Statement of

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THE NATIONAL MILITARY FAMILY ASSOCIATION

Before the

Task Force on the

Future of Military Health Care

March 7, 2007
The National Military Family Association (NMFA) is the only national organization whose sole focus is the military family. The Association’s goal is to influence the development and implementation of policies that will improve the lives of those family members. Its mission is to serve the families of the seven uniformed services through education, information, and advocacy.

Founded in 1969 as the National Military Wives Association, NMFA is a non-profit 501(c)(3) primarily volunteer organization. NMFA represents the interests of family members and survivors of active duty, reserve component, and retired personnel of the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration.

NMFA Representatives in military communities worldwide provide a direct link between military families and NMFA staff in the nation’s capital. Representatives are the "eyes and ears" of NMFA, bringing shared local concerns to national attention. NMFA does not have or receive federal grants or contracts.

NMFA’s website is: http://www.nmfa.org.

Joyce Wessel Raezer joined the staff of the Government Relations Department of the National Military Family Association as a volunteer in September 1995. She served in several paid positions within the Department before being promoted to Director in December 2001. In February, 2007, she was named Chief Operating Officer. In that position, Joyce guides the management of the Association’s programs and initiatives that serve the families of the Uniformed Services.

Joyce has represented military families on several committees and task forces for offices and agencies of the Department of Defense (DoD) and military Services. She has been a member of the Defense Commissary Agency (DeCA) Patron Council since February 2001. She served as a beneficiary representative, from September 1999 to December 2000, on a Congressionally-mandated Federal Advisory Panel on DoD Health Care Quality Initiatives. Joyce has served on several committees of The Military Coalition, an organization of 36 military-related associations, and is co-chair of the Coalition’s Personnel, Compensation, and Commissaries Committee.

In 2004, Joyce authored a chapter on “Transforming Support to Military Families and Communities” in a book published by the MIT Press, *Filling the Ranks: Transforming the U.S. Military Personnel System*. She was the 1997 recipient of NMFA’s Margaret Vinson Hallgren Award for her advocacy on behalf of military families and the Association. She also received the “Champion for Children” award from the Military Impacted Schools Association in 1998. In 2006, she was named a recipient of the Gettysburg College Distinguished Alumni Award.

A Maryland native, Joyce earned a B.A. in History from Gettysburg College, and a M.A. in History from the University of Virginia. An Army spouse of 25 years and mother of two children, she has lived in the Washington, D.C. area (4 tours), Virginia, Kentucky, and California. She is a former teacher and was elected to the Fort Knox Community Schools Board of Education in 1993, serving until August 1995.
Distinguished Members of this Task Force, the National Military Family Association (NMFA) would like to thank you for the opportunity to discuss issues of concern among military families regarding the military health care system. We thank you for your focus on the many elements necessary to ensure quality health care for service members, retirees, their families, and survivors: military readiness, access to care, funding, benefit design, beneficiary costs, coordination of individual patient care, as well as coordination of the various parts of the health care system. We ask you to recognize that the military health care system, which showed signs of stress even before the start of the Global War on Terror, is now significantly taxed. We also ask you to remember the multi-faceted mission of this system. It must meet the needs of service members and the Department of Defense (DoD) in times of armed conflict. It must also acknowledge that military members, retirees, their families, and survivors are indeed a unique population with unique duties, who earn an entitlement to a unique health care program.

NMFA endorses the recommendations contained in the statement submitted by The Military Coalition. In this statement, NMFA will expand on several issues of importance to military families in the following subject areas:

I. The Military Health System Must Perform as a System  
II. Improving Access to Care  
III. TRICARE Standard  
IV. National Guard and Reserve Family Health Care  
V. DoD Must Look for Savings  
VI. TRICARE Fees: What’s the Answer?  
VII. Mental Health  
VIII. Wounded Service Members Have Wounded Families  
IX. Support for Families with Special Needs

The Military Health System Must Perform As a System

Today’s military families are required to be in a constant state of readiness. They are either preparing for deployment, experiencing a deployment, or recovering from a deployment for a short time until it is time to prepare for another one. Family readiness calls for robust, coordinated support programs, access to quality health care and the availability of preventative mental health counseling, as well as therapeutic mental health care. To ensure they have this access, families need to know the various elements of their military health system are coordinated and actually working as a system. Unfortunately, families tell us the various pieces of this system often operate as independent entities, thus making access to care and coordination of care more difficult, especially for the most vulnerable. The system must be judged not just on how well it functions for a population that is basically young and healthy, but how it handles the complex issues involved in caring for patients who have multiple health care needs, who live far from providers, who are learning the ins and outs of the bureaucracy, who move frequently, and, most importantly, are experiencing the stresses caused by war.
NMFA is concerned the Military Health System (MHS) may not have all the resources it needs to meet the military medical readiness mission and the challenges of caring for all eligible beneficiaries. It must be funded sufficiently so the direct care system of Military Treatment Facilities (MTFs) and the purchased care segment of civilian providers can work in tandem to meet the responsibilities given under the TRICARE contracts, meet readiness needs, and ensure access for all military beneficiaries. Adequate funding for sustainment and repair of military facilities must also be provided.

