concurrent Retirement and Disability Payments (CRDP) to disabled retirees not eligible under the current statute, to include vesting of earned retirement credit for Chapter 61 retirees with less than 20 years of service.

- Resolve the so-called Combat Related Special Compensation (CRSC) "glitch" that causes combat-disabled members' compensation to decline when their VA disability rating is increased; or as an interim step.
- Pursue legislation specifying that a disabled retiree's CRSC disability compensation cannot be reduced when his or her VA disability rating increases until the retiree is afforded the opportunity to elect between CRSC and CRDP.

Fair Treatment for Servicemembers Affected by Force Reductions – Over the next five years, over 100,000 additional servicemembers will transition from wearing a uniform into the private sector as part of the force drawdown.

During any force reduction, servicemembers who intend to make the service a career are forced out. We believe the Nation should recognize their service and provide a "transportable" benefit for those that have their careers curtailed involuntarily short of 20 years.

The Coalition recommends enacting temporary legislation that would allow members separated during periods of significant force reductions to deposit part or all of their involuntary separation pay or VSP into their TSP account.

Survivor Issues

SBP-DIC Offset – The Coalition believes widows whose sponsors' deaths were caused by military service should not be last in line for redress.

The Coalition urges the Subcommittee to:
- Continue its leadership in seeking to eliminate the SBP-DIC offset.
- Authorize SBP annuities to be placed into a Special Needs Trust for disabled survivors who otherwise lose eligibility for Supplemental Security Income (SSI) and Medicaid.
- Reduce the age for paid-up SBP to age 67 to be fairer to those who joined the military at age 17, 18 or 19.
- Reinstate SBP annuities to survivors who transfer benefits to their children when the children reach majority, or when a second marriage ends.
- Exempt SBP-eligible children from being inadvertently penalized by the Alternative Minimum Tax (AMT), which treats SBP as unearned income and taxes it at the higher 26% AMT rate.

Final Retired Pay Check – Under current law, DFAS recoups from military widows'/widowers' bank accounts all retired pay for the month in which a retiree dies.

TMC urges the Subcommittee to authorize survivors of retired members to retain the final month's retired pay for the month in which the retiree dies.

Overview

Mr. Chairman, The Military Coalition thanks you and the entire Subcommittee for your strong support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors. Your efforts have had a significant and positive impact in the lives of the entire uniformed services community.

Presently, the Coalition has three major concerns with the Administration's proposed FY2013 Department of Defense (DoD) budget: health care fee increases, force level reductions, and the establishment of a commission to examine military retirement. This statement will focus on two of these areas as well as provide our collective perspective on other issues concerning the entire uniformed service community. We will address health care issues in a separate statement for the March 22 hearing.

The past few years have been exceptionally arduous, with our military winding down operations in Iraq while continuing operations in Afghanistan, all as the nation recovers slowly from the economic crisis. Congress and the Administration have had difficult choices to make as they worked to bolster the weak economy while facing record-breaking budget deficits.

We are grateful that DoD and Congress have given personnel issues top priority in the past few years. However, as we enter the eleventh year of intense wartime operations, the Coalition believes that critical personnel issues are being marginalized in the proposed FY2013 DoD budget.

Despite extraordinary demands, men and women in uniform are still answering the call – thanks in no small measure to the Subcommittee's strong and consistent support – but only at the cost of ever-greater personal sacrifices.

As you know, we have seen dramatic increases in suicide rates which reflect the long-term effects of requiring the same people to return to a combat theater again and again. In addition, there are reports that the military divorce rates are at the highest level since 1999.

In these times of growing political and economic pressures, the Coalition relies on the continued good judgment of the Armed Services Committees to ensure the Nation allocates the required resources to sustain a strong national defense, and in particular, to properly meet the pressing needs of the less than one percent of the American population – our men and women in uniform – who protect the freedoms of the remaining 99 percent.

In this statement, The Coalition offers our collective recommendations on what must be done to meet these essential needs.

Force Levels

Personnel Strength and Associated Funding – The Pentagon's budget submission includes a significant drawdown of over 100,000 troops, predominately affecting troops on the ground – the same troops that have endured repeated deployments over the past decade.

We understand that the Services are looking to reduce force levels as our troops return from the Middle East and the Coalition's primary concern is that the Pentagon's plan does not force additional burdens on our servicemembers and their families by continuing to fall short of dwell time goals.

For the last decade, servicemembers and their families have endured unprecedented sacrifices often having less than a year at home before returning for another year in combat.

Both Defense and Service leaders have acknowledged that minimum dwell time should be at least two years at home after a year deployment. That minimum goal has yet to be attained for all deploying servicemembers.

We are also concerned about sustaining a surge capacity for unexpected contingencies (as of Sept 10, 2011, no one anticipated the following decade-plus of war) and retaining combat experience by encouraging departing veterans to join the Guard and Reserve.

Cutting Guard/Reserve as well as active forces will make achieving these goals even more difficult.

The Coalition urges the Subcommittee to ensure adequate personnel strengths and funding are authorized to meet national security strategy requirements and dwell time goals.

TMC remains concerned about the adequacy of strength levels in light of stress indicators including increased divorces, alarming suicide rates, and other symptoms.

Therefore, the Coalition urges the Subcommittee to:

- ***Ensure that the drawdown does not proceed at a rate which would adversely impact the required dwell time for the troops; that is, sustain force levels which are consistent with the mission.***
- ***Ensure that the Services maximize the use of voluntary drawdown tools (including the temporary early retirement authority included in the FY2012 Defense Authorization Act) before resorting to involuntary measures.***
- ***Sustain adequate recruiting and retention resources to enable the uniformed services to sustain the continuing needs for top-quality personnel.***
- ***Support a defense budget that funds both people and weapons needs.***

Military Retirement

Uniformed Services Retirement System – The entire military compensation system, to include the retirement benefit, is based on principles outlined in the DoD's Military Compensation Background Papers and "should be designed to foster and maintain the concept of the profession of arms as a dignified, respected, sought after, and honorable career."

The purpose of the unique military retirement package is to offset the extraordinary demands and sacrifices inherent in a service career. Benefits provide a powerful incentive for top-quality people to serve 20-30 years in uniform, despite the burden of sacrifices as eloquently articulated by the Secretary of the Air Force during his January 18, 1978 testimony before the President's Commission on Military Compensation:

> "The military services are unique callings. The demands we place on our military men and women are unlike those of any other country. Our worldwide interests and commitments place heavy burdens and responsibilities on their shoulders. They must be prepared to live anywhere, fight anywhere, and maintain high morale and combat efficiency under frequently adverse and uncomfortable conditions. They are asked to undergo frequent exposure to risk, long hours, periodic relocation and family separation. They accept abridgement of freedom of speech, political and organizational activity, and control over living and working conditions. They are all part of the very personal price our military people pay.
>
> "Yet all of this must be done in the light of – and in comparison to – a civilian sector that is considerably different. We ask military people to be highly disciplined when society places a heavy premium on individual freedom, to maintain a steady and acute sense of purpose when some in society question the value of our institutions and debate our national goals. In short, we ask them to surrender elements of their freedom in order to serve and defend a society that has the highest degree of liberty and independence in the world. And, I might add, a society with the highest standard of living and an unmatched quality of life.
>
> "Implicit in this concept of military service must be long-term security and a system of institutional supports for the serviceman and his family which are beyond the level of compensation commonly offered in the private, industrial sector."

There is no better illustration of that reality than the experience of the past decade of war. Absent the career drawing power of the current 20-year retirement system and its promised benefits, the Coalition asserts that sustaining anything approaching needed retention rates over such an extended period of constant combat deployments would have been impossible.

The crucial element to sustaining a high-quality, career military force is establishing a strong bond of reciprocal commitment between the servicemember and the government. If that reciprocity is not fulfilled, if we "break faith" with those that serve, retention and readiness will inevitably suffer.

The Coalition believes the government has a unique employer's responsibility to the small segment of Americans it actively induces to subordinate their interests to the America's for 20 to 30 years that goes far beyond any civilian employer's obligation to its employees.

The uniformed services retirement system has had its critics since the 1970s and even earlier.

In the 1980s, budget pressures led to amending retirement rules twice for new service entrants:

- Basing retired pay calculations on the high-36-month average of basic pay instead of final basic pay (1980), and
- Enacting the REDUX system that cut 20-year retired pay value by more than 25% (1986).

At the time the REDUX plan was being considered, then-Secretary of Defense Caspar Weinberger strongly (but unsuccessfully) opposed it (see attached letter), arguing the change would harm retention and degrade readiness. "It says in absolute terms," said Weinberger, "that the unique, dangerous, and vital sacrifices they routinely make are not worth the taxpayer dollars they receive."

When his prediction of adverse retention consequences proved all too accurate in the 1990s, Congress had to repeal REDUX in 1999 at the urging of the Joint Chiefs of Staff.

Subsequently, innumerable studies and task forces have recommended further dramatic changes, usually either to save money, to make the system more like those offered under civilian programs, or both.

Most recently, groups such as the National Commission on Fiscal Responsibility and Reform, the Debt Reduction Task Force, the Sustainable Defense Task Force, and the Defense Business Board's "Modernizing the Military Retirement" Task Group have all recommended dramatically revamping the system more on civilian lines, with significantly reduced and delayed military retirement compensation.

All too aware of the lessons of REDUX, Congress has wisely ignored and dismissed these ivory-tower recommendations, which propose far greater retirement cuts than REDUX entailed.

The existing retirement system is often characterized as "inflexible", limiting the ability of Service personnel managers to more precisely and effectively manage the force. The Coalition strongly disagrees.

The Services already have substantial authority to adjust high-year-of-tenure limits to enforce the unique military "up-or-out" promotion system. Other authorities exist, and the Services are currently exercising them, to incentivize voluntary separations and voluntary or mandatory early retirements.

The Services routinely tighten retention and reenlistment incentives and other restrictions when budget or other considerations create a need for additional separations and retirements. And when necessary, Congress has provided additional special drawdown authorities.

But the practical reality is that precisely planned force management initiatives are regularly tossed aside in the wake of world events which force dramatic reversals of those planned actions. Plans which envision delaying retirement eligibility until age 57 or 60 belie the reality that the Services don't want the vast majority of members to stay in uniform that long.

Service desires for unlimited flexibility to shape the force may be appropriate for management of hardware and other non-sentient resources. However, the Services are dependent upon attracting and retaining smart people who understand all too well when their leaders put no limits on the sacrifices that may be demanded of them, but also wish to reserve the right to kick them out at will....even while building a system that assumes they will be willing to serve under these conditions until age 60.

Servicemembers from whom we demand so much deserve some stability of career expectations in return.

We believe that "civilianizing" the military benefit package would dramatically undermine the primary military career retention incentive and would be disastrous for retention and readiness, as they increase the incentives to leave and reduce the incentives for career service.

Moreover, we believe it is irresponsible to focus on budget and "civilian equity" concerns while ignoring the primary purpose of the retirement system – to ensure a strong and top-quality career force in spite of arduous service conditions that no civilians experience and few are willing to accept.

The Coalition is particularly concerned that the Administration's budget submission calls for a BRAC-like legislative strategy under which Congress would have to give a retirement study commission's recommendations an "up or down" vote with only limited debate and no opportunity for amendments.

The Coalition is not opposed to a review of retirement pay, but we adamantly oppose a BRAC-like consideration process that would subvert thorough review, consideration, and determinations of propriety by the Armed Services Committees.

The military retirement program that has proven to be so critical to sustaining long-term retention and readiness, must not be subject to a short-circuited legislative process that denies due diligence and leaves this crucial program subject to the whims of a small group tasked to meet a political deadline.

