



**NATIONAL
MILITARY FAMILY
ASSOCIATION**

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Statement

by the

NATIONAL MILITARY FAMILY ASSOCIATION

for

**Subcommittee on
Military Personnel**

of the

**UNITED STATES HOUSE OF REPRESENTATIVES
ARMED SERVICES COMMITTEE**

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The Committee

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

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

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

Our website is: www.MilitaryFamily.org.

Karen Ruedisueli, Government Relations Deputy Director

Karen Ruedisueli joined the National Military Family Association as a Deputy Director of Government Relations in May, 2013. In her role, she conducts research, monitors issues, and advocates for families of the uniformed services. Karen's focus is on military family health care, including the Military Health System, TRICARE, and behavioral health care. In this capacity, she represents the Association on The Military Coalition's (TMC) Health Care Committee. Karen also handles issues related to wounded warriors and military caregivers.

A graduate of the University of Michigan, Karen previously worked as a marketing professional and management consultant. She has extensive experience in market research, brand strategy, and new product/service development. Karen has helped clients such as Sara Lee, Frito-Lay, General Mills and the *Chicago Tribune* assess the effectiveness of their marketing initiatives and develop new product and brand strategies. She has also been a guest lecturer at Northwestern University's Kellogg Graduate School of Management on the topic of brand-based innovation.

As an Army spouse, Karen has had extensive volunteer experience identifying and resolving military family issues. She was an active member of the Family Readiness Group (FRG) and served as a Battery level FRG Leader during the unit's train up and deployment to Afghanistan. She also served as the Co-Director of Research for Blue Star Families and led the development and analysis of their first Military Family Lifestyle Survey. Karen has lived at Fort Sill, MCB Quantico, Fort Drum and Fort Leavenworth. She and her husband, MAJ G. Kurt Ruedisueli, currently reside in the Washington D.C. metro area with their two children.

We appreciate Congress has listened to beneficiary concerns regarding the Military Health System (MHS) and are gratified you want to make the MHS work better for all beneficiaries via military health care reform. We hope the changes Congress enacts will truly make a difference in military families' ability to access the right care, at the right time, and in the right place. Our families deserve no less.

Given the widespread and clearly-stated interest in Congress for MHS Reform this year, our Association had hoped the Department of Defense (DoD) budget proposal would outline plans to improve beneficiary access, quality, safety, and the patient experience in addition to addressing fiscal sustainability and protecting the medical readiness of the force. Instead, DoD has once again rebranded the same old system, incorporated numerous fee increases, and deemed it new and improved.

While we appreciate DoD's budget proposal has finally acknowledged several areas of deficiency within the MHS, simply cataloging the problems does not constitute institutional reform.

We are also concerned the new fee structure is designed to drive more care into Military Treatment Facilities (MTFs), but there are no additional resources identified in the budget proposal to increase MTF capacity, improve access, enhance quality, ensure provider and service member medical readiness, or accurately measure DoD progress in meeting these goals. We fear this scenario will exacerbate current access and quality problems.

On behalf of the military families we serve, we urge you to reject the FY17 DoD health care proposal. It imposes higher fees without enhancing value to beneficiaries and we believe it will put more pressure on the direct care system—a system that frequently fails to fulfill the needs of its current users.

Why MHS Reform is Essential

Although its primary mission is military medical readiness, the MHS has an obligation to deliver a high quality health care benefit to military families, retirees and their families, and survivors. In too many instances, the MHS fails to fulfill this obligation.

In our testimony submitted for the record for the Senate Armed Services Committee Subcommittee on Personnel's February 23, 2016 hearing on military health care reform, we outlined our concerns the MHS would continue to nibble around the edges with the idea of reform: raising fees, but failing to deliver meaningful improvements to the system.¹ DoD's FY17 budget proposal brings those fears to life by focusing on significant fee increases, particularly for retirees, while doing nothing substantive to improve health care delivery for military families.

The status quo is unacceptable. Raising out-of-pocket costs for care that is too often substandard or simply inaccessible is unthinkable.

¹ National Military Family Association Statement for the record, Personnel Subcommittee of the Senate Armed Services Committee, February 23, 2017: <http://www.militaryfamily.org/assets/pdfs/testimony/sasc-hearing-2-23-16.pdf>

As you consider our feedback on DoD's health care proposal, please keep in mind the hurdles our military families regularly face when trying to obtain necessary health care:

On January 6, 2016, I called for an appointment with my PCM for a routine well-woman exam and to discuss throat pain that had been plaguing me. No appointments were available for 30 days with my provider, so they scheduled me for January 19 with another provider.