Officials of the Department of Defense (DoD) often speak of “the Military Health System”, the MHS. There are annual MHS conferences, a Military Health System website (www.tricare.mil), and an MHS Strategic Plan. The current round of TRICARE contracts requires coordination of many health care activities in markets with multiple MTFs and Memoranda of Understanding to govern the relationships between TRICARE contractors and individual MTFs. Battlefield medicine has never been more joint and is supported by the coordination of many staff and operational elements. While NMFA believes DoD has made some progress in living up to the rhetoric regarding a military health “system”, we still see too many stovepipes and too many missed opportunities creating inefficiencies, higher costs, and decreased beneficiary satisfaction. For example,

- In a market served by several military hospitals and clinics, one MTF decides to limit the items carried in its pharmacy. While this decision saves money for this particular MTF, it shifts pharmacy costs to other local MTFs or to DoD as a whole when beneficiaries opt to obtain their medications in the more expensive retail pharmacies.
- In another market with several MTFs, local commanders work together to share providers in order to keep care within the direct care side of the system and avoid the costs of moving more patients to the more expensive purchased care side. Obstetricians from the Air Force facility spend most of their time caring for patients at the nearby Army hospital, which is short-handed because of the deployment of so many of their providers. While they agree this arrangement is best for patient care and savings for the system as a whole, these commanders worry that changes in patient loads in the individual facilities will be difficult to explain and justify to their respective senior leaderships.
- A uniformed pediatric neurologist authorizes therapy for a military child with autism; however, the TRICARE contractor denies that care. The mother asks: “Aren’t you all TRICARE?”
- A referral office at a military clinic directs a mother with a child needing an evaluation for speech therapy to make an appointment with a military specialist at an MTF fifty miles away rather than allowing her to take the child to a civilian TRICARE network facility ten miles away.
- Providers in Department of Veterans’ Affairs (VA) facilities state their ability to provide appropriate care to wounded service members referred from MTFs is hindered because DoD rules governing the access to patient data prevent them from accessing the patients’ medical records electronically.
• TRICARE contracts require the Managed Care Support Contractors (MCSCs) to provide Primary Care Managers in military hospitals with a clear and legible report of diagnosis/treatment within a certain time frame when one of their enrolled patients is referred to a specialist in the TRICARE civilian network. However, specialists in the military hospitals are under no similar obligation to provide such a report when a TRICARE beneficiary enrolled to a network provider is pulled into the MTF for specialty care.

• DoD health officials urge TRICARE beneficiaries to engage in healthy lifestyles in order to reduce overall health care costs and improve quality of life. Some MTFs offer smoking cessation programs to assist beneficiaries who can access them. Unfortunately, smoking cessation programs are not a covered TRICARE benefit, so most beneficiaries do not receive this extra assistance.

At a recent meeting of this task force, NMFA was alarmed by a discussion by the Service Surgeons General that highlighted the inabilities of the military health system to behave as a true system. In an effort to cut health care costs, said the Surgeons, DoD officials created “efficiency wedges”, providing less funding to the Service medical commands and forcing them to make cuts in the direct care part of the system. By cutting clinic hours or providers to meet the needed “efficiencies,” the Services thus cut access to care in their facilities. In order to meet the prescribed access standards for patient care, the MTFs then had to send their beneficiaries enrolled in Prime to providers in the civilian network, at a higher cost to the government than if care could be provided in the MTF.

NMFA asks this Task Force to encourage the military Services and DoD Health Affairs to ensure the activities and resourcing of the various elements of the military health system are coordinated, thus enabling the system to function as a unified entity. We ask this Task Force to consider the advantages of a unified medical command to reduce overhead and to promote coordination of care, especially on the battlefield and at MTFs in multi-Service markets.

Improving Access to Care

NMFA and the families it serves have been gratified to see the medical improvements on the battlefield and in military hospitals, which have raised the survival rate of casualties. NMFA asserts, as we have done for several years, that access to care remains the number one problem facing TRICARE beneficiaries, especially those who depend on military treatment facilities. We were dismayed, but unfortunately not surprised, by the recent press reports highlighting the problems wounded service members face in accessing care at Walter Reed Army Medical Center. Revelations by wounded service members unable to obtain needed care in a timely manner while in out-patient status or in medical hold situations when waiting for the review board process to run its course have cropped up several times since the beginning of the war on terror. We have not been surprised at these stories because we so often hear from military families who cite problems accessing care at MTFs. What is particularly disturbing to us every time we hear of
wounded or injured service members’ difficulties in obtaining care is that we know families have often waited longer than they should for care so service members can receive first priority. Families have every right to be horrified, therefore, when they learn those who bear the scars of battle are having the same or worse access issues.

Responses to an NMFA web survey in early 2006 pointed out military families’ overall satisfaction with improvements in TRICARE and with the quality of care they received in MTFs. However, these responses also highlighted the frustration many families experiencing in accessing care in these facilities:

- **TRICARE has been doing a much better job with its covered members since 2001. The only concern I have now is the availability to even get to see a military provider at my branch medical clinic.** Navy Spouse
- **It seems impossible to see a doctor when I need to. Everything is booked within a month. Sometimes I have to make 6 phone calls before I actually get the information I need.** Marine Corps Spouse

Almost half our survey’s respondents received their care from either military or civilian providers at military hospitals or clinics. Overall, 77 percent of survey respondents stated they were satisfied or very satisfied with their TRICARE benefit. Yet, active duty or active duty family member respondents enrolled in TRICARE Prime at an MTF generally reported more problems in obtaining an appointment than those using civilian providers either in TRICARE Prime or Standard. Access issues surfaced again when respondents were asked about their concerns regarding their health care benefit. Concerns most often cited were: news reports that their family's out of pocket costs may rise, difficulties in getting care at the local MTF, and difficulties in finding civilian providers in the community who will see TRICARE patients. National Guard and Reserve respondents also listed difficulties understanding TRICARE rules. TRICARE Prime respondents listed the inconsistency in quality care as their number three concern.