The Coalition urges the Subcommittee to:

- ***Oppose initiatives that would "civilianize" the military retirement system, ignore the lessons of the ill-fated REDUX initiative, and inadequately recognize the unique and extraordinary demands and sacrifices inherent in a military career.***
- ***Oppose a BRAC-like legislative process for military retirement reform that would short-circuit the opportunity for thorough Armed Services Committee deliberation.***

Currently Serving Issues

Compensation – The Coalition is pleased that the Administration's budget plan envisions proposes military pay raises for 2013 and 2014 that reflect the growth in private sector pay, as measured by the Bureau of Labor Statistics' Employment Cost Index (ECI).

But we are very concerned that the proposal includes plans to break the tie to civilian pay growth by limiting military raises to .5%, 1%, and 1.5% for 2015, 2016, and 2017, respectively.

History has shown that capping military raises is an exceptionally slippery slope that has never ended well.

In the 1970s, a succession of annual pay raise caps contributed to serious retention problems that had to be addressed by two large "catch-up" raises in 1981 and 1982. But that lesson was quickly forgotten.

Throughout the 1980s and '90s, budget problems led to regular capping of military pay raises below private sector pay growth, eventually accumulating a "pay comparability gap" which peaked at 13.5% in 1998-99, and again contributed significantly to serious retention problems.

Congress has made great strides to restore military pay comparability over the intervening 12 years, including a statutory change that explicitly ties military pay raises to ECI growth.

Now that significant progress has been made and the "erosion of pay and benefits" retention-related problems have abated, there have been renewed calls to cut back on military raises, create a new comparability standard or substitute more bonuses for pay raises in the interests of deficit reduction.

The Coalition believes such proposals are exceptionally short-sighted in view of the extensive negative experience with military pay raise caps.

The Coalition is concerned that many in the Administration and some members of Congress are unaware of the history of past compensation changes and their unforeseen outcomes. Moreover, some view these vital programs simply as a source of savings without regard to the impact they may have on long term readiness in the All-Volunteer Force.

History indicates that, once military pay raise caps start, they tend to continue until they cause retention problems that then have to be addressed through significant pay raise plus-ups.

This is a significant irony, in that the whole purpose of sustaining pay comparability through good times and bad is to prevent retention and readiness problems from occurring, rather than going through an endless cycle of causing problems and then repairing them.

Additionally, the Pentagon has been advocating a new comparability standard under which each pay and longevity cell would represent the 70th percentile of compensation for similarly-educated civilians.

A 2010 Congressional Budget Office report asserted that, considering adjustments in housing allowances, many military people actually are paid somewhat more than their civilian counterparts in terms of Regular Military Compensation (RMC), composed of basic pay, food and housing allowances, and the tax advantage that accrues because the allowances are tax-free.

The Coalition believes such assertions are fundamentally flawed for three distinct reasons.

First, the RMC concept was developed in the 1960s, when all servicemembers received the same allowances, regardless of location, and the allowances were arbitrarily established. Congress has since transformed the allowances into reimbursements for actual food costs and median locality-based housing costs. Under the RMC comparability concept, a year in which taxes increase and average housing allowances rise (e.g., based on growth in high-cost areas) would yield a perverse requirement to cut basic pay to restore comparability.

Second, the Coalition is not convinced that the civilian comparison cohort or percentile comparison points as proposed by DoD are appropriate given that the military:

- Recruits from the top half of the civilian aptitude population;
- Finds that only about 25% of America's youth qualify for entry;
- Requires career-long education and training advancement; and
- Enforces a competitive "up-or-out" promotion system to ensure progressive quality enhancements among those with longer service.

Third, the Coalition believes it is essential to recognize that compensation is not simply the amount one is paid. It is pay divided by what's required of the recipient to earn that pay. If we increase pay 25% but require 100% more sacrifice to earn it, that's not a pay raise.

In that context, today's conditions of service are far more arduous than anything envisioned 40 years ago by the creators of the All-Volunteer Force, who believed a protracted war would require reinstitution of the draft.

Moreover, a fundamental requirement for any pay comparability standard is that it should be transparent and understandable by all. The Coalition has sought, but has never been provided by DoD, any data on what civilian comparison cohort was selected and why, and what rationale was used to establish a specific percentile comparison point.

The Coalition agrees with the approach the Congress has consistently taken – that the best comparability measure is a comparison of the military basic pay raise percentage with the percentage growth private sector pay, as measured by the Bureau of Labor Statistics' Employment Cost Index (ECI). The government uses the ECI for every other measure of private pay growth, and it's transparent to government leaders and servicemembers alike.

The Coalition urges the Subcommittee to sustain fully-comparable annual military pay raises based on the Employment Cost Index as specified in current law.

Wounded, Ill, and Injured Servicemember Compensation – As the Pentagon enters the 11th year of war, the seamless transition between DoD and the Department of Veterans Affairs (VA) continues to be problematic in many cases for our wounded, ill, injured troops; disabled veterans; and their family caregivers.

TMC acknowledges the significant progress that has been made in caring for our nation's heroes and thanks the Subcommittee for its leadership and oversight on these pressing issues, particularly in the last five years since the Walter Reed scandal that brought to light the flaws and inadequacies of both DoD and VA health care and benefits systems.

But complex challenges remain in overseeing and validating massive policy and program changes among the military services; the DoD; the VA; several Centers of Excellence; a multitude of civilian contractors and non-governmental agencies; and at least six congressional oversight committees.

There still exists a need to further streamline the Integrated Disability Evaluation System (IDES) and to improve the operational efficiency, effectiveness, consistency, and timeliness of the medical retirement process and DoD-VA coordination in the evaluation of disabilities. We also urge a greater alignment and correlation of federal programs such as TRICARE, Medicare, and Social Security Disability Insurance (SSDI) to ensure that severely wounded warriors who do not enroll in Medicare Part B do not lose TRICARE coverage.

The Coalition looks forward to continued work with the Subcommittee to address the remaining issues and fully establish systems of seamless care and benefits that support our transitioning wounded warriors and family members.

The Coalition urges the Subcommittee to:

- ***Ensure any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled servicemembers.***
- ***Oppose distinguishing between disabilities incurred in combat versus non-combat when determining benefits eligibility for retirement.***
- ***Support extending eligibility for residence in on-base facilities for up to one year to medically retired, severely wounded servicemembers and their families.***

DoD Resale Operations – The Military Coalition strongly believes military commissary, exchange and Morale Welfare and Recreation (MWR) programs contribute significantly to a strong national defense by sustaining morale and quality of life for military beneficiaries both within the United States and around the globe.

The Coalition is very concerned about initiatives to curtail appropriated fund support for these activities.

Repeated studies have shown that military commissaries provide $2 in compensation value to beneficiaries for each $1 of appropriated funding. That constitutes a very significant retention "bang for the buck."

Initiatives to civilianize commissaries or consolidate commissaries and exchanges to achieve budget savings would come only at the expense of devaluing their compensation and retention importance value for military patrons.

In order to be the best steward of our funds, we recommend that Congress direct the Pentagon to provide a report on all DoD and Service MWR Category A, B, and C Programs and Family Support/Readiness (Quality of Life [QoL] Programs). The report should include:

- A current listing of individual program funding levels by category, actual program expenditures vs. program requirement;
- An assessment of the effectiveness of each program including program standards and metrics; and
- A list of recommended changes to policy, including revisions in the current category program listings to more accurately support current war-time mission requirements and meet the needs of the 21st Century all-volunteer force.

The Coalition urges the Subcommittee to resist initiatives to civilianize or consolidate DoD resale systems in ways that would reduce their value to patrons.

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 continuing deployments, they often are being asked to do without in other important areas.

The Coalition urges the Subcommittee to continue to press the Defense Department to exercise its authority to establish flexible spending accounts (FSAs) for servicemembers so they can participate in the same pre-tax program available to all other federal employees for their out-of-pocket health and dependent care expenses.

Quality education is a top priority for military families. Servicemembers are assigned all across the United States and the world. Providing appropriate and timely funding of Impact Aid through the Department of Education with supplemental funding for highly impacted schools in the annual Defense Authorization Bill is critical to ensuring quality education military children deserve, regardless of where they live.

The Coalition urges the Subcommittee to:

- ***Continue much-needed supplemental funding authority to schools impacted by large populations of military students.***
- ***Direct DoD to report on MWR category programs.***
- ***Fully fund effective programs.***
- ***Ensure all National Guard and Reserve Yellow Ribbon Programs meet a standard level of family support within each State.***
- ***Continue support for child care needs of the highly deployable, operational total force community.***
- ***Encourage greater military spouse and surviving spouse educational and career opportunities, and ensure existing programs are accessible and effective.***
- ***Continue pressing the Defense Department to implement flexible spending accounts to enable military families to pay health care and child care expenses with pre-tax dollars.***

Base Realignment and Closure (BRAC) Rounds – The Administration's budget calls for two additional rounds of BRAC in order to garner savings. The Coalition is very concerned that these decisions are driven solely to save money.

Since the implementation of the 2005 BRAC, every GAO report has highlighted significant concerns about the process citing "concerns with DoD under reporting BRAC costs/savings and using non-BRAC accounts to fund requirements." In fact, the long term impact of the 2005 BRAC has yet to be seen, as the deadline ended less than six months ago.

Therefore, the Coalition urges the subcommittee to proceed cautiously with additional BRAC rounds and verify DoD has accounted for all the implementing costs of their proposals.

National Guard and Reserve Forces

Since Sept. 11, 2001, more than 842,000 Guard and Reserve servicemembers have been called up, including over 300,000 who have served multiple tours. There is no precedent in American history for this sustained reliance on citizen-soldiers and their families. To their credit, Guard and Reserve combat veterans continue to reenlist, but the ongoing pace of routine, recurring activations and deployments cannot be sustained indefinitely.

Guard and Reserve members and families face unique challenges in their readjustment following active duty service. Unlike active duty personnel, many Guard and Reserve members return to employers who question their contributions in the civilian workplace, especially as multiple deployments have become the norm. Many Guard-Reserve troops return with varying degrees of combat-related injuries and stress disorders, and encounter additional difficulties after they return that can cost them their jobs, careers and families.

Despite the continuing efforts of the Services and Congress, most Guard and Reserve families do not have access to the same level of counseling and support that active duty members have. In short, the Reserve components face increasing challenges virtually across the board, including major equipment shortages, end-strength requirements, wounded-warrior health care, and pre- and post-deployment assistance and counseling.

Operational Reserve Retention and Retirement Reform – Congress took the first step in modernizing the reserve compensation system with enactment of early retirement eligibility for certain reservists activated for at least 90 continuous days served since January 28, 2008.

Congress authorized a historic expansion of operational reserve policy in the 2012 NDAA. Now up to 60,000 reservists may be called up for up to one year to perform non-emergency missions that are pre-planned and budgeted by the Services.

The Coalition believes this change only further underscores the need to ensure Guard and Reserve members' compensation keeps pace with the increased service expectations being imposed on them. The greater the demands placed on them, the greater the need to enhance inducements that are essential to sustain the operational reserve force over the long term.

Repeated, extended activations make it more difficult to sustain a full civilian career and impede Reservists' ability to build a full civilian retirement, 401(k), etc. Regardless of statutory protections, periodic long-term absences from the civilian workplace can only limit Guard/Reserve members' upward mobility, employability and financial security. Further, strengthening the reserve retirement system will serve as an incentive to retaining critical mid-career officers and NCOs for continued service and thereby enhance readiness.

