



T H E M I L I T A R Y C O A L I T I O N

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STATEMENT OF

THE MILITARY COALITION (TMC)

before the

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

March 01, 2007

Presented by

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MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE. On behalf of The Military Coalition, a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning issues affecting the uniformed services community. This testimony provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

- Air Force Association
- Air Force Sergeants Association
- Air Force Women Officers Associated
- American Logistics Association
- AMVETS (American Veterans)
- Army Aviation Association of America
- Association of Military Surgeons of the United States
- Association of the United States Army
- Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
- Commissioned Officers Association of the U.S. Public Health Service, Inc.
- Enlisted Association of the National Guard of the United States
- Fleet Reserve Association
- Gold Star Wives of America, Inc.
- Jewish War Veterans of the United States of America
- Marine Corps League
- Marine Corps Reserve Association
- Military Chaplains Association of the United States of America
- Military Officers Association of America
- Military Order of the Purple Heart
- National Association for Uniformed Services
- National Military Family Association
- National Order of Battlefield Commissions
- Naval Enlisted Reserve Association
- Naval Reserve Association
- Non Commissioned Officers Association
- Reserve Enlisted Association
- Reserve Officers Association*
- Society of Medical Consultants to the Armed Forces
- The Retired Enlisted Association
- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- Veterans of Foreign Wars of the United States
- Veterans' Widows International Network

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

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

EXECUTIVE SUMMARY

Active Force Issues

End Strength and Associated Funding – The Coalition strongly urges the Subcommittee to provide additional recruiting and retention resources to enable uniformed services to achieve required optimum-quality personnel strength skills/occupational mix and the health of the entire force.

Pay Comparability and Targeted Pay Increases – The Coalition urges the Subcommittee to propose a military pay raise of at least 3.5% for FY2008 (one-half percentage point above private sector pay growth) and to continue such increases until the current 4% pay comparability gap is closed. The Coalition also urges the Subcommittee to continue periodic targeted pay raises as appropriate to recognize the growing education and technical qualifications of enlisted members and warrant officers.

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

Family Readiness and Support – The Coalition urges the Subcommittee to expand family support and financial education programs to meet growing needs associated with extended deployments and the more complex insurance, retirement, and savings choices faced by overworked military families in today's complicated world.

Predatory Lending – The Coalition urges the Subcommittee most strongly to oppose any changes to the statutory provisions enacted in the FY2007 Defense Authorization Act.

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

Permanent Change of Station (PCS) Allowances – The Military Coalition supports upgrading permanent change-of-station allowances to reflect the expenses members are forced to incur in complying with government-directed relocations, with priority on adjusting the twenty two year old PCS mileage rates. Additionally, the Coalition urges authorizing a shipment of a second Privately Owned Vehicle at government expense to overseas' accompanied assignments.

BRAC/Rebasing/Military Construction/Commissaries – The Coalition urges the Subcommittee to ensure family support/quality of life programs and services are not reduced, but are expanded to fully accommodate rebasing/BRAC needs at closing and gaining installations – to include housing, education, child care, military construction, exchanges and commissaries, health care, family centers, unit family readiness, and other support services.

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

National Guard & Reserve Issues

Reserve Retirement and ‘Operational Reserve’ Policy – TMC urges Congress to lower the Reserve retirement age, starting with an adjustment for active duty service, in recognition of the increase in service and sacrifice of Guard and Reserve service members and as an inducement to longer service.

A Total Force Approach to the Montgomery GI Bill – The Coalition strongly supports enactment of H.R. 1102 to consolidate active duty and reserve MGIB programs in Title 38 and align benefit rates according to the length and type of service performed – a Total Force MGIB.

Guard and Reserve End Strength and Readiness – The Coalition urges Congress to maintain and increase Guard and Reserve force end-strengths consistent with the demands being imposed upon them, in addition to providing proper funding for their equipment and training.

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

Reserve Compensation System – The Coalition urges the Subcommittee to address the inequities of the “1/30th” rule for special and incentive pays, the cap on annual training points creditable for retirement, housing allowance restrictions and other compensation elements that disadvantage Guard and Reserve members.