As we stated above, recent statements by the Service Surgeons General before this Task Force highlighted the funding problems facing the direct care system. These shortfalls are experienced first-hand by military families enrolled in TRICARE Prime whenever they find their MTF cannot meet prescribed access standards. No one is more cognizant of the need for superior health care to be provided to service members in harm’s way than their families. In addition, no one is more willing to change providers or venues of care to accommodate the need for military health care providers to deploy than the families of those deployed. However, a contract was made with those who enrolled in Prime. Beneficiaries must seek care in the manner prescribed in the Prime agreement, but in return they are given what are supposed to be guaranteed access standards. When an MTF cannot meet those standards, appointments within the civilian TRICARE network must be offered. In many cases, this is not happening and families are told to call back next week or next month. In other cases, MTFs must send enrolled beneficiaries to providers in the civilian network, thus increasing costs to the system as a whole.
Because operational requirements have reduced the number of uniformed health care personnel available to serve in the MTF system, a more coordinated approach is needed to optimize care and enable MTFs to meet access standards. We continue to hear that difficulties in the Service contracting process prevent MTFs from filling open contract provider slots and thus optimizing care within their facilities. Efficient contracting for health care staffing could increase the amount of care provided in the direct care system, thereby reducing the overall cost of care to the MHS. NMFA suggests this Task Force recommend that DoD reassess the resource sharing program used prior to the implementation of the T-Nex contracts and take the steps necessary to ensure MTFs meet access standards with high quality health care providers.

Quality care must be available to beneficiaries both in the direct care and purchased care systems. Routinely contracting for the lowest cost providers is a high risk strategy that does not serve the long-term interests of the MHS. The inherent risks are heightened by the absence of clear, consistent standards for private companies providing health care staffing to support care in the MTFs. NMFA understands the Joint Commission on Accreditation of Health Care Organizations (JCAHO) has implemented a certification program for private sector health care staffing firms operating in the civilian sector to ensure they meet established standards. We encourage Congress to direct DoD to adopt these JCAHO standards as well for health care staffing firms that support military hospitals and clinics. The military beneficiaries receiving care in MTFs deserve at least the same protections as those who receive care in private sector hospitals.

**MTFs must have the resources and the encouragement to ensure their facilities are optimized to provide high quality, coordinated care for the most beneficiaries possible. They must be held accountable for meeting stated access standards. If funding or personnel resource issues are the reason access standards are not being met, then assistance must be provided to ensure MTFs are able to meet access standards, support the military mission, and continue to provide quality health care.**

**TRICARE Standard**

NMFA is most appreciative of efforts by Congress to force DoD to improve TRICARE Standard. Congressionally-mandated surveys of providers have pointed out some issues related to providers’ reluctance to treat TRICARE patients, including the perennial complaints of complicated paperwork and low reimbursement rates. TRICARE rates are tied to Medicare rates, which often means providers are reluctant to accept too many TRICARE beneficiaries. NMFA is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. A health care benefit is not much of a benefit if you cannot find providers to accept your plan.

NMFA has been encouraged by the TRICARE contractors’ efforts to speed payments, especially to providers who choose to file claims electronically. Now, TRICARE is no longer the slowest payer; however, it remains the lowest payer and the payer with the most complicated claims.
DoD has added a Standard provider directory on its TRICARE website to assist beneficiaries in finding physicians and the TRICARE contractors have their own directories to assist Standard beneficiaries in finding network providers. However, the law allows non-network providers to decide for each appointment whether or not they will accept TRICARE reimbursement. Hence a provider whose name is in the TRICARE directory may not take a particular Standard patient or may not accept TRICARE reimbursement for all of that patient's care. We applaud efforts by some state Governors to encourage providers to accept TRICARE beneficiaries as patients.

Beneficiaries need help in learning about how TRICARE Standard works, including what to ask providers regarding whether they participate in TRICARE for the particular care they need, take the TRICARE reimbursement amount as their full payment, or require the beneficiary to pay up front. More also needs to be done to educate Standard beneficiaries about their benefit and any changes that might occur to that benefit. Last year, Standard beneficiaries received one newsletter from DoD—not much, but an improvement over previous years!

**NMFA believes ending the TRICARE Standard access problem that is a constant complaint of beneficiaries cannot be accomplished if the reasons providers do not accept TRICARE Standard are not addressed. DoD must be directed to improve communication with Standard beneficiaries.**

**National Guard and Reserve Family Health Care**

Despite increased training opportunities for families, educating Guard and Reserve family members about their benefits remains a challenge. New and improved benefits do not always enhance the quality of life of Guard and Reserve families as intended because these families lack the information about how to access them. NMFA is grateful to Congress for its initial efforts to enhance the continuity of care for National Guard and Reserve members and their families by creating TRICARE Reserve Select (TRS). We continue to monitor this new program closely, watching both premium increases and beneficiaries' access to providers. Because TRS is basically the TRICARE Standard benefit, access to providers within certain standards is not guaranteed. National Guard and Reserve members are paying premiums for this program, however, and so we believe they will expect DoD to ensure providers are available and willing to treat beneficiaries in this program.

TRICARE Reserve Select is not the complete answer to Guard and Reserve families’ health care needs. Information and support are improving for Guard and Reserve families who must transition into TRICARE; however, NMFA believes that going into TRICARE may not be the best option for all of these families. Guard and Reserve service members who have been mobilized should have the same option as their peers who work for the Department of Defense: DoD should pay their civilian health care premiums. The ability to stay with their civilian health care plan is especially important when a Guard or Reserve family member has a special need, a chronic condition, or is in the midst of treatment. NMFA also believes that paying a
subsidy to a mobilized Guard or Reserve member for their family’s coverage under their employer-sponsored insurance plan may also prove to be more cost-effective for the government than subsidizing 72 percent of the costs of TRS for Guard or Reserve members not on active duty.