On the day of my appointment, I waited 90 minutes past my appointment time to see the doctor. It took 45 minutes for the nurse to take my history and vitals because she was interrupted no less than 12 times (I counted) by phone calls and leaving the room to find someone to screen her next patient.

During my routine exam, the doctor found a lump and recommended an early diagnostic mammogram. I called the next day and scheduled my appointment for Tuesday, February 9, three weeks away. On Feb 9, I had the mammogram, which confirmed the mass and identified other areas of concern. I had an ultrasound that day and was told by the radiologist that I would need a biopsy.

My referral for the biopsy was processed three days later on a Thursday evening. Since Friday was a training holiday and Monday was a federal holiday, I had to wait until Tuesday morning to call for my appointment. The PCM had suggested the biopsy should be done that week, but an appointment was not available until the first week of March and results would take another 5-10 days. I objected to this timeframe but, since the appointment was technically within 30 days from the date of the referral, it was considered acceptable—despite the fact that the issue had been identified a month prior and results would potentially take another two weeks. I requested a referral to a facility off-post to have the procedure done sooner and they declined to authorize that but offered me an appointment for four days earlier. So, now I wait.

I consider myself aggressively informed and an outspoken advocate. My PCM has sacrificed his personal time for my care, calling me twice from the office after 8pm to discuss my results and follow up referrals. Yet, here I am, at the mercy of an over-worked and inefficient system. The care I need was available this week in a local civilian facility, but won't be authorized due to procedures and rules. Two months to identify a potentially life threatening condition is too long, but it's the best I have been able to do. (Military Spouse)

This story illustrates the maddening inconsistency within the direct care system and the negative impact of TRICARE policy and MTF interpretations of that policy. On the one hand, this spouse has a dedicated medical provider and received immediate turnaround when her mammogram indicated an ultrasound was needed. On the other hand, office closures and inefficiencies created frustration and delay. Most significantly, TRICARE referral policy and the goal of recapturing care trumped the opinion of her medical provider and delayed her biopsy. Military families need a reliable patient-centered health care system that consistently meets their needs.

In late 2015, our Association fielded a survey of 6,148 military spouse scholarship applicants, a population that has consistently matched the overall demographics of currently-serving families. Nearly 30% of respondents who use an MTF for primary care indicated they rarely or never get an acute appointment within the 24-hour access standard. This is consistent with findings from a health care survey fielded by the Military Officers Association of America (MOAA) in December 2015 in which 29% of active duty spouses reported they rarely or never get an acute care appointment within access standards.

We ask Congress to consider the access, consistency of care, and quality issues our families face across the entire MHS—direct care and purchased care segments—as you evaluate TRICARE reform proposals. We would also invite anyone proposing reform to detail how their plans would correct the areas of concern addressed by the Department’s own Military Health System Review conducted in 2014.² How does the FY17 budget proposal address the challenge areas identified in the MHS Review? How will this proposal drive progress in meeting the action items identified by then-Secretary of Defense Chuck Hagel in his October 1, 2014 memorandum?

We appreciate Congress has made TRICARE Reform a priority and trust reform efforts will focus on ensuring both the benefit and the system charged with delivering the benefit work better for military families.

TRICARE Select/Choice: Nothing More than Rebranded TRICARE Prime/Standard

At a time when there is widespread agreement the MHS must be reformed to better meet beneficiary needs, DoD has proposed nothing more than a rebranding of TRICARE Prime and Standard. The new TRICARE Select and TRICARE Choice options do nothing to improve the MHS for beneficiaries.

In the budget overview, DoD contends TRICARE Select/Choice offers greater choice at a modestly higher cost. Building on that, in a February 21, 2016 DefenseNews interview³, Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs, stated:

“In revising the plan, we listened to the beneficiaries. Beneficiaries want more choice. The preferred provider plan actually gives them the choice. They can go see the physicians they want when they want and it gives them much more latitude in self-managing their care. We also heard from beneficiaries that some wanted to be in this HMO-like managed care product. So that’s what we did. We simplified all the varieties of programs we had into two. One, a preferred provider product which gives you self-managed abilities and great choice and the other is a managed care choice.”