Tangible Support for Employers – The Coalition urges the Subcommittee to use all possible influence with the Ways and Means Committee to support needed tax relief for employers of Selected Reserve personnel.

Retirement Issues

Concurrent Receipt – The Coalition urges the Subcommittee to authorize full concurrent receipt of earned military retired pay and VA disability compensation at the earliest possible time, with particular priority for immediate “vesting” of earned military retired pay for Chapter 61 retirees forced into medical retirement before attaining 20 years of service and full, immediate concurrent receipt for retirees deemed “unemployable” by the VA.

Uniformed Services Retiree Entitlements and Benefits – The Coalition urges the Subcommittee to oppose initiatives to “civilianize” the military retirement system in ways that reduce the value of the current retirement system and undermine long-term retention.

Former Spouse Issues – The Coalition urges the Subcommittee to move forward on initiatives to ease at least the most significant inequities under the USFSPA.

Survivor Issues

SBP-DIC Offset – The Military Coalition urges the Subcommittee most strongly to take immediate action to provide relief for this most-aggrieved group of military widows, and pledges

to work with the Subcommittee as needed to avoid another year with no progress at all toward this important goal.

30-Year Paid-Up SBP – The Coalition urges the Subcommittee to seize the opportunity to provide at least one year of relief for the “Greatest Generation” retirees who already have paid nearly 30% more SBP premiums than their successors ever will.

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

Health Care Issues

Full Funding for the Defense Health Program – The Military Coalition strongly urges the Subcommittee to take all possible steps to restore the \$1.8 billion in TRICARE-related budget authority and ensure continued full funding for Defense Health Program needs.

Protecting Beneficiaries Against Cost-Shifting – The Coalition urges the Subcommittee to require DoD to pursue greater efforts to improve TRICARE and find more effective and appropriate ways to make TRICARE more cost-efficient without seeking to “tax” beneficiaries and make unrealistic budget assumptions.

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

- Active duty members and families should be charged no fees except retail pharmacy co-payments, except to the extent they make the choice to participate in TRICARE Standard or use out-of-network providers under TRICARE Prime.
- For retired and survivor beneficiaries, the percentage increase in fees, deductibles, and co-payments that may be considered in any year should not exceed the percentage increase beneficiaries experience in their compensation.
- The TRICARE Standard copay should not be increased further for the foreseeable future. At \$535 per day, it already far exceeds inpatient copays for virtually any private sector health plan.
- There should be no enrollment fee for TRICARE Standard, since Standard does not offer assured access to TRICARE-participating providers. An enrollment fee implies enrollees will receive additional services, as Prime enrollees are guaranteed access to providers in return for their fee.
- There should be one TRICARE fee schedule for all retired beneficiaries, just as all legislators, Defense leaders and other federal civilian grades have the same health fee schedule. The TRICARE schedule should be significantly lower than the lowest tier recommended by the Defense Department, recognizing that all retired members paid

large up-front premiums for their coverage through decades of arduous service and sacrifice.

TRICARE Standard Enrollment – The Coalition recommends strongly against establishment of any TRICARE Standard enrollment system; to the extent enrollment may be required, any beneficiary filing a claim should be enrolled automatically, without denying the claim.

Private Employer Incentive Restrictions – The Coalition recommends Congress modify the law restricting private employer TRICARE incentives to explicitly exempt employers who offer only cafeteria plans (i.e., cash payments to all employees to purchase care as they wish) and employers who extend cash payments (e.g., \$100 per month) to any employee who uses health coverage other than the employer plan (e.g., FEHBP, TRICARE, or commercial insurance available through a spouse or previous employer).

TRICARE Standard Improvements – The Coalition urges the Subcommittee to establish requirements for TRICARE Standard beneficiary surveys and a definition of what level of provider participation shall be deemed to require positive action to increase it.

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

TRICARE Reimbursement Rates – The Coalition urges the Subcommittee to exert what influence it can to persuade the Ways and Means/Finance Committees to reform Medicare/TRICARE statutory payment formula. To the extent the Medicare rate freeze continues, we urge the Subcommittee to encourage the Defense Department to use its reimbursement rate adjustment authority as needed to sustain provider acceptance.