NMFA also believes it is time to update the Transitional Assistance Management Program (TAMP) health care benefit to reflect recent changes in the TRICARE Prime benefit. Currently, service members who have been demobilized and their families are eligible for 180 days of TAMP health care benefits. If TRICARE Prime is available, they may re-enroll in Prime during the TAMP benefit period. Service members and families who live in areas where there is no Prime network were eligible for TRICARE Prime Remote when the service member was on active duty. During the TAMP benefit period, they are no longer eligible for Prime Remote because the service member is no longer on active duty. In some cases, the family must find another provider, thus disrupting continuity of care. Families formerly in Prime Remote must revert to Standard, with its higher cost shares and deductibles. NMFA believes that the legislative language governing the TAMP benefit should be updated to reflect the availability of TRICARE Prime Remote and that service members and families in TAMP be allowed to remain in Prime Remote.

Emphasis must continue on promoting continuity of care for families of National Guard and Reserve service members. NMFA’s recommendation to enhance continuity of care for this population is to allow members of the Selected Reserve to choose between buying into TRICARE when not on active duty or receive a DoD subsidy allowing their families to remain with their employer-sponsored care when mobilized. NMFA also recommends that the rules governing health care coverage under TAMP be updated to allow the service member and family to remain eligible for TRICARE Prime Remote.

DoD Must Look for Savings

Last year’s proposal by DoD to raise TRICARE fees by exorbitant amounts resonated throughout the beneficiary population. Beneficiaries saw the proposal as a concentrated effort by DoD to change their earned entitlement to health care into an insurance plan. NMFA appreciates the concern shown by Members of Congress last year in forestalling any premium increase, emphasizing the need for the Department to institute more economies, and suggesting further investigation of the issue through a report by the Government Accountability Office and the creation of this Task Force. We ask you to press DoD officials for more information about their budget assumptions, the effects of possible fee increases on beneficiary behavior, the need for DoD to implement greater efficiencies in the Defense Health Care Program (DHP), and the adequacy of the DHP budget as proposed by DoD. We appreciate the continued Congressional oversight of these issues, but ask the help of this Task Force in avoiding a funding train wreck that could impede military families’ access to quality care. NMFA urgently requests that you ask Congress to reinstate the $1.9 billion deducted by DoD from the FY 2008 DHP budget proposal to reflect savings from their proposed policy initiatives, such as increased TRICARE fees.
NMFA believes DoD has many options available to make the military health system more efficient and thus make the need for large increases in beneficiary cost shares unnecessary. For example, had DoD implemented a marketing plan for the TRICARE Mail Order Pharmacy (TMOP) several years ago instead of waiting until beneficiary associations and Congress forced the issue, the migration to TMOP might have reduced health care costs significantly. Even after a year of what DoD officials viewed as a major marketing blitz, DoD beneficiaries use the TMOP at a significantly lower rate than experienced by civilian plan mail order pharmacies. DoD must develop a new strategy to achieve a further increase in TMOP utilization. This strategy should include incentives to beneficiaries who use TMOP, not penalties for those who do not. Similarly, if DoD had implemented the TRICARE Uniform Formulary when first authorized by Congress in the FY 2000 NDAA rather than just starting in March of 2005, it could have realized additional savings. Last year, DoD was thwarted by other offices in the Executive Branch when it attempted to get federal pricing for medications in the TRICARE Retail Pharmacy (TRRx); however, in the meantime, it may have passed up several opportunities to receive significant discounts from pharmaceutical companies.

In recent years at the annual TRICARE conferences and other venues, DoD officials have discussed the benefits of disease management, especially for certain chronic illnesses. These benefits flow to the beneficiaries through better management of their conditions and to DoD through patients’ decreased need for costly emergency room visits or hospitalizations. Last year, Congress mandated that DoD offer certain disease management programs across the system. However, DoD must encourage the TRICARE contractors and MTFs to create comprehensive programs that include pharmacy coordination.

Similarly, Section 739 of the FY 2006 NDAA directed DoD to conduct a study evaluating the feasibility and cost effectiveness of a Medicare Advantage Regional PPO demonstration for TRICARE for Life (TFL) beneficiaries. This demonstration, focused on the TFL population with its high utilization of resources, could provide another opportunity to determine potential benefits from case management and disease management programs for beneficiaries with complex and/or chronic conditions. NMFA expects this program would be voluntary and would preserve all the benefits currently available to TFL beneficiaries under TRICARE and Medicare. Unfortunately, it has been over a year since this provision was enacted and NMFA has not yet heard from DoD regarding its plans to implement this demonstration.

Despite the successes of the TRICARE Next Generation (T-Nex) managed care support contracts, NMFA remains concerned that efforts to optimize the military treatment facilities have not met expectations in terms of increasing or even maintaining access for TRICARE beneficiaries. NMFA believes optimizing the capabilities of the facilities of the direct care system through timely replacement construction, funding allocations, and innovative staffing would allow more beneficiaries to be cared for in the MTFs, which DoD asserts is the least costly venue. Innovative staffing approaches should look at the mix of staff available through a variety of sources: military, civilian, contract, and resource sharing. As
with disease management, staffing initiatives must involve a systemic approach to make the best use of resources available through both the MTFs and the Managed Care Support Contractors.