Although DoD and Dr. Woodson assert the new proposal provides beneficiaries with more choice, we fail to see how this is the case. Beneficiaries currently have a self-managed option called TRICARE Standard, which contains a Preferred Provider Option (PPO) called TRICARE

² Secretary of Defense Military Health System Review Final Report: <http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/MHS-Review>

³ DefenseNews interview with Vago Muradian, 2/21/16: <http://www.defensenews.com/videos/defense-news/tv/2016/02/21/80700472/>

Extra. Renaming TRICARE Standard as TRICARE Choice does nothing to increase options for beneficiaries.

DoD's references to TRICARE Choice as a modern PPO led us to hope expanded network coverage might be part of the proposal. However, when asked about expanded networks to ensure all beneficiaries have access to the PPO, DoD stated networks will cover 85 percent of the population similar to current network coverage—yet again, no additional value to beneficiaries. Therefore, TRICARE Choice maintains the current options available under TRICARE Extra and TRICARE Standard. The only difference? Patients using a network provider under the PPO option of TRICARE Choice will pay a fixed co-payment instead of a reduced cost-share. Many patients will still have no option other than non-network providers, but will pay more for the privilege of using them because of the proposed "participation fee" for TRICARE Choice and the higher deductibles and catastrophic cap.

Our Association is concerned that even though the proposed plan outlines no discernible benefit to military families in terms of access to care or quality, it will result in implementation costs to DoD. In fact, DoD estimates Managed Care Support Contractor contract changes and other start-up costs will be \$57 million in FY17.

Acknowledging Problems ≠ Fixing Problems

We appreciate that DoD has reached out to beneficiary organizations and listened to our concerns, as evidenced by Dr. Woodson's numerous public statements and are gratified the FY17 budget acknowledges the Department must commit to institutional health care reform and implement targeted solutions to solve the variety of issues facing beneficiaries. Unfortunately, the budget proposal does little more than list some MHS problem areas including:

- Direct Care access problems
- Lack of first call resolution
- Cumbersome referral process resulting in administrative burdens and delayed access to care
- Lack of seamless mobility for beneficiaries who move around the globe
- Failure to properly address pediatric care issues

The proposal does not even acknowledge several additional areas where the MHS fails to meet beneficiary needs, including:

- Problems with Reserve Component coverage
- Failure to consistently issue referrals to TRICARE network providers when access standards cannot be met within the direct system
- Demand for behavioral health care that continues to outstrip supply in both direct and purchased care
- Variable quality and safety within the direct care system
- Inadequate medical case management services and Extended Care Health Option (ECHO) benefits for special needs families
- TRICARE coverage gaps, such as refusal to cover numerous lab developed tests, including noninvasive prenatal testing
- Customer service issues
- Inconsistent policy implementation at the MTF level

We believe MHS Reform demands credible and detailed plans to address deficiencies within the system. These plans must be accompanied by robust and reliable metrics to monitor progress.

New Fees and Fee Increases: The Primary Element of DoD Health Care “Reform”

We appreciate some elements of DoD’s proposal adhere to key principles of military health care, including:

- Zero out-of-pocket costs for Active Duty Service Members (ADSMs)—nothing changes for ADSMs with DoD’s proposal
- Minimal out-of-pocket cost option for Active Duty Family Members (ADFMs)
- Minimal out-of-pocket cost option for medically retired and their families and survivors—they are treated the same as ADFMs

We also appreciate DoD has removed the ER misuse fee included in the FY16 proposal. Given acute care appointment shortages at some MTFs, together with inconsistently applied referral policies for civilian urgent care, many TRICARE Prime families face situations where the ER is their only option for care. It would be inappropriate to penalize military families for seeking care in the ER given direct care access challenges.

Active Duty Families—Fee Increase Specifics

Given the extraordinary risks, sacrifices and stressors associated with military service, it is critical any MHS Reform efforts maintain a minimal out-of-pocket cost option for active duty families. No/low out-of-pocket costs facilitate access to health care and contribute to overall family readiness. They also serve to recognize the value of military service.

We are gratified DoD’s proposal offers a minimal out-of-pocket cost option for all active duty families. Past proposals have imposed out-of-pocket costs on families without access to an MTF. We appreciate DoD listened to our feedback and will allow remotely located active duty families to self-manage their care without incurring copays or deductibles.

While we are pleased TRICARE Select maintains a no/low cost option for active duty families, we do have some concerns regarding fee changes for ADFMs.