The Coalition urges the Subcommittee to require a Comptroller General report on the relative propensity of physicians to participate in Medicare vs. TRICARE, and the likely effect on such relative participation of a further freeze in Medicare/TRICARE physician payments along with the affect of an absence of bonus payments.

Minimize Medicare/TRICARE Coverage Differences – The Coalition urges the Subcommittee to align TRICARE coverage to at least match that offered by Medicare in every area.

Setting the TRICARE Reserve Select (TRS) Premium – The Coalition recommends that the percentage increase in TRS premiums should not exceed the percentage increase in military basic pay, and that there should be no increases for at least two years in light of the 8% increase imposed in 2006. The Coalition further recommends that the Subcommittee request a report from the Department of Defense on options to assure TRS enrollees' access to TRICARE-participating providers.

Private Insurance Premium Option – The Coalition recommends developing a cost-effective option to have DoD subsidize premiums for member's private insurance as an alternative to TRICARE Reserve Select coverage.

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

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

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

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

TRICARE Prime Remote exceptions – The Coalition recommends removal of the requirement for the family members to reside with the active duty member to qualify for the TRICARE Prime Remote Program.

BRAC, Re-Basing, and Relocation – The Coalition recommends codifying the requirement to provide TRICARE Prime in BRAC-affected areas and ensuring, via a report from DoD, that adequate health resources are available to provide care within access standards for those affected by re-basing plans.

Mental Health – The Coalition strongly recommends requiring DoD and the VA to work in concert to ensure a unified strategy to address PTSD and other mental health problems, providing consistent guidance, coordination of efforts, and cross-feed of results of segmented studies, task forces and programs that are currently underway among military services and the two departments.

Pharmacy Co-payment Changes – The Coalition recommends no increases to the co-payment rates until all medications are available in the mail order program. The Coalition further recommends that the percentage of any future pharmacy co-payment increase should be limited to the percentage increase in retired pay since the last co-payment increase, rounded down to the next lower dollar.

Mail-Order Pharmacy – The Coalition recommends eliminating beneficiary co-payments in the mail-order pharmacy system for generic and preferred brand name medications to incentivize use of this lowest-cost venue and generate substantial cost savings.

Rapid Expansion of “Third Tier” Formulary – The Coalition urges the Subcommittee to monitor DoD’s consideration of Beneficiary Advisory Panel input in future Uniform Formulary decisions and reassert its intent that the Panel should have a substantive role in the process, including access to meaningful data on relative drug costs in each affected class.

Referral and Authorization System – The Coalition recommends that Congress require a cost analysis report concerning the referral process within DoD and reliance on Civilian Network Providers within an MTF’s Prime Service Area.

DoD/VA Health Care – The Military Coalition recommends that Congress mandate a single Joint Transition Office, permanently staffed with personnel from both VA and DoD and having primary responsibility for top-down planning and execution of all “seamless transition” initiatives, including a joint in-patient electronic health record; joint DoD/VA physical; traumatic brain injury, PTSD, and special needs care; coordinated access to care (including long-term support services), and joint research.

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

OVERVIEW

Mr. Chairman, The Military Coalition (TMC) thanks you and the entire Subcommittee for your continued, steadfast support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors. The Subcommittee's work in the 109th Congress generated improvements in military end strength, Reserve health care, survivor benefits, and disabled retiree programs. These improvements continue to make a positive difference in the lives of active, Guard and Reserve personnel, retirees, and families.

As our men and women in uniform continue to prosecute the Global War on Terror, the Coalition believes it is critical that the Nation support our troops with the appropriate resources. The services are reporting that they are wearing out equipment at a record pace – the Coalition is concerned that we are wearing out more than just equipment. The current rate of deployments and the accompanied stress to our troops and their families are also wearing out our most precious weapon system – our men and women in uniform.

The men and women in uniform are answering the call – but not without ever-greater sacrifice. They, with the support of their families, continue to endure mounting stress brought about by repeated deployments and ever-increasing workloads. Therefore, now is not the time to scrimp on the needs for our troops and their families.