NMFA also believes the Managed Care Support Contractors have additional beneficial suggestions that could reduce health care costs through more efficient claims processing, the elimination of redundancies, and the reduction of the number of DoD-unique requirements in the contracts. Because the costs of recompeting and implementing large contracts can be extremely high, NMFA applauds the language in the FY 2007 NDAA authorizing an extension of the current contracts. We are concerned that DoD seems to be disregarding that language. The implementation of the T-Nex contracts went more smoothly than many predicted, but beneficiaries and providers still experienced a certain amount of turmoil. Both would benefit from a longer period of stability and anticipated improvements in customer service as the contractors become more familiar with their regions and their implementation tasks. DoD could probably better serve its beneficiaries and enhance savings and efficiency if it would take the time to test new concepts for the next contracts through demonstration projects evaluated in the current program rather than implementing them untested in the new contracts. DoD should also ensure the three major issues still outstanding in the implementation of the current contracts—electronic claims, clean and legible records, and referrals and authorizations—have been solved before launching into another contract round.

**NMFA strongly suggests that DoD look within itself for cost savings before first suggesting that beneficiaries bear the burden! We encourage DoD to investigate further cost saving measures such as: a systemic approach to disease management, a concentrated marketing campaign to increase use of the TRICARE Mail Order Pharmacy, eliminating contract redundancies, delaying the recompetition of the TRICARE contracts, speeding implementation of the Uniform Formulary process, and optimizing military treatment facilities.**

**TRICARE Fees—What’s the Answer?**

NMFA remains especially concerned about what we believe is DoD’s continued intention to create a TRICARE Standard enrollment fee. The precursor to TRICARE Standard, the basic benefit provided for care in the civilian sector, was CHAMPUS, which was then, as TRICARE Standard is now, an extension of the earned entitlement to health care. Charging a premium (enrollment fee) for TRICARE Standard moves the benefit from an earned entitlement to an opportunity to buy into an insurance plan. Standard is the only option for many retirees, their families, and survivors because TRICARE Prime is not offered everywhere. Also, using the Standard option does not guarantee beneficiaries access to health care, which beneficiaries opting to use Standard rather than Prime understand. DoD has so far not linked any guarantee of access to their proposals to require a Standard enrollment fee.

In the ongoing debate about whether or not to raise TRICARE beneficiary fees, NMFA believes it is important for everyone participating in that debate to
understand the difference between TRICARE Prime and TRICARE Standard and to distinguish between creating a TRICARE Standard enrollment fee and raising the Standard deductible amount. TRICARE Prime has an enrollment fee for military retirees; however, it offers enhancements to the health care benefit. These enhancements include: lower out-of-pocket costs, access to care within prescribed standards, additional preventive care, assistance in finding providers, and the management of one’s health care. In other words, enrollment fees for Prime are not to access the earned entitlement, but for additional services. These fees, which have not changed since the start of TRICARE, are $230 per year for an individual and $460 per year for a family.

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1 Providers may charge 15% above the TRICARE allowable and the beneficiary is responsible for this additional cost, making the potential cost share 40%.
2 If care is accessed from a TRICARE Prime/Extra network provider the cost share is 20%.
3 If care is received in a TRICARE Prime/Extra network hospital, the daily hospitalization rate is the lesser of $250/day or 25% of negotiated charges.
(For a more detailed comparison of TRICARE costs, go to: http://www.tricare.mil/tricarecost.cfm)
NMFA opposes any proposal to institute a TRICARE Standard enrollment fee and because it would change beneficiaries’ entitlement to health care under TRICARE Standard to just another insurance plan. However, we would be remiss if we did not ask the many questions beneficiaries have about how a Standard enrollment fee would be implemented and its implications regarding access to care:

1. Will retirees who do not enroll in Prime and do not pay a premium (enrollment fee) for Standard be refused space available care in MTFs, including their emergency rooms?
2. Will these same retirees be refused pharmaceutical services at MTFs or be unable to use TRICARE retail network pharmacies and the TRICARE mail order pharmacy?
3. Will retirees who only use Standard as a wrap-around to their employer-provided health care insurance pay the same premium (enrollment fee) as those who will use Standard as their primary benefit?
4. What type of open enrollment season will be needed to provide retirees with the opportunity to coordinate coverage between TRICARE and their employer-sponsored insurance?
5. How will DoD inform all eligible beneficiaries of this significant change in their benefit and of the opportunity to enroll?
6. What additional resources will DoD require the TRICARE Managed Care Support Contractors to put in place to handle the enrollment of beneficiaries?
7. How much will it cost to implement the enrollment fee, including the education efforts, additional tasks imposed on the TRICARE contractors, and the inevitable cost of handling appeals from beneficiaries whose claims were denied because they did not know they had lost their benefit?
8. Has DoD incorporated realistic cost estimates for the implementation of a Standard premium into its budget proposal and savings projections?

We also ask what additional services beneficiaries who enroll in Standard will receive after paying the enrollment fee. Or, will they only be paying for the “privilege” of having to seek their own providers, often filing their own claims, meeting a deductible, paying a 20 percent cost share for their care (plus an additional 15 percent if the provider does not participate in the claim), and being liable for a daily hospitalization charge of up to $535? And, because they recognize the cost liabilities of being in Standard, we know most will continue to bear the cost of a TRICARE supplemental insurance policy.