- ***TRICARE Select vs. TRICARE Prime—Out-of-Network Care:*** With TRICARE Prime, families who must use out-of-network care do not incur out-of-pocket costs if they follow Prime’s referral and authorization process. With TRICARE Select, there are deductibles and cost shares associated with all out-of-network care. TRICARE Prime families who rely on out-of-network providers could see significant out-of-pocket costs with the new plan. We fear these costs will disproportionately affect special needs families.
- ***TRICARE Choice vs. TRICARE Standard:*** Utilization data for TRICARE Standard, the current TRICARE Choice equivalent, suggest active duty family members who opt to self-manage use significantly more health care than the average Prime enrolled ADFM.⁴

⁴ Evaluation of the TRICARE Program FY2015

This is consistent with anecdotal evidence suggesting that within the ADFM population, special needs families and those dealing with chronic health conditions are the most likely to opt for TRICARE Standard. They are willing to incur out-of-pocket costs to avoid barriers to care prevalent in TRICARE Prime policy and the direct care system. How will the TRICARE Choice fee structure impact TRICARE Standard ADFMs?

- ***Network deductible is eliminated*** to encourage use of network versus non-network providers. For families with moderate utilization, this change will likely lower total out-of-pocket costs. However, for special needs families with high utilization, eliminating the deductible only serves to spread costs out over a longer time period. **We support eliminating the network deductible, but it is important to recognize it will provide minimal benefit for many TRICARE Choice families.**
- ***Out-of-network deductible is doubled.*** This will increase and/or accelerate out-of-pocket costs for those families who must rely on out-of-network care—most likely special needs families and those seeking behavioral health care (a known TRICARE network inadequacy issue). Our survey of 6,148 military spouses indicates 40% have tried to make a behavioral health appointment for someone in their family. We are concerned about this high rate of behavioral health usage among military families, but even more concerned that raising the non-network deductible will create a barrier to access for behavioral health care. **Given that use of non-network providers is largely driven by inadequate network coverage, we believe it is inappropriate to double the out-of-network deductible.**
- ***Catastrophic cap is increased by 50 percent.*** The catastrophic cap is designed to protect families from financial hardship. Many families already incur out-of-pocket costs in excess of the catastrophic cap since the cap does not apply to any amount non-participating providers may charge above the TRICARE maximum allowable amount. Additionally, we know many families make the switch to TRICARE Standard after encountering difficulties with the direct care system or the referral/authorization process. **We fear raising the catastrophic cap 50 percent will trap some military families in an underperforming direct care system by presenting a financial barrier to switching to TRICARE Standard/Choice.** This will disproportionately impact special needs families, those with chronic conditions, and families seeking ongoing behavioral health care.

Retirees and Families — Fee Increase Specifics

Career military service can present significant obstacles to long-term financial stability, including compromised spouse employment, the inability to grow equity in a primary residence, and the unavoidable midlife career change upon military retirement. Military retirement benefits, including low cost health care, enable career military members to serve 20+ years and achieve long-term financial stability in spite of those challenges. Robust retirement benefits also serve to recognize the extraordinary sacrifices associated with a military career. **While we have always been willing to entertain modest fee increases for**

working-age retiree health care, we also believe fees must be contained to preserve the value of the retirement benefit.

Under the FY17 DoD proposal, retirees face fee increases in almost every area. TRICARE Prime/Select participation fees would be increased and the plan again proposes a new participation fee for TRICARE Standard/Choice beneficiaries. The annual catastrophic cap for retiree families would be increased to \$4,000. Furthermore, participation fees would no longer accrue to the catastrophic cap, increasing potential total out-of-pocket costs. Of course, retiree families would also be subject to the doubled out-of-network deductible.

TRICARE Standard/Choice families are hit particularly hard. TRICARE Standard Retiree families who hit the catastrophic cap (primarily special needs families and those facing chronic conditions, including behavioral health challenges) face a 63 percent increase in potential out-of-pocket costs due to the new participation fee and higher catastrophic cap. These fee increases are particularly objectionable as they are not accompanied by any improvement in the Standard/Choice option, not even an acknowledgement of areas needing such improvement.

Another element resurrected in the FY17 budget is an annual open enrollment period with payment of the participation fee. Retirees who fail to enroll during this time will forfeit coverage for the year, unless they can show they are eligible for enrollment due to a qualifying life event. **While we understand DoD's rationale for seeking clarity on how many beneficiaries will use their TRICARE benefit in a given year, we believe existing historical data and trend analysis can provide this information without the cost of implementing an enrollment fee process that restricts access to the earned health care benefit. We oppose the institution of beneficiary fees for the Standard/Choice option while beneficiaries are still waiting for DoD to make needed improvements.**

Our Association also continues to oppose instituting a DoD TRICARE for Life participation fee. Our Medicare-eligible beneficiaries—retirees, some severely wounded medically-retired service members, and surviving spouses—already pay a high price just to maintain their TRICARE benefit, at least \$104.90 per month in Medicare Part B premiums. DoD should not impose additional costs on this population.