As a minimum, the next step in modernizing the reserve retirement system is to eliminate the inequity inherent in the current fiscal year retirement calculation, which only credits 90 days of active service for early retirement purposes if it occurs within the same fiscal year. The current rule significantly penalizes members who deploy in July or August vs. those deploying earlier in the fiscal year to provide equal retirement-age-reduction credit for all activated service rendered since Sept. 11, 2001.

The current law that credits only active service since January 28, 2008 disenfranchises and devalues the service of hundreds of thousands of Guard/Reserve members who served combat tours (multiple tours, in thousands of cases) between 2001 and 2008.

Operational Reservists contributions to national security is demeaned by crediting a 90-day tour served from January through March, but only half credit for a 120-day tour served from August through November (because the latter covers 60 days in each of two fiscal years).

Moreover, the law-change authorizing early reserve retirement credit for qualifying active duty served after 28 Jan 2008 severed eligibility for TRICARE coverage until the reservist reaches age 60.

The Coalition urges the Subcommittee to:

- ***Eliminate the fiscal year limitation which effectively denies full early retirement credit for active duty tours that span the Oct 1 start date of a fiscal year.***
- ***Modernize the reserve retirement system to incentivize continued service beyond 20 years and provide fair recognition of increased requirements for active duty service.***
- ***Authorize early retirement credit for all Guard and Reserve members who have served on active duty tours of at least 90 days retroactive to September 11, 2001.***

Yellow Ribbon Reintegration Program – Congress has provided increased resources to support the transition of warrior-citizens back into the community. But program execution remains spotty from state to state and falls short for returning Federal Reserve warriors in widely dispersed regional commands. Programs should meet a standard level of family support within each state. Military and civilian leaders at all levels must improve the coordination and delivery of services for the entire operational reserve force. Many communities are eager to provide support and do it well. But Yellow Ribbon efforts in a number of locations amount to little more than PowerPoint slides and little or no actual implementation.

DoD must ensure that state-level best practices – such as those in Maryland, Minnesota and New Hampshire – are applied for all operational reserve force members and their families, and that Federal Reserve veterans have equal access to services and support available to National Guard veterans. Community groups, employers and service organization efforts need to be encouraged and better coordinated to supplement unit, component, Service and VA outreach and services.

The Military Coalition urges Congress to hold oversight hearings and direct additional improvements in coordination, collaboration and consistency of Yellow Ribbon services between States.

Reserve Compensation System – The increasing demands of qualifications, mental skills, physical fitness, and training readiness on the Guard and Reserve to perform national security missions at home and abroad and increased training requirements indicate that the compensation system needs to be improved to attract and retain individuals into the Guard/Reserve. The added responsibility of returning to active duty multiple times over the course of a reserve career requires improvements to the compensation package and to make it more equitable with the active component.

The Coalition recommends Congress authorize:

- ***Credit for all inactive duty training points earned annually toward reserve retirement.***
- ***Parity in special incentive pay for career enlisted/officer special aviation incentive pay, diving special duty pay, and pro-pay for reserve component medical professionals.***
- ***Recalculation of retirement points after 1 year of activation. A recent law change allowed certain flag and general officers to recalculate retirement pay after one year of active duty. TMC believes this opportunity should be made available to all ranks.***

Guard/Reserve GI Bill – The Coalition is most grateful to Congress for passage of the Post-9/11 GI Bill, which incorporates a number of major Coalition goals including benefits that match the cost of education, extension of the post-service usage period to 15 years, and cumulative credit for Guard-Reserve service on active duty. However, volunteers who join the Selected Reserve were left behind in this legislation.

Benefits for joining the Selected Reserve were not upgraded or integrated in the Post-9/11 GI Bill as TMC has long recommended. However, the Budget request proposes to reduce contributions into the DoD Educational Benefit Trust Fund. This could result in future cuts to this program.

The Coalition recommends the Subcommittee to:

- ***Restore basic reserve MGIB benefits for initially joining the Selected Reserve to the historic benchmark of 47-50% of active duty benefits.***
- ***Integrate reserve and active duty MGIB laws in Title 38.***
- ***Enact academic protections for mobilized Guard and Reserve students, including refund guarantees and exemption of Federal student loan payments during activation.***

Guard/Reserve Family Support Programs – We have seen considerable progress in outreach programs and services for returning Guard-Reserve warriors and their families. Family support programs promote better communication with servicemembers. Specialized support and training for geographically separated Guard and Reserve families and volunteers are needed.

The Coalition urges the Subcommittee to:

- ***Ensure programs are in place to meet the special information and support needs of families of individual augmentees or those who are geographically dispersed.***
- ***Fund joint programs among military and community leaders to support servicemembers and families during all phases of deployments.***
- ***Provide preventive counseling services for servicemembers and families.***
- ***Authorize child care, including respite care, family readiness group meetings and drill time.***
- ***Improve the joint family readiness program to facilitate understanding and sharing of information between all family members.***

Retiree Issues

Cost-of-Living Adjustments (COLAs) – In recent years, several commissions have proposed adjusting the Consumer Price Index (CPI) methodology to the so-called "chained CPI" calculation as a means of holding down COLA growth for military and federal civilian retired pay, Social Security and all other federal annuities over time.

Proponents of the chained CPI say it more accurately reflects changes in annuitants' cost of living by recognizing that their purchasing behavior changes as prices change. If the price of beef rises, for example, consumers may purchase more chicken and less beef.

The real issue with the chained CPI is whether one is measuring changes in prices or changes in quality of life. If one continues the logical progression of the argument, consumers might find themselves substituting hot dogs or pasta for chicken, etc.

The Bureau of Labor Statistics has estimated that implementation of the chained CPI would depress COLAs by about one-quarter of a percentage point per year.

The DoD actuary estimates that inflation will average 3 percent per year over the long term.

Using those two estimates, applying chained-CPI COLAs for a servicemember retiring at age 42 would yield about 10 percent less in his or her retired pay check at age 80 relative to the current COLA system.

Additionally, some commissions have proposed delaying any COLAs on military retired pay until age 60 or later, barring COLAs on annuity levels above some set dollar amount, or reducing the CPI by one-half percent or a full percentage point per year.

The Coalition believes such initiatives would constitute a breach of faith with military people and constitute a disproportional penalty.

COLAs are particularly important to military retirees, disabled retirees, and survivors because they start drawing their annuities at younger ages than most other COLA-eligibles and thus experience the compounding effects over a greater number of years. To the extent that COLAs fail to keep up with living costs, real purchasing power continues to decline ever more dramatically as long as one lives.

The Coalition urges the Subcommittee to ensure continued fulfillment of congressional COLA intent, as expressed in House National Security (HNSC) Committee Print of Title 37, USC: "to provide every military retired member the same purchasing power of the retired pay to which he was entitled at the time of retirement [and ensure it is] not, at any time in the future...eroded by subsequent increases in consumer prices."

Concurrent Receipt – In the FY2003 and 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 many disabled retirees. The Coalition is extremely grateful for the Subcommittee's efforts to continue progress in easing the adverse effects of the offset.

We were very optimistic in 2009 and 2010 that another very deserving group of disabled retirees would become eligible for concurrent receipt when the White House included a concurrent receipt proposal in the Budget Resolution – the first time in history any Administration had ever proposed such a fix.

The Administration's proposal would have expanded concurrent receipt eligibility over a five year period to all those forced to retire early from Service due to a disability, injury, or illness that was service-connected (chapter 61 retirees).

The Coalition is dismayed that, despite the Subcommittee's leadership efforts and White House support, the provision has not yet been enacted – an extremely disappointing outcome for a most deserving group of disabled retirees.

We recognize only too well the challenges associated with adding new mandatory spending provisions in this difficult budget environment. But making at least some progress to address this grievous inequity (e.g., covering all 100-percent disabled retirees with less than 20 years of service) is an important goal.

Additionally, the Coalition is concerned that an inadvertent problem persists in the statutory Combat-Related Special Compensation (CRSC) computation formula causes many seriously disabled and clearly eligible members to receive little or nothing in the way of CRSC. The Defense Department has acknowledged the problem in discussions with the Subcommittee staff, and the Coalition urges the Subcommittee to correct this technical problem.

The Coalition believes strongly in the principle that career military members earn their retired pay by service alone, and that those unfortunate enough to suffer a service-caused disability in the process should have any VA disability compensation from the VA added to, not subtracted from, their service-earned military retired pay and this remains a key goal in 2012.

The Coalition urges the Subcommittee to continue to seek options to:

- ***Expand Concurrent Retirement and Disability Payments (CRDP) to disabled retirees not eligible under the current statute, to include vesting of earned retirement credit for Chapter 61 retirees with less than 20 years of service.***
- ***Resolve the so-called Combat Related Special Compensation (CRSC) "glitch" that causes combat-disabled members' compensation to decline when their VA disability rating is increased; or as an interim step.***
- ***Pursue legislation specifying that a disabled retiree's CRSC disability compensation cannot be reduced when his or her VA disability rating increases until the retiree is afforded the opportunity to elect between CRSC and CRDP.***

Fair Treatment for Servicemembers Affected by Force Reductions – Over the next five years, over 100,000 additional servicemembers will transition from wearing a uniform into the private sector as part of the force drawdown.

Even though the President's budget includes additional funding for transition assistance for the Department of Labor, the Coalition remains concern over the adequacy of funding for DoD and the services based on what will be an ever increasing demand on transition services.

In addition, throughout the 1990s the services had several drawdown tools at their disposal to incentivize members to voluntarily leave the service: Voluntary Separation Incentive (VSI), Special Separation Benefit (SSB), and Temporary Early Retirement Authority (TERA). Voluntary Separation Pay (VSP) still exists and a recently reauthorized TERA will greatly aid the Services over the next five years.

During any force reduction, servicemembers who intend to make the service a career are forced out. We believe the Nation should recognize their service and provide a "transportable" benefit for those that have their careers curtailed involuntarily short of 20 years.

The Coalition emphasizes that this limited "vesting" initiative should be applied only during periods of significant force reductions and funding for it should not come at the expense of those who serve 20 years or more.

Authorizing separated servicemembers the ability to contribute part or all of their involuntary or voluntary separation pay into their Thrift Savings Plan (TSP) account would appropriately recognize their past service and provide a level of "transportable" career benefit under these difficult times.

The Coalition recommends enacting temporary legislation that would allow members separated during periods of significant force reductions to deposit part or all of their involuntary separation pay or VSP into their TSP account.

Survivor Issues

The Coalition is grateful to the Subcommittee for its significant efforts in recent years to improve the Survivor Benefit Plan (SBP), especially its major achievement in eliminating the significant benefit reduction previously experienced by SBP survivors upon attaining age 62.

SBP-DIC Offset – The Coalition believes strongly that current law is unfair in reducing military SBP annuities by the amount of any survivor benefits payable from the 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 annuity is reduced by the amount of DIC. A pro-rata share of the 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 insurance 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 annuity 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 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. This reality was underscored by the August 2009 Federal Court of Appeals ruling in *Sharp v. U.S.* which found, "After all, the servicemember paid for both benefits: SBP with premiums; DIC with his life."

The Veterans Disability Benefits Commission (VDBC) was tasked to review the SBP-DIC issue, among other DoD/VA benefit topics. The VDBC's final report to Congress agreed with the Coalition in finding that the offset is inappropriate and should be eliminated.

In 2005 then-Speaker Pelosi and other House leaders made repeal of the SBP-DIC offset a centerpiece of their GI Bill of Rights for the 21st Century. Leadership has made great progress in delivering on other elements of that plan, but the only progress to date on the SBP-DIC offset has been the enactment a small monthly Special Survivor Indemnity Allowance (SSIA).