DoD’s proposal last year to increase TRICARE Prime enrollment fees, while completely out-of-line dollar wise, was not unexpected. In fact, NMFA had been surprised DoD did not include an increase as it implemented the recent round of new TRICARE contracts. While Congress at least temporarily forestalled any increases last year, NMFA believes DoD officials continue to support large increased retiree enrollment fees for TRICARE Prime, combined with a tiered system of enrollment fees and TRICARE Standard deductibles. NMFA believes any tiered system would be arbitrarily devised and would fail to acknowledge the needs of the most vulnerable beneficiaries: survivors, wounded service members, and their families.
Acknowledging that the annual Prime enrollment fee has not increased in more than 10 years and that it may be reasonable to have a mechanism to increase fees, NMFA last year presented an alternative to DoD’s proposal should Congress deem some cost increase necessary. The most important feature of this proposal was that any fee increase be no greater than the percentage increase in the retiree cost of living adjustment (COLA). If DoD thought $230/$460 was a fair fee for all in 1995, then it would appear that raising the fees simply by the percentage increase in retiree pay is also fair. NMFA also suggests it would be reasonable to adjust the TRICARE Standard deductibles by tying increases to the percent of the retiree annual COLA.

**NMFA believes tying increases in TRICARE enrollment fees to the percentage increase in the retiree Cost of Living Adjustment (COLA) is a fair way to increase beneficiary cost shares should Congress deem an increase necessary. We encourage this Task Force to recommend that DoD to continue efforts to gain real efficiencies, improve the quality of care, and access. NMFA also recommends a review be conducted to see if the Uniform Formulary process is producing the savings projected and the extent, if any, beneficiaries believe they have been denied medications they and their provider believe would be more clinically appropriate for them.**

**Mental Health**

As the war continues, families’ need for a full spectrum of mental health services—from preventative care to stress reduction techniques, to individual or family counseling, to medical mental health services—continues to grow. Recently, in a meeting in Alaska with Chairman of the Joint Chiefs of Staff General Peter Pace, military spouses asked for more counseling resources to help them recognize potential difficulties their service members were facing as a result of combat experience. They also asked these services be made available to service members and commanders grappling with these problems. The recent press reports on Walter Reed Army Medical Center also emphasized the need for additional counselors and mental health services for both wounded service members and their families.

The Army’s recently-released Third Mental Health Advisory Team report links the need to address family issues as a means for reducing stress on deployed service members. The team found the top non-combat stressors were deployment length and family separation. They noted that Soldiers serving a repeat deployment reported higher acute stress than those on their first deployment. They found that, while multiple deployers felt they were better prepared due to improved pre-deployment training, they also acknowledged their families are experiencing more stress. The study also determined that leading suicide risk factors were relationship issues at home and in theater.

As service members and families experience numerous lengthy and dangerous deployments, NMFA believes the need for mental health services will continue to
rise. It will also remain high for some time even after military operations scale down in Iraq and Afghanistan. NMFA has seen progress in the provision of mental health services, access to those services, and military service member and family well-being. Information gathered in the now-mandatory post-deployment health assessments may also help identify service members who may need more specialized assistance in making the transition home. Successful return and reunion programs will require attention over the long term, as well as a strong partnership at all levels between the various mental health arms of the DoD and VA. In some cases, however, the progress is ongoing and barriers to quality mental health care remain.

The military offers a variety of mental health services, both preventative and treatment, across many helping agencies and programs. On a typical installation, families can access stress management classes through the family center staff, the military and family life consultants, chapel programs, hospital, family readiness group meetings, or through orientation programs such as Army Family Team Building. They can find marriage and family counseling through the family centers, chaplains, or social workers at the military hospitals. They can call Military OneSource and request a visit with a counselor outside the military system paid through that contract. If a medical condition, such as depression or an anxiety disorder, is suspected, families can receive services, where available, through military treatment facilities or TRICARE civilian providers.

These programs and services are primarily stand-alone. Coordination across the spectrum is rare. Families tell NMFA that the proliferation of programs, while beneficial to those who seek them out or are able to take advantage of them, has increased their confusion about where to go or who to see to get the help they need. A first step in this needed coordination would be to integrate training among Military OneSource counselors, installation-based family support professionals, and Family Assistance Center employees of the Guard and Reserve to facilitate information, collaboration, and counseling efforts to best support military families. A second step would be to increase linkages at the local level between military installation mental health providers, civilian providers, and school personnel to enhance training and access to care. Third, DoD should investigate alternative methods such as telehealth for delivering mental health counseling, especially in rural areas.

Timely access to the proper provider remains one of the greatest barriers to quality mental health services for service members and their families. NMFA and the families it serves have noted with relief that more providers are deployed to theaters of combat operations to support service members. The work of these mental health professionals with units and individuals close to the combat action they experience have proved very helpful and will reduce the stress that impedes service members’ performance of their mission and their successful reintegration with their families.

While families are pleased more mental health providers are available in theater to assist their service members, they are less comfortable with the resulting
limited access to providers at home. Families report increased difficulty in obtaining appointments with social workers, psychologists, and psychiatrists at their military hospitals and clinics. The military fuels the shortage by deploying some of its child and adolescent psychology providers to the combat zones. Providers remaining at home stations report they are frequently overwhelmed treating active duty members who either have returned from deployment or are preparing to deploy to fit family members into their schedules. A recent survey on counseling conducted by the European Command documents the access problems NMFA has heard from military families both CONUS and OCONUS. Many respondents stated that appointments are difficult to obtain, chaplains and family center staff are also overworked, and the specialized care needed for children and adolescents is persistently difficult to obtain.

National shortages in this field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographical challenges: large populations in rural or traditionally underserved areas. Over the past year, several groups of civilian mental health providers who are willing to donate their services to service members and family members have contacted NMFA. One of these groups is SOFAR, the Strategic Outreach to Families of All Reservists (www.sofarusa.org). SOFAR providers, mostly based in New England, provide stress management sessions to Family Readiness Groups and individual counseling to family members, to spouses and children, as well as non-military-ID card holders, such as parents and significant others. The non-profit Give an Hour (www.giveanhour.org) asks mental health providers to donate one hour per week for a year to assist service members or family members who need these services. NMFA applauds the spirit to help military families that drives these ventures and believes that well-trained providers in these organizations can supplement local support services available to family readiness groups and unit rear detachment/party personnel, especially for isolated Guard and Reserve units. However, we are concerned about the difficulties in coordinating care provided outside the TRICARE system in case more serious issues emerge and the patient must come back into the system. While willing to see military beneficiaries in a voluntary status, these providers often tell us they will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. More must be done to persuade these providers to participate in TRICARE and become a resource for the entire system.