NMFA Perspective on FY17 Fee Increases

Our Association rejects the notion military health care reform starts with the question: "How much should military families pay for their health care?" We believe the starting point for reform is a demonstrated ability to better meet beneficiary needs, together with a plan for continuous improvement and modernization of the health care benefit. Discussions about the appropriate level of out-of-pocket costs should follow, and those discussions should always be grounded in the principles of low/no cost health care for active duty families and retiree costs that reflect the extraordinary sacrifices associated with career military service and preserve the value of the retirement package.

We contend the FY17 proposed out-of-pocket cost increases are too high given DoD's health care proposal provides no corresponding increase in value for military families. What is the value equation for military families? We believe value equals access to timely and appropriate care + the quality of that care + the overall patient experience divided by the

cost of that care. The budget proposal, by focusing primarily on the cost of care to the beneficiary fails to address known MHS problems such as access, quality, and the direct care patient experience. It does not even acknowledge TRICARE coverage issues such as the failure to cover emerging treatments and technologies or lack of coverage for alternative therapies (such as chiropractic.) It also does not acknowledge the costs incurred by many families, whether monetary or borne from the frustration experienced when trying to access quality care in an environment with inconsistent rules and procedures.

Our Association also believes out-of-pocket fee increases must be used only to sustain or improve the health care benefit. We will not support fee increases that fund other DoD initiatives such as lump sum retirement payouts.

Our Association is willing to consider modest out-of-pocket cost increases only if they correspond to enhanced value for beneficiaries and are used only to sustain or improve the military health care benefit.

National Health Expenditures Index

Over and above the cost increases specific to FY17, the DoD proposal would inflate out-of-pocket costs annually by the National Health Expenditures (NHE) Per Capita Index. Although the only mention of the NHE Index occurs in the participation fee section of the FY17 budget, senior Defense officials have clarified the Index would apply to all out-of-pocket costs including copays, deductibles, and catastrophic caps.

For 2014-24, per capita health spending is projected to grow at an average rate of 4.9 percent.⁵ This far outstrips recent military retirement cost of living allowances (COLA) and MHS pending growth, which has leveled off in recent years. An index this high would reduce the overall value of the military retirement benefit as health care costs would outpace COLA. It also shifts the cost burden of the health care benefit from DoD to beneficiaries over time.

Recognizing the fiscal environment meant some fee increases were inevitable, we did not oppose recent TRICARE pharmacy fee hikes. We now have a pharmacy benefit with copays that mirror those of many commercial plans. Our Association is concerned the DoD proposal sets us on a path to an overall health benefit, particularly for retirees, that is not sufficiently differentiated from civilian plans in terms of costs. That outcome is unacceptable.

It is unrealistic to think military health care out-of-pocket costs will never change. We acknowledge it is preferable to increase some beneficiary fees slowly over time versus sporadically implementing larger increases, the rationale for which is not transparent to the beneficiary. Not only would a fee index be more predictable, but it would set clear beneficiary expectations for out-of-pocket costs. An ambiguously defined health care benefit, together with careless verbal promises, has led to feelings of disappointment and betrayal, particularly among military retirees. A clearly defined health care benefit is vital for the future of the all-volunteer force. Career military service must not become a buyer beware proposition.

⁵ NHE Fact Sheet: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

That said, we believe **the NHE Per Capita Index—far higher than recent COLA or MHS spending growth rates—is too steep and will result in a health benefit with reduced value that does not adequately protect military families from health care related financial risk.** Any mechanism for indexing fees must be designed to ensure out-of-pocket costs remain significantly lower than civilian plans. An index designed to shift the health care cost burden from DoD to retirees, such as the proposed NHE index, is unacceptable.

Concerns Regarding FY17 Health Care Recapture Strategy

Changes in the TRICARE fee structure are designed to drive more patient care into the direct system. While we appreciate the need to better leverage the MHS's fixed facility and military medical personnel investments, we are concerned increased demand will exacerbate MTF appointment access problems.