The Coalition recognizes that the Subcommittee's initiative in the FY2008 defense bill to establish the Special Survivor Indemnity Allowance (SSIA) was intended as a first, admittedly very modest, step in a longer-term effort to phase out the Dependency and Indemnity Compensation (DIC) offset to SBP.

We're very grateful for the Subcommittee's subsequent efforts to increase SSIA amounts as additional steps toward the goal of eliminating the offset.

While fully acknowledging the Subcommittee's good-faith efforts to win more substantive progress, the Coalition shares the extreme disappointment and sense of abandonment of the SBP-DIC widows who are forced to sacrifice up to $1,195 each month and being asked to be satisfied with a $80 monthly rebate.

The Coalition understands the mandatory-spending constraints the Subcommittee has faced in seeking redress, but also points out that those constraints have been waived for many, many far more expensive initiatives, including the recent extension of civilian unemployment benefits.

The Coalition believes widows whose sponsors' deaths were caused by military service should not be last in line for redress.

The Coalition urges the Subcommittee to:

- ***Continue its leadership in seeking to eliminate the SBP-DIC offset.***
- ***Authorize SBP annuities to be placed into a Special Needs Trust for disabled survivors who otherwise lose eligibility for Supplemental Security Income (SSI) and Medicaid.***
- ***Reduce age for paid-up SBP to age 67 to be fairer to those who joined the military at age 17, 18 or 19.***
- ***Reinstate SBP annuities to survivors who transfer it to their children when the children reach majority, or when a second marriage ends.***
- ***Exempt SBP-eligible children from being inadvertently penalized by the Alternative Minimum Tax (AMT), which treats SBP as unearned income and taxes it at the higher 26% AMT rate.***

Final Retired Pay Check – Under current law, DFAS recoups from military widows'/widowers' bank accounts all retired pay for the month in which a retiree dies. Subsequently, DFAS pays the survivor a pro-rated amount for the number of days of that month in which the retiree was alive. This often creates hardships for survivors who have already spent that pay on rent, food, etc., and who routinely are required to wait several months for DFAS to start paying SBP benefits.

The Coalition believes this is an extremely insensitive policy imposed by the government at the 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.

In contrast to the law governing military retired pay treatment of survivors, the title 38 statute requires the VA to make full payment of the final month's VA disability compensation to the survivor of a disabled veteran.

The disparity between DoD and VA policy on this matter is indefensible. Congress should do for retirees' widows the same thing it did ten years ago to protect veterans' widows.

TMC urges the Subcommittee to authorize survivors of retired members to retain the final month's retired pay for the month in which the retiree dies.

Summary

The Military Coalition again thanks the Subcommittee for your unfailing support of the entire uniformed service community and for taking our concerns and priorities into consideration as you deliberate on the future of the one weapon system that has never let our Nation down – the men and women who wear and have worn the uniform and their families.

THE SECRETARY OF DEFENSE

WASHINGTON, THE DISTRICT OF COLUMBIA

15 NOV 1985

Honorable Thomas P. O'Neill, Jr.
Speaker of the House of
Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

The enclosed report complies with the requirements of section 667 of the Defense Authorization Act for fiscal year 1986.

Included in the report are drafts of the two pieces of legislation that would change the military non-disability retirement system. Each would result in a reduction in military retirement accrual funding of $2.9 billion in fiscal year 1986 as mandated by the Congress. This is a 16 percent reduction in military retired pay from the current system and is in addition to the 10 percent reduction that was imposed by the Congress in the high-three-year averaging adjustment in 1980.

Although the Department of Defense has prepared the draft legislation as required by the Congress, I want to make it absolutely clear that such action is not to be construed as support for either of the options for change. To the contrary, the Department of Defense is steadfastly opposed to the significant degradation in future combat readiness that would result from the changes required to achieve the mandated reduction. I am particularly concerned about the potential loss of mid-level officers, NCOs and Petty Officers who provide the first-line leadership and technical know-how so vital to the defense mission. Unless offsetting compensation is provided, our models conservatively indicate that our future manning levels in the 10 to 30 year portion of the force would drop below the dismal levels of the late 1970s when aviator shortages and shortfalls in Army NCO and Navy Petty Officer leadership seriously degraded our national security posture.

While the changes we have been required to submit technically affect only future entrants, we expect an insidious and immediate affect on the morale of the current force. No matter how the reduction is packaged, it communicates the same message, i.e., the perception that there is an erosion in support from the American people for the Service men and women whom we call upon to ensure our safety. It says in absolute terms that the unique, dangerous and vital sacrifices they routinely make are not worth the taxpayers' dollars they receive, which is not overly generous. I do not believe the majority of the American people support this view and ask that you consider this in your deliberations on this very crucial issue to our national security.

Sincerely,

Caspar Weinberger

Enclosure

Attachment

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

MARCH 21, 2012

RESPONSE TO QUESTION SUBMITTED BY DR. HECK

Secretary WOODSON. DOD considers Doctors of Osteopathy and Doctors of Medicine as equivalent. I am not aware of any effort or interest that would not recognize the American Osteopathic Association accredited osteopathic residency programs. [See page 17.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

MARCH 21, 2012

QUESTIONS SUBMITTED BY MRS. DAVIS

Mrs. DAVIS. This year, the Department of Defense has proposed yet another change to its governance structure. In 2006, the Department approved a change to its medical governance structure. Of the seven governance initiatives that were supposed to achieve economies of scale and operational efficiencies to the tune of $200 million, to date, how many have actually achieved any savings?

Secretary WOODSON. The GAO has conducted a study to address this question. The findings from that study are poised for release in late April 2012. In the report, the GAO specifically assessed each of the seven governance initiatives with regard to savings achieved. The Department has reviewed the report and has concurred with the findings; however, the GAO has asked the department to refrain from quoting from the study entitled "Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System" until the formal release of the report. If additional changes to MHS governance are implemented, the Department is committed to a rigorous approach for measuring and monitoring costs and benefits of change.

Mrs. DAVIS. Last year, this Congress directed the Comptroller General to conduct a review of women-specific health services and treatment. What is the Department and the Services doing to address the healthcare needs of female service members and dependents?

Secretary WOODSON. The National Defense Authorization Act of 2012, Section 725 directed the Comptroller General, as head of the Government Accountability Office (GAO), to conduct a review of women-specific health services and treatment for female members of the Armed Forces. This report is to be submitted by the Comptroller General to the congressional defense committees no later than December 31, 2012. GAO has initiated two new engagements which are to be conducted by its Defense Capabilities and Management and Health Care teams. One engagement addresses DOD-wide, women-specific healthcare services 'at home,' while the other engagement pertains to deployment issues, and care for female sexual assault victims domestically and abroad. A May 2002 GAO Report of the adequacy and quality of the health care provided to women in DOD found that a full range of healthcare services for women are offered, and that members' satisfaction with care was well above average. Some concern was noted in areas regarding healthcare services or availability of gender-specific supplies in austere environments.

The provision of health care for women in the Armed Forces represents not only a clinical concern, but a tactical imperative in keeping DOD's forces fit to fight. The Department provides a continuum of care ranging from preventive services (including contraception) to robust access to primary care; assessment and treatment of medical emergencies; referral to specialty care as indicated; care for chronic conditions; and rehabilitation and support for transition and disability for those whose illnesses or injuries do not permit return to full duty. Some medical services, such as Obstetrics and Gynecology, are focused on the medical needs of women, but most other adult medical services are designed and capable of assessing and treating medical conditions regardless of age or sex. When medical needs of any Service member exceed capabilities in their duty location, we also have the capacity to use medical evacuation to move the Service member to a location capable of meeting the specific medical need. The continuum of care includes both military and civilian treatment facilities, and we work especially closely with our VA colleagues when needs include transition from active to veteran status.

Recent policy initiatives, research, and leadership focus have addressed some specific needs and illustrate our commitment to Service women. It is important to note that policies on management of sexual assault are equally applicable to both male and female victims.

In FY11, the three new DOD policies augmented efforts to improve access to quality healthcare services for the victims of sexual assault and ensure continuity of medical care in both deployed and non-deployed environments:

- In December 2011, a policy "Expedited Transfer of Military Service Members Who File Unrestricted Reports of Sexual Assault" was generated to affect ex-

pedited transfer of Service members who file an unrestricted report of sexual assault.
- Also in December 2011, Document Retention in Cases of Restricted and Unrestricted Reports of Sexual Assault, established comprehensive policy for the retention of sexual assault records.
- The DOD Sexual Assault Prevention and Response (SAPR) Program policy was revised for reissuance and published in March 2012. Better policies for prevention, response and oversight of the SAPR program were promulgated.

In 2008 and 2009, significant advances were made to evaluate and meet the medical needs of deploying and returning female Service members:

- The Deputy Secretary of Defense convened a Scientific Oversight Committee meeting which specifically addressed Women Wounded Warrior Issues, appraised gender-specific foci in clinical and research studies, and reviewed compliance with the NDAA FY 2008 mandates.
- In October 2009, the Armed Forces Health Surveillance Center published a monograph that focused on the unique health issues of women in combat environments and identified conditions with consistently high incidence rates among females, which served to highlight treatment essentials and inform clinicians' diagnostic sensibilities and medical system requirements in theater.

Mrs. DAVIS. There continues to be concern that diagnosis and treatment for PTS and TBI are still not at the levels needed to ensure that service members are getting the proper diagnosis and treatment for either PTS or TBI. Where is the Department and the individual Services on this issue?

Secretary WOODSON. The Defense Department (DOD) and Military Healthcare System (MHS) remain committed to the delivery of high quality care by appropriately diagnosing and treating Service members (SMs) with posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI). To address PTSD, the DOD has added over 2,000 behavioral health providers to military hospitals and clinics, and 10,000 more to the care networks since 2009. There are currently many collaborative programs in the MHS, to include the Army Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT–Mil) and the USAF Behavioral Health Optimization Project (BHOP), that systematically coordinate care for SMs with psychological health (PH), TBI and other co-occurring conditions. The DOD is also highly invested in efforts to enhance psychological resilience/prevention, stigma reduction, and improved access to PH and TBI services.

Further, the DOD has placed increased emphasis on PTSD and TBI screening in all individual Services to ensure that SMs are getting proper and timely diagnoses and treatment. The DOD has established enterprise wide screening and assessment procedures to identify both PH and TBI in SM at the earliest opportunity. For example, the Directive-Type Memorandum (DTM) 09–033: "Policy Guidance for the Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting," requires the assessment of all SMs involved in potentially concussive events. Events requiring mandatory screening include any SM within 50 meters of a blast, involved in a vehicle collision or rollover, any SM who sustained a direct blow to the head or had loss of consciousness. All personnel with potentially concussive events are evaluated through evidence based clinical algorithms utilizing a mandatory standardized screening. Results are recorded for each screened individual, and submitted as part of the significant activities (SIGACT) report required for blast-related events. The DTM also outlines four clinical practice algorithms used by medical personnel. These were recently revised in 2012 by a DOD working group that included representatives from all Services. Additional efforts are underway at Military Treatment Facilities (MTFs) to identify SMs who are medically evacuated for any illness or injury, or are otherwise redeployed from theater for signs or symptoms of TBI. These additional screenings help to identify those SMs with a prior history of TBI or concussion exposure, are newly symptomatic, or those with poly-trauma whose injuries may have precluded an earlier evaluation for mild TBI. Receiving CONUS MTFs also rescreen wounded or ill SMs that are evacuated.