NMFA also believes a legislative change is needed to expand the TRICARE provider base. Currently, by law, clinical social workers and marriage and family therapists can independently treat TRICARE beneficiaries for TRICARE-covered mental health conditions. Licensed mental health counselors are professionals with master’s or doctoral degrees in counseling or a related discipline, training similar to that of clinical social workers and marriage and family therapists. They were excluded from the legislative authority to treat TRICARE patients as independent providers and may only see TRICARE patients under the supervision of a physician. This requirement increases the difficulty for TRICARE patients in accessing care, limits their choice of provider, and may, by providing an additional step in the process of obtaining care, discourage beneficiaries from seeking care. A provision to
grant licensed mental health counselors independent practice authority under TRICARE was included in the House version of the FY 2006 and 2007 NDAAs, only to fall out of the final conference versions. NMFA asks this Task Force to investigate the feasibility of this opportunity to expand the military medical facility and TRICARE provider base by authorizing independent practice by licensed mental health counselors.

NMFA continues to hear that some service members and families feel the stigma against seeking mental health care and choose to try to “ride out” the rough spots on their own. We believe, however, based on our survey data and conversations with family members, that the increased stress caused by multiple deployments is causing more families to seek help. While this increased stress in the military family is bad news, the good news for family support professionals who believe military families are reluctant to seek help for mental health issues is many now recognize counseling is an option for them. Families perceive counseling and mental health support as especially helpful if it is confidential and with a professional familiar with the military. One spouse who met recently with General Peter Pace in Alaska noted what she felt she and her service member spouse needed most: “When my husband talks to me, I don’t even know how to respond to some of the things he says. If they can talk among themselves, without fear of repercussion, maybe that would help.”

To measure the stigma associated with seeking behavioral health care, the Army’s Third Mental Health Advisory Team (MHAT) asked Soldiers five different questions. The team found that the number of Soldiers who agreed there was stigma associated with seeking this care decreased significantly from MHAT I to MHAT III. While these findings are encouraging, we include the persistent stigma as a barrier that must still be addressed. Commanders must be engaged in this process to model behaviors that promote the seeking of counseling and support.

Many mental health experts state that some post-deployment problems may not surface for several months or years after the service member’s return. NMFA is especially concerned not as many services are available to the families of returning Guard and Reserve members and service members who leave the military following the end of their enlistment. They may be eligible for transitional health care benefits and TRICARE Reserve Select. The service member may seek care through the VA, but what happens when the military health benefits run out and deployment-related stresses still affect the family? Reports of Vietnam and even World War II veterans showing up at VA facilities in need of counseling after viewing news reports of the war in Iraq remind all of us that PTSD and other mental health effects of the war can linger for years, thus requiring the availability of care for many years in the future. In your investigations, please address not just the current needs of the force and families, but also their long-term need for continued access to services.

We also ask you to address the distance issues families face in linking with military mental health resources and obtaining appropriate care. Isolated Guard and Reserve families do not have the benefit of the safety net of services provided
by military treatment facilities and installation family support programs, however strained. They look to resources in their communities. Often, however, these local providers may not have an understanding of military life or an appreciation of the service member's choice to serve. Especially when dealing with the mental health consequences of deployment, families want to be able to access care with a provider who understands or is sympathetic to the issues they face. More education to civilian health care providers, as well as religious and education professionals, will help to broaden the support base for military families and improve the quality of the mental health services they receive.

In the sixth year of the war on terror, care for the caregivers must become a priority. NMFA hears from the senior officer and enlisted spouses who are so often called upon to be the strength for others. We hear from the health care providers, educators, rear detachment staff, chaplains, and counselors who are working long hours to assist service members and their families. Unless these caregivers are also afforded a respite and care, they will be of little use to those who need their services most.

NMFA also sees a need for specific training in bereavement and other counseling for family readiness group leaders, ombudsmen, and key volunteers. Many widows say they suddenly felt shut out by their old unit or community after the death of their service member. Often the perceived rejection is caused by a lack of knowledge on the part of other families about how to meet the needs of the survivors in their midst. Because they find contact with survivors difficult, they shy away from it. In some communities, support groups outside the unit family support chain have been established to sustain the support of the surviving families in the days and months after the death of the service member. As part of the standardization and improvement of the casualty assistance process, more effort needs to be placed at the command level on supporting the long-term emotional needs of survivors and of communities affected by loss.

Because the VA has as part of its charge the “care for the widow and the orphan,” NMFA was concerned about recent reports that many Vet Centers did not have the qualified counseling services they needed to provide promised counseling to survivors, especially to children. DoD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need. New legislative language governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement or grief counseling. While some widows and surviving children suffer from depression or some other medical condition for a time after their loss, many others simply need counseling to help in managing their grief and helping them to focus on the future. Many have been frustrated when they have asked their TRICARE contractor or provider for “grief counseling” only to be told TRICARE does not cover “grief counseling.” Available counselors at military hospitals or clinics can sometimes provide this service and certain providers have found a way within the reimbursement rules to provide needed care, but many families who cannot access military hospitals are often left without care because they do not know what to ask for or their provider does not know how to help them obtain covered services. Targeted grief counseling
when the survivor first identifies the need for help could prevent more serious issues from developing later.