In Congressional testimony, Dr. Woodson has stated the **FY17 proposal includes zero additional direct care resources to address increased demand for MTF services.** Instead, DoD plans to handle the extra patient load by extracting efficiencies from the existing system via extended MTF hours on evenings and weekends and expanded use of technology including secure messaging, telehealth, and the Nurse Advice Line. We believe this plan is unrealistic and inadequate for addressing increased demand and believe all of these "efficiencies" will actually take resources to implement. We have the following concerns:

- **Secure Messaging** and the **Nurse Advice Line (NAL)** are already in place and do not appear to have had much impact on beneficiary appointment access challenges. In fact, DoD has failed to address known billing problems related to NAL authorized urgent care, leading to growing distrust of the NAL within the military family community. DoD must provide specifics on how they will better leverage these technologies to free up additional capacity within the direct care system. Simply hoping or planning that increased Secure Messaging and NAL use will lead to greater efficiencies is not an acceptable solution to the inevitable influx of MTF patients under the FY17 proposal.
- While we are optimistic about the possibilities surrounding **telehealth**, we are skeptical DoD will have a comprehensive telehealth platform up and running by the projected TRICARE Choice/Select launch date of January 2018. We are even more skeptical that a newly introduced telehealth system will immediately be able to absorb enough clinical care to address the increased demand resulting from DoD's proposed TRICARE Select/Choice fee structure.
- **Readiness requirements** limit the availability of military medical personnel for beneficiary health care delivery. We are not convinced DoD has a full understanding of MTF capacity for beneficiary care given the readiness requirements demanded of military medical staff. Our concern is increased beneficiary demand will lead to either greater access problems or compromised military medical readiness.

Not only has DoD proposed an unrealistic and inadequate plan to address increased demand posed by the FY17 proposal, **we are not convinced DoD has the ability to measure MTF capacity for beneficiary care, demand for MTF services, or MTF performance against appointment access standards.** In a recent meeting with leadership from DHA and the Services' medical commands, it became clear DoD continues to use the same flawed measure to evaluate beneficiary access to acute appointments that was discredited during the 2014 MHS Review. This misleading measure reports the percent of acute appointments scheduled within access standards but does not track suppressed demand or those beneficiaries who are

directed to the NAL, civilian urgent care, or the ER. To successfully transition significantly more care into the MTFs, it will be vital to quantify additional demand and pinpoint areas where beneficiary needs are not being met so adjustments can be made. Without proper metrics, it will be impossible to monitor progress against MHS Reform goals for improving access, quality, safety, and the patient experience.

Final Thoughts

Our Association urges you to reject not only the specifics contained in the FY17 budget proposal, but also DoD's approach to MHS Reform. We strongly believe MHS Reform starts with tangible improvements to access, quality, safety, and the patient experience. We realize costs will also be a key component of reform and trust you will ensure they reflect the value of military service.

The military is a uniquely demanding profession. The combination of risk to personal safety, frequent geographic relocations, and lengthy family separations is unmatched in the civilian sector. While no financial compensation can fully offset the sacrifices made by service members and their families, it is imperative the compensation and benefits package—including active duty and retiree military health care benefits—reflect the costs of service.

We appreciate that recent MHS Reform proposals, including DoD's FY17 budget and the Military Compensation and Retirement Modernization Commission (MCRMC) proposal, adhere to the principle of no/low cost care for active duty family members. A robust health care benefit alleviates barriers to health care, enhances family readiness, and allows families to endure the many sacrifices associated with military life. We hope as Congress considers reforms you will maintain this aspect of the system—it is working and it is essential.

As you deliberate on the appropriate fee levels for working-age retirees, we encourage you to consider the cumulative effects of a military career. Under the best of circumstances, career service members and their families endure risk, upheaval and sacrifice on a scale that is unimaginable to many civilians. Those currently approaching retirement eligibility have served the greater part of their careers during wartime—a time characterized by relentlessly high operational tempo, multiple combat deployments, and tumultuous unpredictability. For nearly 15 years, our service members and their families have done everything that was asked of them, often at great expense to their family relationships and stability and physical and mental health. And, it's not over yet. Young service members currently contemplating their futures do so with the understanding global threats persist and extraordinary wartime sacrifices and uncertainty will be part and parcel of a military career for the foreseeable future. For those who endure the extraordinary sacrifices of military service for 20+ years, we contend the appropriate health care benefit should be equally extraordinary with far lower beneficiary costs than “a discount off the comparable civilian equivalent.”