Additional screening of all SMs for TBI and PTSD also occurs through DOD Post-Deployment Health Assessments (PDHA) and Post-Deployment Health Reassessments (PDHRA). SMs who respond positively are referred for further clinical evaluation for mild TBI/concussion and/or PTSD. The DOD's focus on TBI screening, diagnosis, and treatment has resulted in the development of over 60 TBI programs in MTFs in the non-deployed setting with varying levels of capabilities, and the establishment of 11 Concussion Restoration Care Centers in the deployed setting. There are over 377 programs available to help SMs with PH problems (including PTSD), in addition to clinical treatment available at MTF's and locally through Tricare providers stateside, and through deployed providers in-theater.

Other initiatives to strengthen diagnosis and treatment efforts for PTSD and TBI involve the Joint Clinical Practice Guidelines (CPGs), which have been created by the DOD and VA to identify and promote effective PH and TBI care practices within and between the departments. Companion Clinical Support Tools for PTSD are in development and scheduled to be released in late summer of 2012. DOD has also developed Clinical Recommendations for managing neuroendocrine, visual and vestibular disturbances following mild TBI, scheduled to be released in 2012. Another cooperative effort between the DOD and VA, known as the "Integrated Mental Health Strategies" (IMHS), was developed to identify specific mutual goals that improve the quality, consistency, and continuity of PH and TBI health care for SMs, Veterans, and their families. All individual Services have representatives working on these initiatives.

Finally, the DOD has made a strong financial commitment to continue to support research related to factors that inform the development of evidence based treatment for both PTSD and TBI. The DOD's neurotrauma research portfolio through MRMC includes more than 600 clinical research studies encompassing novel treatment modalities to include nutraceuticals, complementary and alternative medicine, hyperbaric oxygen and other pharmacotherapies. The DOD also currently funds nine on-going additional studies to investigate the use of cognitive rehabilitation therapies in TBI. The DOD has made cognitive rehabilitation techniques available to SMs with cognitive and behavioral deficits subsequent to TBI. MRMC also supports DOD efforts to sustain a robust PTSD research program. The PTSD portfolio represents broad areas of study to include epidemiology, basic science, prevention and education, early screening and interventions, assessment, treatment, and recovery/return to duty. There are now over 300 PTSD studies funded and in progress. PTSD and TBI research results are used to inform and guide new clinical practices and these interventions are systematically taught to providers who treat SM's with PTSD and TBI. DOD research efforts will continue to ensure that our SMs receive the greatest benefit, via accurate diagnosis and effective treatment derived from the most current scientific knowledge in the field.

Mrs. DAVIS. What are the strategic issues that the subcommittee should be considering to ensure the success of the military healthcare system?

Secretary WOODSON. The Military Health System has adopted the Quadruple Aim to describe our high level goals: improved readiness, better health, better care and lower costs. We have grouped the high level strategic issues according to the aim they most affect.

Readiness:

- Understanding and meeting the long term needs for medical care generated by 10 years of war
- Integrating and optimizing psychological health programs to improve outcomes
- Maintaining the skills and capabilities of the all-volunteer medical force that has performed so well in serving the warfighter

Population Health:

- Addressing the behaviors that influence the majority of health outcomes starting with obesity and tobacco use

Experience of Care:

- Improving safety and quality by implementing evidence based practices across the enterprise and making the MHS the safest health system in the world
- Implementing the integrated Electronic Health Record (iEHR) with the VA to support better decisions, integrate patients into the care process and reduce waste

Per Capita Cost:

- Optimizing market management to bring care back to our Military Treatment Facilities to support readiness, strengthen Graduate Medical Education and reduce costs
- Aligning incentives to pay for value
- Rebalancing government and beneficiary cost shares

Mrs. DAVIS. The Department of Defense has proposed cost increases for the health care of our military retirees. Why is the Department proposing such large fee increases for our military retirees? What was the rationale to begin a means testing for healthcare fees?

Secretary WOODSON. Our proposed changes in the cost-sharing formula for health care will mostly affect retirees and, especially, retirees who are under the age of 65 and are still in their working years. Since 2001, the cost of military pay and benefits

has grown by over 87 percent (30 percent more than inflation), while Active Duty end strength has grown by about three percent. We felt we had to review pay and benefits to avoid overly large reductions in forces and investments.

The military and civilian leadership considered changes in pay and benefits based on several guiding principles. To begin with, the military compensation system must take into account the unique stress of military life. It should not simply be a copy of civilian systems. The system must also enable us to recruit and retain needed personnel. And we must keep faith with our military personnel.

Changes affecting pay and compensation were designed to be disproportionately small when compared to the changes in forces and investments. While pay and benefits account for about one-third of the Defense budget, savings from the initiatives we are proposing will amount to about $29 billion over the FYDP, which is slightly more than 10 percent of our savings target.

It is important to note that the proposed cost-sharing changes are still modest compared to the cost-shares, as a percentage of total healthcare costs, borne by beneficiaries as recently as 1996. In that year, we estimate that retiree beneficiaries were responsible for out-of-pocket costs representing 27 percent of the total healthcare costs. Due to the fact that virtually all beneficiary cost-shares were either frozen (or dropped further) since 1996, these out-of-pocket costs dropped to 10 percent of the total healthcare costs. While cost-sharing is increasing, it is still well below 1996 levels, and will stabilize at approximately 14 percent of total health costs under this proposal.

Where feasible, the proposed fee increases were tiered by military retirement pay, based on the principles of the FY 2007 Task Force on the Future of Military Medicine. In its deliberations, the Task Force recognized that military retirement is not like most civilian retirement systems and that the entire military compensation system differs from the typical civilian "salary" system because much of the compensation is "in-kind" or "deferred." Thus, changes in the healthcare benefit were examined in the context of this unique system and its compensation laws, policies, and programs. The Task Force believes that, for equity reasons, military retirees who earn more military retired pay should pay a higher enrollment fee than those who earn less. While this "tiering" approach is not commonly used in the private sector for enrollment fees, the Task Force believed that it made sense in a military environment.

Mrs. DAVIS. With your statements supporting the proposed changes to TRICARE, what is the impact to the DHP if Congress does not authorize the TRICARE fee increases? Even if Congress was to approve the fees, how will the Department cover unanticipated costs if the savings estimated from beneficiaries opting out of TRICARE do not materialize to the estimated levels?

Secretary WOODSON. If Congress does not provide us with needed support for the health reform proposals, the Department will have to find about $12.9 billion, the projected savings from these proposals, from other Defense programs to meet its healthcare obligations. Such action would place the new defense strategy at risk. Without needed authority, the Department will face further cuts in forces and investment to be consistent with the Budget Control Act. The Department's budget proposal already makes substantial reductions in the investment accounts so further cuts might fall mostly on forces. This could mean cutting additional Active Duty and Reserve Forces by FY17 at a magnitude that could jeopardize the Department's ability to pursue the new defense strategy.

If the assumptions on the behavioral changes projected in the Budget are overstated, savings will be reduced and the Department would have to review all requirements and resources available at that point in time. However, it is important to note that, if the behavior effect is not seen as modeled, the Department would still capture savings because those beneficiaries will still be subject to the higher fees. For example, if a beneficiary does not switch a prescription from retail to mail order, which results in some savings, they would still be subject to the higher copay in retail which would still result in some savings. However, since the proposals provide some incentive to motivate beneficiaries to use more cost-effective healthcare options, some behavioral effects will be inevitable. The Department will be able to refine its projections over time, based on actual experience.

Mrs. DAVIS. Vision injuries have impacted 58,000 OIF and OEF service members according to DOD, hearing loss has been diagnosed in over 189,000 veterans from OIF and OEF according to VA, and male urological injuries from blasts have exceeded 1,670 and yet these battlefield wounds have not received the research funding that other types of defense medical research programs have in past budgets. Should additional funding be provided for these types of injuries given their traumatic impact on service members?

Secretary WOODSON. Research in vision injuries, hearing loss, and genitourinary injury are included in the Clinical and Rehabilitative Medicine Research Program (CRMRP). The CRMRP focuses on definitive and rehabilitative care innovations required to reset our wounded warriors, both in terms of duty performance and quality of life. Due to advances in trauma care, increasing numbers of service members are surviving with extreme trauma to the extremities and head. The program has multiple initiatives to achieve its goals, including improving prosthetic function, enhancing self-regenerative capacity, improving limb/organ transplant success, creating full functioning limbs/organs, repairing damaged eyes, treating visual dysfunction following injury, improving pain management, and enhancing rehabilitative care. These initiatives leverage research across the CRMRP to address dismounted complex blast injuries that include genitourinary injuries.

Mrs. DAVIS. Where is the Army in implementing a confidential alcohol program? A pilot program was established in three bases. What is the current status of those programs, and what is the Army's plan to address the increasing concern of alcohol abuse among soldiers?

General HOROHO. In July 2009, the Army Center for Substance Abuse Programs (ACSAP) initiated the Confidential Alcohol Treatment and Education Pilot (CATEP) program at Fort Lewis, Fort Richardson, and Schofield Barracks. After conducting initial evaluations of the pilot, the Army expanded its implementation to Fort Carson, Fort Riley and Fort Leonard Wood in August 2010. In July 2011 the Army approved testing of CATEP procedural improvements, which included an enrollment contract in an effort to decrease the voluntary dropout rate and to ensure Soldiers with alcohol disorders receive the treatment their conditions require. As of August 2012, CATEP participation at the six pilot sites is as follows: a total of 1310 Soldiers self-referred; of which 924 were screened and enrolled and 386 were screened, but not enrolled. A total of 253 Soldiers have successfully completed CATEP and another 127 are currently enrolled. In August 2012, the Deputy Chief of Staff, G–1 will provide the Vice Chief of the Army with results of CATEP and recommendations for the way ahead on the expansion of CATEP Army-wide by Fiscal Year 2013.

In addition to its efforts with CATEP, the Army recognizes the increasing role substance abuse plays in many high-risk behaviors, including suicide, and therefore is responding with comprehensive prevention resources, increased counselor hiring, and anti-stigma campaign efforts.

To deliver substance abuse prevention services to Soldiers, the Army adopted Prime For Life (PFL) as its Alcohol and Drug Abuse Prevention Training (ADAPT). PFL, a classroom training platform developed over a 25-year time span, is delivered by certified Prevention Coordinator instructors. In April 2012, the Army began fielding a 4-hour standardized universal prevention training package for Soldiers. The Army will continue to define, develop and field leader-centric training for substance abuse, leveraging squad and platoon leaders.

As of 25 July 2012, the Army has 481 substance abuse counselors, an increase of 57 since September 2011, providing education and treatment for Soldiers. We continue recruiting efforts to fill vacancies and put several initiatives in place to create a pipeline of resources that will be available to fill vacancies.

The ACSAP completed a comprehensive study of stigma associated with substance abuse treatment and found stigma to be prevalent. As a result, the Army initiated a new campaign focusing on a more comprehensive view of stigma and developed messaging on a broader range of issues to encourage Soldiers to seek help for substance abuse, behavioral health, sexual assault and other personal challenges.

ACSAP is currently rewriting Army Regulation 600–85, The Army Substance Abuse Program, to codify ASAP policies related to the fitness and combat readiness of Soldiers.

Mrs. DAVIS. Last year, this Congress directed the Comptroller General to conduct a review of women-specific health services and treatment. What is the Department and the Services doing to address the healthcare needs of female service members and dependents?

General HOROHO. The Women's Health Campaign Plan focuses on standardized women's health education and training, logistical support for women's health items, fit and functionality of the Army uniform and protective gear for females, research and development into gynecologic issues during deployment, sexual assault case management, and the psychosocial effects of combat on women.