Over the past several years, the Pentagon has been constrained in its budget even as it sought to address rising military personnel costs, aging weapons systems, and equipment and facilities shortfalls. To accommodate this no-win situation, Defense leaders have chosen to seek dramatic force reductions in the Air Force and the Navy, drive military retirees away from using their earned health coverage via proposed large fee increases, delay key acquisition plans, and cut back on installation quality of life programs.

The Coalition believes these efforts to “rob Peter to pay Paul” rather than funding the amounts required to meet real readiness program needs will only make the uniformed services more vulnerable in current and future military engagements.

What is encouraging is the Administration's recent endorsement of overdue increases to Army and Marine Corps end strength; however, this is a belated acknowledgement that our troops are being stretched to the breaking point. The Coalition believes that the end strength increase must be programmed and funded through permanent increases in the defense budget, without being forced to rely on temporary supplemental appropriations or continued, short-sighted budget-shifting that cannibalizes funds from selected branches or programs to pay others.

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

ACTIVE FORCE ISSUES

The Subcommittee's key challenges will be to fend off those that wish to cut needed personnel and quality of life programs while working with DoD and the Administration to reduce the stress on the force and their families already subjected to repeated, long-term deployments. Rising day-to-day workloads for those few remaining behind and extending units and members in

unaccompanied locations overseas creates a breeding ground for retention problems. Meeting these challenges will require a commitment of personnel and resources on several fronts.

End Strength and Associated Funding – The Coalition was encouraged when the Subcommittee refused to allow Army and Marine Corps authorized end strengths to decline in FY2007, and we are further encouraged that the DoD has asked for additional manpower increases for the Army and Marine Corps over the next five years.

However, Congress needs to ensure that these increases are sufficient to significantly ease the rotation burdens faced by ground forces for the foreseeable future and the services are fully funded in order to achieve the new end strength. Increasing end strength is not a quick fix that will ease the stressors on service members who are currently serving and their families. A full range of funding is necessary to achieve this end strength, not just the actual personnel and recruitment costs. Funding for housing, health care, family programs, and child care must be included. Asking the services to take these costs out of pocket is a non-starter.

Furthermore, as the Army and Marine Corps increase over the next five years, the Coalition remains concerned about the scope of Navy and Air Force active and Reserve personnel cuts over several years which we believe are driven by budget considerations rather than operational requirements.

The Coalition strongly urges the Subcommittee to provide additional recruiting and retention resources to enable uniformed services to achieve required optimum-quality personnel strength skills/occupational mix and the health of the entire force.

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

Since the turn of the century, Congress and DoD have made significant progress to improve the lives of men and women in uniform and their families. Since 1999, when military pay raises had lagged a cumulative 13.5% behind the private sector pay comparability standard, the Subcommittee has worked hard to narrow the pay comparability gap to 4%. Each year during that span, the Subcommittee has ensured at least some progress in shrinking that disparity further. TMC is grateful for that progress, and believes strongly that it should continue until full pay comparability is restored.

DoD has used the 70th percentile of earnings of private workers of comparable age, experience and education as a standard to help rebalance the military pay table through special targeted pay increases depending on grade and longevity status. The Coalition believes this measure is useful as one tool in the process of establishing the proper progression of the pay table, and needs to be monitored and applied as necessary in the future. But it does not, by itself, supplant overall growth in the Employment Cost Index as the measure of pay comparability, nor does it erase the remaining 4% gap between military pay raises and private sector pay growth.

In that regard, the Coalition was disappointed that Congress couldn't see its way clear last year to provide more than a 2.2% raise – the smallest in 13 years – for the troops who are putting their

lives on the line every day for the rest of America. Congress will never find a better opportunity to make progress on reducing the pay gap than when private sector pay growth is relatively low.

In assessing the proper amount to reduce the pay gap, Congress also should consider the perspective that today's troops are having to work much harder – and their families have to sacrifice more – for that earned compensation.

This year, the Defense budget proposes a 3% raise for military personnel – a percentage equal to the growth in private sector pay. The Coalition believes strongly that this is not the time to end Congress' steady path of progress in reducing the military pay comparability gap.

The Coalition urges the Subcommittee to propose a military pay raise of at least 3.5% for FY2008 (one-half percentage point above private sector pay growth) and to continue such increases until the current 4% pay comparability gap is closed. The Coalition also urges the Subcommittee to continue periodic targeted pay raises as appropriate to recognize the growing education and technical qualifications of enlisted members and warrant officers.