Many of the issues facing survivors also face service members who were wounded or injured and their families. Because many of these service members are medically retired and will continue to access military health care benefits, in addition to VA assistance, appropriate mental health services must be available in both health care systems to them and their families. Counselors working with these families must understand the effects of trauma and help them deal with the ongoing challenges involved in the care of the service member, as well as the upheaval that injury has caused to the family as a whole. Mental health professionals must have a greater understanding of the effects of mild Traumatic Brain Injury in order to help accurately diagnose and treat the service member's condition. They must be able to deal with polytrauma—PTSD in combination with multiple physical injuries.

**DoD must balance the demand for mental health personnel in theater and at home to help service members and families deal with unique emotional challenges and stresses related to the nature and duration of continued deployments. Rear detachment personnel and family readiness volunteers need mental health professionals dedicated to assist them in supporting families of the fallen and injured and others who may become overwhelmed by the stresses of deployment. We ask you to encourage DoD to step up the recruitment of uniformed mental health providers and the hiring of civilian providers to assist service members in combat theaters AND at home stations to care for the families of the deployed and service members who have either returned from deployment or are preparing to deploy. TRICARE contractors should be tasked with increasing their efforts to attract mental health providers into the TRICARE networks and to identify and ease the barriers providers cite when asked to participate in TRICARE.**

**Wounded Service Members Have Wounded Families**

As revealed in the series of articles about Walter Reed Army Medical Center, post-deployment transitions can be especially problematic for injured service members and their families. NMFA asserts that behind every wounded service member is a wounded family. Spouses, children, parents, and siblings of service members injured defending our country experience many uncertainties. Fear of the unknown and what lies ahead in future weeks, months, and even years, weighs heavily on their minds. Other concerns include the injured service member’s return and reunion with their family, financial stresses, and navigating the transition process to the VA. The system should alleviate, not heighten these concerns, and provide for coordination of care that starts when the family is notified the service member has been injured and ends with the DoD and VA working together to create a seamless transition as the injured service member transfers from active duty status to veteran.
Traumatic Brain Injury (TBI) is the signature wound for Operation Enduring Freedom and Operation Iraqi Freedom injured service members. Long-term effects and appropriate treatment for this condition have not been adequately assessed. NMFA is concerned with DoD’s decision to cut funding for basic research by 9 percent and 18 percent for applied research. Accurate diagnosis and proper treatment for TBI requires forward leaning initiatives by DoD and VA founded on solid research.

When designing support for the wounded/injured in today’s conflict, the “government”—whether in the guise of commander, non-commissioned officer, Service personnel office, a family assistance center, an MTF, or the VA—must take a more inclusive view of military families and remember that a successful recovery depends on caring for the whole patient and not just the wound. Those who have the responsibility to care for the wounded service member must also consider the needs of the spouse, children, and the parents and siblings of single service members. It is time to update TRICARE benefits to meet the needs of this population by allowing medically-retired wounded service members and their families to retain access to the set of benefits available to active duty families during a transitional period following the service member’s retirement. These benefits would include the ability to enroll in TRICARE Prime Remote and to continue coverage of a disabled family member under the Extended Care Health Option (ECHO).

To support wounded and injured service members and their families, NMFA recommends the three-year transitional survivor health care benefit be extended to service members who are medically retired and their families and direct DoD to establish a Family Assistance Center and additional counseling resources at every MTF caring for wounded service members.

Support for Families With Special Needs
NMFA is grateful to Congress for directing DoD, in Section 717 of the FY 2007 NDAA, to develop a plan to provide services to military dependent children with autism. This complicated condition places a burden on many military families. Unfortunately, current TRICARE policies increase that burden because families cannot access the care their children need. Frequent military moves make it difficult for these children to receive a consistent level of services. Deployment of a service member removes a caregiver from the home, making managing therapy and doctors’ appointments, negotiating with school officials for suitable services, and caring for other children in the family difficult for the parent remaining behind. In the FY 2002 NDAA, Congress authorized the Extended Care Health Option (ECHO) to provide additional benefits to active duty family members with a qualifying mental or physical disability in recognition of extraordinary challenges faced by active duty families because of the service member’s deployment or frequent relocations that often make accessing services in the civilian community difficult.

We remain concerned that military service members with special needs family members continue to battle a lack of information or support and are often
frustrated by the failure of the military health care and family support systems to work together and with civilian agencies to support their families’ needs. Like the service members featured in the recent press reports of problems at Walter Reed, special needs military families often experience a system that relies on them to connect the dots and seek out resources rather than providing the care coordination they need.

**NMFA requests this Task Force emphasize the importance of coordinated services and case management to support military family members with special needs.**

**Survivors**

NMFA applauds the enhancement of medical benefits included in the FY 2006 NDAA making surviving children eligible for full medical benefits to age 21 (or 23 if they are enrolled in college) bringing them in line with the active duty benefit for dependent children. To complete the benefit package we recommend allowing surviving children to remain in the TRICARE Dental Program until they age out of TRICARE and, in cases where the surviving family had employer-sponsored dental insurance, treat them as if they had been enrolled in the TRICARE Dental Program at the time of the service member’s death.

**NMFA recommends that surviving children be allowed to remain in the TRICARE Dental Program until they age out of TRICARE eligibility.**

Military families support the Nation’s military missions. The least their country can do is make sure they have consistent access to high quality health care. Strong families equal a strong force. Family readiness is integral to service member readiness. The cost of that readiness is an integral part of the cost of the war and a National responsibility. We ask this Task Force to assist in meeting that responsibility.