Mrs. DAVIS. There continues to be concern that diagnosis and treatment for PTS and TBI are still not at the levels needed to ensure that service members are getting the proper diagnosis and treatment for either PTS or TBI. Where is the Department and the individual Services on this issue?

General HOROHO. The Army provides behavioral health care for all recognized behavioral health conditions as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. In February 2010 the Army launched the Behavioral Health System of Care Campaign Plan to standardize, synchronize, and coordinate behavioral health care, including PTSD, across the Army and throughout the Army Force Generation cycle. The Army has implemented a comprehensive TBI Action Plan based on the 2007 TBI Task Force Report and has hired over 460 providers since 2007 to evaluate and treat Soldiers with TBI. Providers at Army treatment facilities utilize the 2008 VA–DOD Clinical Practice Guidelines (CPGs) for the medical management of Service Members with concussion/mTBI. This set of CPGs was recently rated as the best of 8 CPGs for concussion/mTBI management and represent the highest level of scientific evidence. TBI care policy and medical algorithms in the deployed environment include special provisions for recurrent concussions within the previous 12 months. This proactive policy promotes early detection, medical management, and helps prevent subsequent concussion while the brain is still healing. In order to assist with the medical evaluation and advance TBI research, the Department of Defense deployed 3 MRI machines to Afghanistan in October 2011.

The U.S. Army Medical Research and Material Command has invested over $633 Million since 2007 to advance the science of TBI detection/screening, diagnosis, and treatment. While a definitive diagnostic biomarker for TBI is not available, Army Medicine is collaborating with academic and civilian scientists to evaluate tests that help identify TBI. The scientific community is also researching promising treatments to ensure that they are both safe and effective for TBI rehabilitation.

Mrs. DAVIS. The Department of Defense has proposed cost increases for health care that not only will impact retirees, but they could also impact military dependents. Has your Service looked at the potential impact of these fee increases and its impact on retention of the force?

General HOROHO. The Army Medical Department has not studied any impact of TRICARE fee proposals on retention of the force.

Mrs. DAVIS. With your statements supporting the proposed changes to TRICARE, what is the impact to the DHP if Congress does not authorize the TRICARE fee increases? Even if Congress was to approve the fees, how will the Department cover unanticipated costs if the savings estimated from beneficiaries opting out of TRICARE do not materialize to the estimated levels?

General HOROHO. If Congress does not support proposed reform, ASD(HA) has projected a Department deficit of $12.9 billion which will impact other Defense programs in order to meet healthcare obligations. Without needed authority, ASD(HA) states the Department will face further cuts to important programs and investments. If the assumptions on the behavioral changes projected in the Budget are overstated, savings will be reduced and the Department would have to review all requirements and resources available at that point in time.

Mrs. DAVIS. There are anecdotal stories that service members are self-medicating themselves through alcohol consumption. What are your Services doing as well to address alcohol abuse among airmen, sailors, and marines as well?

Admiral NATHAN. Navy Medicine has launched the MORE program (My Online Recovery Experience), a web- and phone-based recovery support program for Service members recovering from alcohol dependence. MORE offers individually tailored patient education and support over a secure web-based system with world-wide access, 24 hour-day, seven-days a week.

Additionally, the Navy has a long-standing and extensive Substance Abuse & Rehabilitation Program (SARP):

—SARP has transitioned from an addiction-only treatment program to a dual diagnosis program that identifies and treats mental health illnesses in addition to identifying and treating substance use disorders. SARPs located at Naval Medical Center Portsmouth and Naval Medical Center San Diego also treat patients with dual diagnoses (substance use disorder and mental health illness).

—SARP has established screening and treatment protocols for substance abuse and dependence, providing necessary treatment and rehabilitation with pre- and continuing after-care where appropriate.

—All program activities comply with established DOD, DON, and Navy Medicine guidance or governance.

—SARPs screen over 10,000 individuals a year, with an estimated 7,000 to 8,000 enrolling as patients annually.

—Fifty-two SARPs exist throughout the Navy Medicine enterprise, with a mix of Active Duty and civilians who provide screening, evaluation, and treatment. Treat-

ments range from education with early intervention, to outpatient and intensive outpatient therapies, up to the highest level of inpatient care.

Mrs. DAVIS. Last year, this Congress directed the Comptroller General to conduct a review of women-specific health services and treatment. What is the Department and the Services doing to address the healthcare needs of female service members and dependents?

Admiral NATHAN. Navy Medicine is committed to delivering outstanding, patient-centered healthcare services to our female Sailors and Marines wherever and whenever needed. This support includes access to care in both operational settings and at our medical treatment facilities (MTFs). Navy Medicine continues to offer a full spectrum of services to address the unique healthcare needs of female service members and their family members. Referral processes are in place to provide services not available at local MTFs.

In addition, Navy Medicine has Clinical Advisory Boards that provide current evidence-based practice guidance from subject matter experts throughout the Navy Medicine enterprise. Specifically, they recommend policy, evaluate clinical practice guidelines and provide an endorsement to support Navy-wide integration. At 18 MTFs, there are peri-natal clinical advisory boards to guide the practice of maternal-child health. Town hall meetings, local forums and patient satisfaction surveys are used to gather feedback to ensure our patients have the required access to services.

Mrs. DAVIS. There continues to be concern that diagnosis and treatment for PTS and TBI are still not at the levels needed to ensure that service members are getting the proper diagnosis and treatment for either PTS or TBI. Where is the Department and the individual Services on this issue?

Admiral NATHAN. Post-Traumatic Stress Disorder (PTSD) is one of many psychological health conditions that adversely impacts operational readiness and quality of life. Navy Medicine has an umbrella of psychological health programs that target multiple, often co-occurring, mental health conditions including PTSD. These programs support prevention, diagnosis, mitigation, treatment, and rehabilitation of PTSD. Our efforts are also focused on appropriate staffing, meeting access standards, implementing recommended and standardized evidence-based practices, as well as reducing stigma and barriers to care. Priorities include:

- Embedding psychological health providers in Navy and Marine Corps units, ensuring primary and secondary prevention efforts and appropriate mental health care are readily accessible for Sailors and Marines.
- Embedding psychological health providers in the primary care setting where most service members and their families first seek assistance for mental health issues enhancing integrated treatment, early recognition and access to the appropriate level of psychological health care. The Behavioral Health Integration Program in the Medical Home Port is a new program that is actively being implemented across 69 Navy and Marine Corps sites.
- Maintaining support to 17 Deployment Health Centers (DHCs) as non-stigmatizing portals of care for service members outside the traditional mental health setting.
- Implementing innovative programs like Overcoming Adversity and Stress Injury Support (OASIS) at the Naval Medical Center San Diego is providing intensive mental health care for service members with combat-related mental health symptoms from posttraumatic stress disorder, as well as major depressive disorders, anxiety disorders and substance abuse problems. Care is provided seven days a week for 10–12 weeks, and service members reside within the facility while they receive treatment.
- Providing active consultative subject matter expertise to Line Leaders, focusing on preventive measures, early pre-clinical recognition and intervention, as well as recommended treatment management.

In addition, TBI care on the battlefield has improved significantly since 2007 when it was labeled as a "signature injury" of the current conflicts. Most improvements have targeted early screening and diagnosis followed by definitive treatment. In 2010, Directive-type Memorandum 09–033 resulted in improved diagnosis and treatment of battlefield concussion. Policy highlights include mandatory screening by line commanders for any service member in a potentially concussive event, standardized medical screening with a 24 hour rest/recovery period regardless of diagnosis, rest and education (the only proven clinically effective treatments) for diagnosed concussion, and guidelines for evaluation, treatment and return to duty for symptom-free service members with 1, 2 or 3 concussions in a 12-month period.

From 1 AUG 2010 to 30 AUG 2011 this policy resulted in the enhanced screening for 187 Sailors and 4684 Marines, resulting in diagnoses of concussion in 27 Sailors

and 803 Marines from that group. For the Navy and Marine Corps, the primary treatment site for concussed service members is the Concussion Care Restoration Center in Camp Leatherneck.

Since opening in 2010, the Camp Leatherneck has treated over 930 service members with first-time concussions, resulting in a greater than 98% return to duty (RTD) rate, and an average of 10.1 days of duty lost from point of injury to symptom-free RTD. There is also a concussion clinic at the NATO Role III Hospital in Kandahar. Upon return from deployment, enhanced screening methods for TBI and mental health conditions are being piloted at several Navy and Marine Corps sites. This includes increasing use of the National Intrepid Center of Excellence (NICoE) along with development of NICoE satellite sites to provide state-of-the-art screening and treatment for those patients that do not improve with routine clinical care.

We are also heavily engaged in active and expansive partnerships with the other Services, our Centers of Excellence, the VA, and leading academic medical and research centers to make the best care available to our warriors afflicted with PTSD and TBI.

Mrs. DAVIS. The Department of Defense has proposed cost increases for health care that not only will impact retirees, but they could also impact military dependents. Has your Service looked at the potential impact of these fee increases and its impact on retention of the force?

Admiral NATHAN. The Department of Navy supports these proposals and believes they are important for ensuring a sustainable and equitable benefit for all our beneficiaries. While the proposed increases will primarily impact our retired beneficiaries, military medicine provides one of the most comprehensive health benefits available. These changes will help us better manage costs, provide quality, accessible care and keep faith with our beneficiaries.

Mrs. DAVIS. With your statements supporting the proposed changes to TRICARE, what is the impact to the DHP if Congress does not authorize the TRICARE fee increases? Even if Congress was to approve the fees, how will the Department cover unanticipated costs if the savings estimated from beneficiaries opting out of TRICARE do not materialize to the estimated levels?

Admiral NATHAN. Based on information provided by the Assistant Secretary of Defense for Health Affairs, if Congress does not provide the needed support for the health reform proposals, the Department of Defense will have to find about $12.9 billion, the projected five year savings from these proposals, from other Defense programs to meet its healthcare obligations. If the assumptions on the behavioral changes projected in the Budget are overstated, savings will be reduced and the Department of Defense would have to review all requirements and resources available at that point in time.

Mrs. DAVIS. There are anecdotal stories that service members are self-medicating themselves through alcohol consumption. What are your Services doing as well to address alcohol abuse among airmen, sailors, and marines as well?

General GREEN. As with any community, there are members of the Air Force who will use alcohol to self-medicate. Therefore, the Air Force has implemented processes to educate service members about the dangers of alcohol misuse, to recognize this when self-medication and other forms of alcohol misuse occurs, and to provide services when needed to treat both substance abuse and other problems that individuals may use alcohol to address.

One means of addressing alcohol misuse is that Air Force medical professionals provide alcohol abuse prevention briefings to our first-term Airmen, at base Newcomers' events, and annually to commanders, first sergeants, other senior enlisted personnel and medical professionals. Airmen involved with alcohol-related misconduct are provided individualized, focused education to prevent recurrence or worsening of alcohol related problems.

Additionally, Air Force medical providers also provide screenings and treatment for alcohol abuse. Our medical providers screen patients from all Services for alcohol misuse at each visit to primary care medical home, and screen Air Force members during their annual health assessment. Service members are also screened for depression and Post Traumatic Stress Disorder and are provided effective mental health treatment when necessary so there is no need to self-medicate with alcohol. We also screen Airmen four different times as part of the pre- and post-deployment health assessments. Healthcare providers address concerns regarding a service member's drinking behaviors as they arise. When further evaluation or treatment is necessary, a referral is made to an integrated behavioral health provider in the primary care clinic or to the specialty substance abuse providers. Our staff in the Specialty Substance Abuse Programs at each Air Force installation will assess service members and provide the appropriate education or treatment, including a refer-

ral to a civilian program if a higher level of care is needed than can be provided on the installation.