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

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

The Coalition supports revised housing standards that are more realistic and appropriate for each pay grade. Many enlisted personnel are unaware of the standards for their respective pay grade and assume that their BAH level is determined by a higher standard or by the type of housing for which they would qualify if they live on a military installation. For example, only 1% of the enlisted force (E-9) is eligible for BAH sufficient to pay for a 3-bedroom single-family detached house, even though thousands of more junior enlisted members do, in fact, reside in detached homes. The Coalition believes that as a minimum, this BAH standard (single family detached house) should be extended gradually to qualifying service members beginning in grade E-8 and subsequently to grade E-7 and below over several years as resources allow.

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

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

Last year, Congress authorized a Joint Family Support Assistance Program to augment family center services. TMC applauds that, believing a joint program helps comprehensive integration of Web and family support systems and expanded outreach capability, particularly for Guard and Reserve families who often have limited access to installation resources.

TMC particularly appreciates the Subcommittee's support for \$50 million in Impact Aid last year, and we ask for your continued support in ensuring quality education for all military children.

Yet, resource issues continue to plague basic installation support programs. At a time when families are dealing with increased deployments, they are being asked to do without. Often family centers are not staffed for outreach. Library and sports facilities hours are being abbreviated or cut altogether. Manpower for installation security is being reduced. This is one more sacrifice that we are imposing on our families left behind while their service member is deployed.

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

In particular service members must be educated on the long-term financial consequences of electing to accept the \$30,000 REDUX retention bonus after 15 years of service vice continuing under the High-3 retirement program.

The Coalition urges the Subcommittee to expand family support and financial education programs to meet growing needs associated with extended deployments and the more complex insurance, retirement, and savings choices faced by overworked military families in today's complicated world.

Predatory Lending – The Coalition applauds the Subcommittee's work to prevent unscrupulous predatory lenders from preying on military personnel by establishing a 36% rate cap on loans to military members and their families.

But we are concerned that some in the financial industry – with the assistance of some Members of Congress – are working to roll back that limit and other restrictions even before they go into effect. We do not believe that any statutory adjustments will serve military members' and families' interests at this time.

The Coalition urges the Subcommittee most strongly to oppose any changes to the statutory provisions enacted in the FY2007 Defense Authorization Act.

Flexible Spending Accounts – The Coalition cannot comprehend the Defense Department's continuing failure to implement existing statutory authority for active duty and Selected Reserve members to participate in Flexible Spending Accounts (FSAs), despite both Armed Services Committees' prodding on this subject.

All other federal employees and corporate civilian employees are able to use this authority to save thousands of dollars a year by paying out-of-pocket health care and dependent care expenses with pre-tax dollars. It is unconscionable that the Department has failed to implement

this money-saving program for the military members who are bearing the entire burden of national sacrifice in the Global War on Terrorism.

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

Permanent Change of Station (PCS) Allowances – The Coalition is very appreciative of the significant change in last year’s Authorization Act that required full replacement value for damaged household goods on PCS moves and we look forward to its implementation – at last.

This was a significant step forward; however, service members and their families continue to incur significant out-of-pocket costs in complying with government-directed moves.

For example, PCS mileage rates still have not been adjusted since 1985. The current rates range from 15 to 20 cents per mile – less than half the 2007 temporary duty mileage rate of 48.5 cents per mile for military members and federal civilians. Also, military members must make any advance house-hunting trips at personal expense, without any government reimbursement such as federal civilians receive.

Additionally, the overwhelming majority of service families own two privately owned vehicles, driven by the financial need for the spouse to work and families living some distance from an installation and its support services. Authority is urgently needed to ship a second POV at government expense to overseas accompanied assignments. In many overseas locations, families have difficulty managing without a second family vehicle because family housing is often not co-located with installation support services. They shouldn’t be forced by government orders into inevitable financial losses entailed in selling their second car before leaving and buying another upon arrival.

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

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

The Military Coalition supports upgrading permanent change-of-station allowances to reflect the expenses members are forced to incur in complying with government-directed relocations, with priority on adjusting the twenty two year old PCS mileage rates. Additionally, the Coalition urges authorizing a shipment of a second Privately Owned Vehicle at government expense to overseas’ accompanied assignments.