Mrs. DAVIS. Last year, this Congress directed the Comptroller General to conduct a review of women-specific health services and treatment. What is the Department and the Services doing to address the healthcare needs of female service members and dependents?

General GREEN. The Air Force maintains a robust women's healthcare program and provides women's health services at all Air Force bases in the United States and overseas by either direct provision of care or through timely referral. Most of our 75 medical treatment facilities provide women's healthcare services through separately established women's health clinics. These clinics provide comprehensive women's health services, including well exams, health teaching and screening, gynecological services, colposcopy, loop electrosurgical excision procedure (LEEP), birth control services, and hormone replacement therapy, to active duty, retired and dependent females. In addition to primary care physicians and obstetrician/gynecologists, the Air Force employs approximately 70 active duty Women's Health Nurse Practitioners (WHNPs) and 14 civilian WHNPs.

In 2008, the Air Force began promoting full-time clinical WHNPs to the rank of colonel with the specific goal of keeping these women's health "master clinicians" at the bedside caring for women and running the women's health clinics. Many of our WHNPs are trained as sexual assault forensic examiners and providers and in this capacity they perform the forensic/legal exams for victims of sexual assault. In addition, our WHNPS are deployed around the world to provide care for female airman, sailors, marines, and soldiers.

Air Force Surgeon General obstetric modernization funds have been used to: establish an Obstetric Quality Forum to promote patient safety, quality outcomes and process improvement; provide lactation consultants for each Air Force site that delivers babies; create a prenatal care counseling and education video; host a national Patient Safety and Critical Care Obstetric conference; and lead a tri-service effort to create an evidence-based practice guideline for the management of pregnancy across the DOD and VA.

The Air Force Medical Service is also involved in a number of ongoing women's health research projects. The San Antonio Military Medical Health System (SAMMHS) Outcomes Coordinator and Pregnancy Coordinator completed a prospective randomized trial of 1800 women comparing routine one-on-one visits to a group prenatal care model. Preliminary results published as part of a collaborative nonrandomized study with the March of Dimes showed a 60% reduction in the risk of preterm birth. The results are being further analyzed and if sustained have the potential to change the format of prenatal care around the world. The Patient and Physician Radiotherapy Schedule Preferences for Breast Cancer treated with Breast Conservation Therapy study seeks to align of physician practice patterns with best evidence and patient preferences in order to enhance patient autonomy and improve cancer care. Recognizing that the pregnant spouses of deployed service members face unique challenges, the Air Force Medical Service is engaged in the Mentors Offering Maternal Support (M.O.M.S.) study to test the effectiveness specialized support services for pregnant spouses of deployed service members with the goal of promoting prenatal maternal adaptation. Other ongoing studies include a research collaboration on a FDA-promoted, multinational study involving 17–OH progesterone use for the reduction of preterm birth, a randomized controlled trial evaluating the use of lavender aromatherapy to reduce pain and anxiety during cervical colposcopy, and a study of post-breast lumpectomy reconstruction using cell-enriched fat grafting.

Mrs. DAVIS. There continues to be concern that diagnosis and treatment for PTS and TBI are still not at the levels needed to ensure that service members are getting the proper diagnosis and treatment for either PTS or TBI. Where is the Department and the individual Services on this issue?

General GREEN. Thank you for the opportunity to explain the Air Force's approach for treating Service members who suffer from Traumatic Brain Injury (TBI) or Post-Traumatic Stress Disorder (PTSD).

The Air Force's goal is to identify and address PTSD and TBI symptoms as early as possible, before problems develop and to allow for full return to duty. This goal is pursued through a combination of programs aimed at screening, awareness education, and evidence-based treatment.

Fortunately, despite Airmen deploying in roles involving combat or being involved in the rescue or treatment of those with severe injuries, the rate of both PTSD and TBI in Airmen has remained low. Per our recent report to Congress, for example, the average PTSD rate of new cases for active duty Airmen for 2003 through 2010 was 2.0 per thousand (0.2%). The rate of TBI is about 10 per thousand (1%), nearly

90% of which are mild in severity. In mild TBI full recovery can be expected by the majority within weeks.

The Air Force proactively screens for TBI, PTSD, and other mental health concerns on a recurrent basis. This is accomplished via annual Preventive Health Assessments and via Post-Deployment Health Assessments and Post-Deployment Health Re-Assessments. Additionally, Airmen are screened with the Automated Neuropsychological Assessment Metrics (ANAM) prior to deployment in order to establish a baseline measure of cognitive functioning. Deployed Service members who are involved in an event which may cause a TBI are screened for TBI and referred for further medical evaluation and treatment if the screening is positive. In addition to history and examination, the ANAM may be used post-injury in theater and compared to baseline pre-deployment ANAM results to aid in the medical evaluation.

Airmen are provided with awareness education on PTSD and TBI and are offered multiple opportunities to identify symptoms and concerns. To ease access to mental health providers, many medical treatment facilities have one or more mental health providers working directly in the primary care clinics.

Formal training has significantly increased for providers on assessment, diagnosis, and treatment of PTSD and TBI. The majority of Air Force mental health providers have attended formal training in evidence-based treatment of PTSD, and it is included in Air Force social work and psychology training programs to ensure providers appropriately recognize and treat affected individuals. Education on the causes, signs, and symptoms of TBI and PTSD are provided through new training modules in Self Aid and Buddy Care, an annually required computer based training for all Airmen. More advanced education on TBI and PTSD is provided in pre-deployment courses including Expeditionary Medical Support course and Combat Casualty Care Course, to include use of the Military Acute Concussion Evaluation and the Clinical Practice Guidelines for TBI in the Deployed Setting. VA/DOD clinical practice guidelines are also taught and used for the management of PTSD and TBI in post-deployment health throughout the Air Force. There has been increased emphasis on these topics during mental health and neurology internship and residency programs. Finally, the Defense and Veterans Brain Injury Center hosts an annual TBI Training Program to educate DOD and VA healthcare providers. The formal training emphasizes the use of evidence-based practices for the treatment of PTSD and/or TBI, to include exposure-based therapies (with or without virtual reality enhancement), medication management, and combinations of treatments.

Mrs. DAVIS. The Department of Defense has proposed cost increases for health care that not only will impact retirees, but they could also impact military dependents. Has your Service looked at the potential impact of these fee increases and its impact on retention of the force?

General GREEN. Our retiree population actively shapes perceptions of the value of military service. Any action that discourages our retiree population can adversely impact recruiting activities. Healthcare benefits for active duty military personnel are not impacted under the current proposal. TRICARE standard caps affect the small number of active duty family members not enrolled in Prime. The pharmacy co-pay increases only affect those who do not get their prescription filled at an Military Treatment Facility. Although increases in healthcare fees may be perceived as a loss of benefit to our retiree population, the increases are not expected to negatively influence retention of active duty military personnel.

Mrs. DAVIS. With your statements supporting the proposed changes to TRICARE, what is the impact to the DHP if Congress does not authorize the TRICARE fee increases? Even if Congress was to approve the fees, how will the Department cover unanticipated costs if the savings estimated from beneficiaries opting out of TRICARE do not materialize to the estimated levels?

General GREEN. If Congress does not provide us with needed support for these proposals, the Department will have to find about $12.9 billion, the projected five year savings from these proposals, from other Defense programs to meet its healthcare obligations. Without needed authority, we will face further cuts in forces and investment to be consistent with the Budget Control Act. Because our budget proposal already makes substantial reductions in the investment accounts, further cuts may impact end strength. If, for example, Congress did not support any of our proposed TRICARE changes, the Department would have to make very difficult choices between further cuts to weapons systems or reducing end strength to cover the $12B hole in the budget. Cuts of this magnitude would jeopardize our ability to pursue some priorities as planned the new defense strategy and force potential cutbacks in both direct and private sector care.

QUESTIONS SUBMITTED BY MR. JONES

Mr. JONES. Medicare pays about 60% and DOD pays 40% of the overall TRICARE For Life (TFL) beneficiary costs, does your office have any ideas on how to reduce the cost? Have you considered looking at a management option for TFL beneficiaries?

Secretary WOODSON. TRICARE for Life provides Medicare wrap-around coverage when health care is a benefit under both programs, as long as the beneficiary is enrolled in Medicare Part B. Medicare pays 80 percent of their allowed amount, and claims automatically cross over to TRICARE where TRICARE processes the remainder for payment.

Recently, TRICARE Management Activity staff met with representatives from the Centers for Medicare and Medicaid Services' (CMS) Innovation Center to discuss the Comprehensive Primary Care Initiative that CMS is developing. This initiative will use a managed care approach to providing preventive care and disease management for Medicare and other patients. It will reward providers when costs are reduced as participants in the initiative achieve desired health outcomes. Many TFL beneficiaries are likely participants in the initiative, and TRICARE intends to monitor progress and results of the initiative to assess how and whether to apply the care approach to a broader segment of our TFL population.

We have also instituted new management controls that are applicable when TRICARE becomes primary payer for a TFL beneficiary's stay in a skilled nursing facility (SNF). This occurs after exhaustion of the 100-day SNF care coverage provided by Medicare. We have found that bills for SNF care are among the largest of any that TFL must cover. Now we require that SNF care beyond 100 days be preauthorized, and base the decision upon review of medical records to ensure (a) that skilled care truly is required and (b) if skilled care is required, that it is of such intensity that it cannot be safely provided at a lower, less expensive level, than in a SNF.

Mr. JONES. It is my understanding that DOD proposes to tie the cost that the military retiree will pay to a "means test" system, meaning the greater the annuity that a retiree receives, the more they will pay for their health care. As you know, no other Federal retired employee healthcare cost is "means tested." Don't you think that this proposed system is unfair to our service members and their families who have sacrificed so much, especially this last decade?

Secretary WOODSON. Where feasible, the proposed fee increases were tiered by military retirement pay, based on the principles of the FY 2007 Task Force on the Future of Military Medicine. In its deliberations, the Task Force recognized that military retirement is not like most civilian retirement systems and that the entire military compensation system differs from the typical civilian "salary" system because much of the compensation is "in-kind" or "deferred." Thus, changes in the healthcare benefit were examined in the context of this unique system and its compensation laws, policies, and programs. The Task Force believed that, for equity reasons, military retirees who earn more military retired pay should pay a higher enrollment fee than those who earn less. While this "tiering" approach is not commonly used in the private sector for enrollment fees, the Task Force believed that it made sense in a military environment.

QUESTIONS SUBMITTED BY MS. BORDALLO

Ms. BORDALLO. Do you believe that in this era of declining budgets and military end-strength, that the prohibition on converting medical military personnel to civilian personnel should be continued?

Secretary WOODSON. No, I do not believe that the prohibition should be continued. Given the fiscal and budgetary pressures facing the Department and nation, the Department can achieve savings from pursuing such conversions. Additionally, with declining end-strengths and changing force structures, the Department must do everything it can to minimize the utilization of uniformed military personnel in positions that are not military essential, or do not require military unique knowledge and skills to support readiness or career progression. A significant portion of the current medical positions filled by military personnel do not meet these criteria and could, and should, be considered for conversion to civilian performance (or in certain circumstances, private sector performance if appropriate and in accordance with statutes). Doing so will not only achieve savings associated with lower civilian personnel costs but also free military personnel for more pressing needs of the Services and Combatant Commanders.

Ms. BORDALLO. How many military medical positions does the Department currently have that could potentially be converted to civilian performance because military incumbency is not essential?