BRAC/Rebasing/Military Construction/Commissaries – TMC remains concerned about lack of detail in communicating an implementation plan for DoD transformation, global repositioning, Army modularity, and BRAC initiatives. Given the current wartime fiscal environment, TMC is greatly worried about sustaining support services and quality of life programs for members and families. These programs are clearly at risk – not a week goes by

that the Coalition doesn't hear reports of cutbacks in base operation accounts and base services because of funding shortfalls.

These concerns have been deepened by the House-passed FY2007 Continuing Resolution, which reduced BRAC funding by \$3 billion below the Administration's budget request. Additionally, we are worried by feedback from some locations where military populations are expected to grow substantially that initiatives to accommodate the increased demand for housing, child care, infrastructure and other needs are behind schedule – or not yet underway.

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

The Coalition urges the Subcommittee to ensure family support/quality of life programs and services are not reduced, but are expanded to fully accommodate rebasing/BRAC needs at closing and gaining installations -- to include housing, education, child care, exchanges and commissaries, health care, family centers, unit family readiness, and other support services.

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

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

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

NATIONAL GUARD AND RESERVE FORCE ISSUES

Reserve Retirement and 'Operational Reserve' Policy – The assumption behind the 1948-vintage G-R retirement system – retired pay eligibility at age 60 – was that these service members would be called up only infrequently for short tours of duty, allowing the member to pursue a full-time civilian career with a full civilian retirement. Under the Nation's adoption of an "Operational Reserve" policy, however, Reservists will be required to serve one-year active duty tours every 5 or 6 years. Since Sept. 11, 2001, more than 85,000 Reservists already have served second or third active duty tours.

Repeated, extended activations devalue full civilian careers and impede Reservists' ability to build a full civilian retirement, 401(k), etc. Regardless of statutory reemployment protections, periodic long-term absences from the civilian workplace can only limit Guard and Reserve members' upward mobility, employability and financial security. Further, strengthening the

Reserve retirement system is needed as an incentive to retaining critical mid-career officers and NCOs for a full Reserve career, essential to overall readiness.

TMC urges Congress to lower the Reserve retirement age, starting with an adjustment for active duty service, in recognition of the increase in service and sacrifice of Guard and Reserve service members and as an inducement to longer service.

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

For the first 15 years of the MGIB, Guard and Reserve MGIB benefits (Chapter 1606, Title 10 USC) maintained almost 50% parity with active duty MGIB benefits. Slippage from that level occurred after the September 11, 2001 attacks. Today the G-R MGIB pays about 29% of the active duty program.

A new Guard and Reserve mobilization MGIB benefit was established in 2004 that authorized MGIB benefits for activated members (Chapter 1607, Title 10 USC). But these benefits can only be used during continued service even though “Operational Reserve” policy requires frequent activations that preclude student-Reservists from using them.

The lack of a readjustment feature to the mobilization MGIB is the ONLY veteran’s benefit denied Guard and Reserve veterans of the war on terror.

A member who serves as little as two years on active duty and who may never deploy can have 10 years after leaving service to use his or her MGIB benefit. But a Guard and Reserve member who may serve two or three tours in Iraq is allowed no MGIB benefits after leaving service, having honorably completed his or her military service obligation. The Coalition believes this is a grievous inequity which must be fixed.

The Coalition strongly supports enactment of H.R. 1102 to consolidate active duty and reserve MGIB programs in Title 38 and align benefit rates according to the length and type of service performed – a Total Force MGIB.

Guard and Reserve End Strength and Readiness – Defense and Service leaders have reported that the Guard and Reserve will continue to be integrated into ongoing war on terror operations for the indefinite future. Yet, the FY 2007 National Defense Authorization Act authorizes cuts in the Navy Reserve, Air Reserve Components, and the Army Reserve. The cuts appear to be based only on budget requirements, not missions.

Coupled with a growing backlog of equipment for training, the Guard and Reserve find themselves increasingly unable to meet the new high-optempo “train-mobilize-deploy” cycle. (Previously plans called for lengthy post-call-up training, but that is precluded under DoD’s new 12-month maximum tour policy).

The Coalition urges Congress to maintain and increase Guard and Reserve force end-strengths consistent with the demands being imposed upon them, in addition to providing proper funding for their equipment and training.

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

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

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

Reserve Compensation System – Increasing demands on the Guard and Reserve to perform national security missions at home and abroad and increased training requirements indicate that the compensation system needs to be improved to attract and retain individuals into the Guard and Reserve. The added responsibility and the reality of returning to active duty multiple times over the course of a Reserve career require improvements to the compensation package and to make it more equitable with the active component. Programs requiring modifications include:

- Career enlisted/officer aviation incentive pay
- Diving special duty pay
- Hazardous duty pay
- Special duty assignment pay
- Pro-pay for Reserve component medical professionals
- Allow full-retirement credits for all inactive duty training points earned annually
- Veteran status to Guard and Reserve members who successfully complete 20 qualifying years of service, but who do not otherwise qualify as veterans under Title 38
- Elimination of BAH II, and authorization of full BAH for any active duty service
- Improved Space-A Travel provision for Guard and Reserve members and their spouses

The Coalition urges the Subcommittee to address the inequities of the “1/30th” rule for special and incentive pays, the cap on annual training points creditable for retirement, housing

allowance restrictions and other compensation elements that disadvantage Guard and Reserve members.

Tangible Support for Employers – Employers of Guard and Reserve service members shoulder an extra burden in support of the national defense. The new “Operational Reserve” policy – requiring extended activation of Reserve formations every five or six years – places even greater strain on employers. For their sacrifice, they get plaques to hang on the wall.

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

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

The Coalition urges the Subcommittee to use all possible influence with the Ways and Means Committee to support needed tax relief for employers of Selected Reserve personnel.

RETIREMENT ISSUES

The Military Coalition is grateful to the Subcommittee for its historical support of maintaining a strong military retirement system to help offset the extraordinary demands and sacrifices inherent in a career of uniformed service. However, the Coalition believes significant inequities still remain that require the Subcommittee’s immediate attention.

Concurrent Receipt – Disabled retirees are extremely grateful for this Subcommittee’s action to ease the unfair retired pay loss that has disadvantaged disabled retirees for over a century. The concurrent receipt provisions enacted by Congress to date provided substantive relief for tens of thousands of disabled retirees; yet, an equal number are still excluded from the same principle that eliminates the disability offset for those with 50 percent or higher disabilities. The principle is the same for all disabled retirees, including those not covered by concurrent receipt relief enacted so far – they earned their retired pay through years of service and sacrifice, and should not be forced to forfeit their earned retired pay simply because they also suffered a service-connected disability.

The most severe inequity not yet addressed at all affects members who had their careers cut short by a combat-incurred or other service-caused disability and were forced into medical retirement before attaining 20 years of service. These retirees must fully fund their own VA disability compensation by giving up most or all of their military retired pay. It is impossible to explain to such a member why the government appears to award no compensation value for his or her service (perhaps as much as 19 years, 11 months).

Simply put, the imposition of a 20-year service requirement assumes a voluntary service continuation choice that simply does not exist in these cases.

The Coalition believes strongly that, when a member is forced to leave service short of 20 years because that very service caused him or her to become disabled, then the government has an obligation to “vest” that member’s retirement credit for whatever service is rendered. For Chapter 61 (disability) retirees forced out short of 20 years, that vesting formula should be the same formula now set in concurrent receipt law for Chapter 61 retirees with more than 20 years’ service – 2.5% times years of service times the applicable pay base.

In this regard, the Coalition strongly supports legislation introduced this year by Rep. Gus Bilirakis (R-FL) (HR 89 and HR 303), Rep. Jim Marshall, (D-GA) (HR 333), and Sen. Harry Reid (D-NV) (S 439).

The Coalition recognizes that the Veterans Disability Benefits Commission has an ongoing review in this area. But we believe these two inequities are so obvious as to require immediate redress.

The Coalition urges the Subcommittee to authorize full concurrent receipt of earned military retired pay and VA disability compensation at the earliest possible time, with particular priority for immediate “vesting” of earned military retired pay for Chapter 61 retirees forced into medical retirement before attaining 20 years of service and full, immediate concurrent receipt for retirees deemed “unemployable” by the VA.