Secretary WOODSON. The Military Readiness Review (MRR) mandates the number of uniformed men and women necessary to deliver military medical and health care, and is established to meet service wartime requirements and to provide adequate rotational and training opportunities in order to maintain required skill levels for deployment. The number of military providers above the level dictated by the MRR could, and should, be converted to civilian positions (or contract if appropriate and in accordance with policies and statutes) without degrading either unit readiness or the training and deployability of the military member. Prior to the prohibition on conversion of such billets, the Department had estimated nearly 17,000 positions for conversion. Current data points to at least 6,000 medical military positions that could potentially be converted to civilian performance, at significant savings to the Department and in support of the end-strength reductions.

Ms. BORDALLO. Given the opportunity, could the Department save money by converting medical military positions to civilian positions?

Secretary WOODSON. Yes, the Department can save money by converting medical military positions to civilian performance, or, in certain circumstances, private sector performance (if appropriate and in accordance with statutes). The Department estimates it could potentially save in excess of $1.5 billion over a five year period (with savings continuing annually beyond that) by converting military medical positions to civilian performance, with no degradation to quality of care. This is based on approximately 16,000 military medical positions that were slated to be converted prior to the prohibition and annual savings of approximately $22,000 per position. In addition to these direct savings to the Department, additional government and taxpayer savings would be realized by the Departments of Veterans Affairs and Treasury by avoiding long-term deferred costs associated with military incumbency.

Ms. BORDALLO. Notwithstanding the current congressionally imposed prohibition, how could the Department convert medical military personnel to civilians given the current mandate across DOD to maintain FY10 civilian levels?

Secretary WOODSON. Absent the congressionally mandated prohibition, medical military personnel could be converted to civilian personnel by absorbing work into existing government positions by refining duties or requirements; establishing new positions to perform these medical duties by eliminating or shifting equivalent existing manpower resources (personnel) from lower priority activities; or requesting an exception. Any large-scale conversion of medical military manpower to civilian, as originally programmed prior to the congressional prohibition on such conversions, would require deviation and an exception from the fiscal year 2010 civilian personnel levels the Services have been directed to maintain.

Ms. BORDALLO. What instances and requirements would justify military incumbency for medical requirements instead of civilian performance?

Secretary WOODSON. The primary instance or requirement for military incumbency is predicated on the fact that military members have an obligation to deploy and medical personnel are a key element of the operating forces. They are responsible for providing world class medical and health care on the battlefield, referred to as "Service Wartime Requirements". Additionally, career progression, overseas rotation, and military unique skills/knowledge requirements necessitate military incumbency outside of these "Service Wartime Requirements". In order to maintain the necessary level of skills to meet operational, mobilization, and wartime requirements, it is critical that military medical professionals receive the training and patient load necessary to provide experience with current medical scenarios, diagnoses and treatments. Maintaining training and rotational practice opportunities for military providers is critical to the continued health of the Military Health System.

Ms. BORDALLO. How many medical military positions were originally slated to be converted to civilian positions prior to the prohibition on such?

Secretary WOODSON. The number of medical military positions originally slated to be converted, prior to the implementation of the congressional mandated prohibition, between fiscal years 2005 and 2013 was 16,876.

Ms. BORDALLO. Do you believe that medical care for our uniformed men and women and unit readiness would suffer if delivered by civilian personnel instead of military personnel?

Secretary WOODSON. The Military Readiness Review (MRR) mandates the number of uniformed men and women necessary to deliver military medical and health care. This number is established to meet service wartime requirements and to provide adequate rotational and training opportunities in order to maintain required skill levels for deployment. I believe that any military medical billets above the level dictated by the MRR could, and should, be converted to civilian positions (or contract

if appropriate and in accordance with policies and statutes) without degrading medical care, unit readiness, or the training and deployability of the military medical providers.

Ms. BORDALLO. What impact has the civilian cap had on the Defense Health Program and ability to deliver care?

Secretary WOODSON. The Military Health System (MHS) draws healthcare providers from three different labor sources: active and reserve military, government civilian employees, and contracted support. Any arbitrary personnel ceiling that limits the Department's potential ability to hire civilian employees forces the MHS to increase contracted support, both within the military treatment facilities and in the local economy. The Department is committed to providing world class healthcare to Service members, and that level of healthcare will continue regardless of any constrants, but will come a significantly higher cost if the MHS is forced to utilize contracted support in lieu of government civilians. Such increased costs will impact availability of care and the patient share of the cost, and take funding away from other pressing medical and health needs of the force, as well as reducing available funding for other compelling needs across the Department.

Ms. BORDALLO. Do you believe that in this era of declining budgets and Army end-strength, that the prohibition on converting medical military personnel to civilian personnel should be continued?

General HOROHO. The current congressional prohibition has effectively reduced programmatic and operational turmoil to our complex medical workforce. Previous rounds of medical military to civilian conversion directly impacted Army Medical Department mission capabilities to the detriment of medical support to our Soldiers and their Families. The inability to backfill military conversions with qualified civilians in a timely basis generated shortfalls in the delivery of health care, especially in the ancillary workforce required to support our physicians and nurses. The Army restored military billets converted between FY07–FY11, recognizing the negative effects of reduced support staff and resulting decreased clinician efficiency and effectiveness which directly impacted quality and access to care.

Ms. BORDALLO. How many military medical positions does the Army currently have that could potentially be converted to civilian performance because military incumbency is not essential?

General HOROHO. An assessment of military medical billets, potential readiness impact, cost, and local market availability is necessary to determine if any medical positions could be converted to civilian performance. Military to civilian conversion would require the programming of additional funding for the required civilian medical workforce.

Ms. BORDALLO. Do you believe that medical care for your soldiers and unit readiness would suffer if delivered by civilian personnel instead of military personnel?

General HOROHO. The Army Medicine Team is composed of a symbiotic core of military, civilian and contract healthcare personnel. As an Army in persistent conflict for over a decade, we stand shoulder-to-shoulder with the Warfighter, both on the battlefield and at home. Our military healthcare personnel are the critical link between care in the garrison environment and on remote battlefields. The combined Army Medicine team leverages the strengths, competencies, Duty and Selfless Service necessary to ensure a fit and medically ready force.

Ms. BORDALLO. Do you believe that in this era of declining budgets and Navy/Marine Corps end-strength, that the prohibition on converting medical military personnel to civilian personnel should be continued?

Admiral NATHAN. Military to civilian conversions in the Medical Department are often independent of declining budgets and end strength reductions. The ideal mix of personnel; active duty, civilians, contractors, is established first and foremost to meet operational requirements, and then to appropriately augment the team with civilian and contractor staff; as is currently done. Uniformed staffing requirements are directly linked to the operational needs of the Fleet and Fleet Marine Forces. Active duty personnel directly support and mobilize, when needed, to meet Combatant Commanders' requirements. Civilian and contract staff augment and complete the staffing at our fixed military treatment facilities, providing much needed continuity of care delivery. As was learned during the last effort of Military-to-Civilian conversions, ending the prohibition on converting military personnel to civilian personnel will not necessarily lead to lower costs.

Ms. BORDALLO. How many military medical positions does the Navy/Marine Corps currently have that could potentially be converted to civilian performance because military incumbency is not essential?

Admiral NATHAN. Navy Medicine uses an operational requirements model, based on the Combatant Commanders' needs, to determine the appropriate, number of

uniformed medical department personnel needed to ensure that the Navy and Marine Corps missions are met. The total number of uniformed personnel within Navy Medicine today is adequate to meet currently identified operational requirements. Uniformed personnel are allocated to operational units and, when not deployed, are assigned to our fixed military treatment facilities. There they hone and sustain their needed clinical and ancillary skills in order to prepare for their mobilization assignments. The number of medical professionals needed to staff these Medical Treatment Facilities, in excess of active duty requirements, may be supported by any personnel category (military, civilian, or contractor). Navy Medicine's complement of total staff, comprising all of these categories is approximately 63,000 men and women supporting Navy's healthcare missions.

Ms. BORDALLO. Do you believe that medical care for sailors and marines, and unit readiness would suffer if delivered by civilian personnel instead of military personnel?

Admiral NATHAN. Navy maintains one high standard of health care, whether that care is delivered by military or civilian providers. Military or civilian providers maintain the same qualifications and credentialing standards. Navy Medicine meets the unit readiness and the beneficiary peacetime missions while in-garrison, by employing available uniformed staff, augmented by civilian and contract providers and support staff at our fixed facilities. Civilians delivering care to our deployable forces in our fixed Medical Treatment Facilities would not degrade unit readiness, so long as a uniformed force is maintained at the appropriate levels required to support our operational missions.

Ms. BORDALLO. Do you believe that in this era of declining budgets and Air Force end-strength, that the prohibition on converting medical military personnel to civilian personnel should be continued?

General GREEN. In certain locations, and for certain Air Force Specialty Codes, military-to-civilian conversions provide an effective option to the Air Force Medical Service for managing costs while continuing to deliver outstanding healthcare. The NDAA prohibition inhibits the ability to optimize force structure for emerging and changing missions and operations tempo by eliminating military to civilian/contract conversion options when conversion is deemed the most effective and efficient funding source. However, we need to ensure that the conversions are in the appropriate market due to the availability of civilians with the required skills/training and the potential competition and pay disparities with the civilian sector.

Ms. BORDALLO. How many military medical positions does the Air Force currently have that could potentially be converted to civilian performance because military incumbency is not essential?

General GREEN. The Air Force Defense Health Program current Critical Operational Readiness Requirement is 25,284 and current active duty Defense Health Program end-strength is 31,544. In theory, the Air Force could potentially convert approximately 6,200 positions from Military to Civilian across the Future Year Defense Plan (Fiscal Year 14–18) at an estimated rate of 1,240 positions per year.

Three very important issues that would impact the number of conversions would be: 1. In theory, we could covert 6,200 Military to Civilian positions; however, we may not be able to execute because of the availability of civilians with the required skills/training and the potential competition and pay disparities with the civilian sector. 2. Currently there are ongoing discussions with Health Affairs and the Service Surgeon Generals to develop strategies for determining medical requirements and medical force sizing for future contingencies. 3. There needs to be consistent civilian pay categories across all government pay systems (e.g. DOD, VA, Public Health Service) to simplify recruiting and retention of civilians.

Ms. BORDALLO. Do you believe that medical care for airmen and unit readiness would suffer if delivered by civilian personnel instead of military personnel?

General GREEN. The Air Force does not believe that medical care for Airmen would suffer if delivered by civilian personnel. The Air Force has successfully utilized Active Duty, civilian and contract personnel to provide medical care to our active duty population in our Medical Treatment Facilities. Unit readiness requires a health system to assist commanders' track and resolve health related readiness concerns. Any Shift that eliminated the health system from assisting commanders could impact readiness.

QUESTION SUBMITTED BY MR. LOEBSACK

Mr. LOEBSACK. My understanding is that an announcement was recently made about the TRICARE program in the TRICARE West Region. Can you tell me what the Department has done to ensure that there will be no disruption in care for my constituents or for any TRICARE beneficiaries in the region? What has been done to ensure that any changes in the TRICARE West Region will not result in a reduction of healthcare services available in rural states like Iowa for our service members (including in the Reserve Component), retirees, and military families?

Secretary WOODSON. The West contract is under protest and services will continue under the old contract until the protest is resolved. However, all TRICARE Regional contracts have transition periods as required by statute and those transition periods address the transfer of responsibility in a timely and orderly fashion. The contracts also contain required access standards and networks of adequate size and composition to cover all needed services in the Regions. While it cannot be guaranteed that all providers currently in the TRIWEST network will continue as providers under the new contractor, most will be likely retained and beneficiaries will not be without services nor should they experience any disruption of service as a result of the transition, regardless of the area they live in.

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