Uniformed Services Retiree Entitlements and Benefits – The Coalition is concerned, but not surprised, by the recommendations of the Defense Advisory Committee on Military Compensation (DACMC) to modify the military retirement system to more closely reflect civilian practices, including vesting for members who leave service short of a career and delaying retired pay eligibility until age 60 for those who serve a career.

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

The Coalition believes such initiatives to “civilianize” the military retirement system in ways that reduce the value of the current retirement system and undermine long-term retention are based on a seriously flawed premise. The reality is that unique military service conditions demand a unique retirement system. Surveys consistently show that the military retirement system is the single most powerful incentive to serve a full career under conditions few civilians would be willing to endure for even one year, much less 20 or 30. Such a system could only work if military service conditions were similar to civilian working conditions – which they most decidedly are not. The Coalition believes strongly that, if such a system as recommended by the DACMC had been in being for today’s force under today’s service conditions, the military services would already be mired in a deep and traumatic retention crisis.

We are aware that the DACMC recommendations will be reviewed by the 10th Quadrennial Review of Military Compensation.

The Coalition urges the Subcommittee to oppose initiatives to “civilianize” the military retirement system in ways that reduce the value of the current retirement system and undermine long-term retention.

Former Spouse Issues – The Military Coalition recommends corrective legislation be enacted to address long-standing inequities in the Uniformed Services Former Spouse Protection Act (USFSPA).

The Coalition supports the recommendations in the Defense Department's September 2001 report, which responded to a request from this committee for an assessment of USFSPA inequities and recommendations for improvement. We believe that, at a minimum, the Subcommittee should move forward on the reports' recommendations.

The Coalition urges the Subcommittee to move forward on initiatives to ease at least the most significant inequities under the USFSPA.

SURVIVOR ISSUES

The Coalition is grateful to the Subcommittee for recent improvements to the Survivor Benefit Plan (SBP), especially the phase-out of the age-62 annuity reduction and expansion of SBP coverage options for active duty deaths since 7 Oct 01.

But two serious SBP inequities still remain. The Coalition hopes that this year the Subcommittee will be able to support ending the SBP-DIC offset and accelerating by at least one year the effective date for paid-up SBP to October 1, 2007.

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

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

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

In the case of members killed on active duty on or after October 7, 2001, a surviving spouse who has children can temporarily avoid the dollar-for-dollar offset only by assigning SBP to the children. But that forces the spouse to give up any SBP claim after the children attain their majority – leaving the spouse with just a \$1,067 monthly annuity from the VA. And that provision offers no relief at all to survivors of members who died before 10/7/01 or who have no children.

Unfortunately, some have a misconception that Congress “solved the SBP problem” by authorizing the recent lump sum increases in SGLI and the death gratuity. Nothing could be

further from the truth. In fact, 94% of the more than 61,000 survivors affected by the SBP/DIC got no benefit from those recent changes. That's because only 4,000 SBP/DIC –eligibles had sponsors who died on active duty since 10/7/01.

The vast majority of the affected survivors received far smaller payments – as little as \$50,000 in SGLI or \$3,000 as a death gratuity.

The Military Coalition urges the Subcommittee most strongly to take immediate action to provide relief for this most-aggrieved group of military widows, and pledges to work with the Subcommittee as needed to avoid another year with no progress at all toward this important goal.

30-Year Paid-Up SBP – Congress approved a provision in the FY 1999 Defense Authorization Act authorizing retired members who had attained age-70 and paid SBP premiums for at least 30 years to enter "paid-up SBP" status, whereby they would stop paying any further premiums while retaining full SBP coverage for their survivors in the event of their death. Because of cost considerations, the effective date of the provision was delayed until October 1, 2008.

As a practical matter, this means that any SBP enrollee who retired on or after October 1, 1978 will enjoy the full benefit of the 30-year paid-up SBP provision. However, members who enrolled in SBP when it first became available in 1972 (and who have already been charged higher premiums than subsequent retirees) will have to continue paying premiums for up to 36 years to secure paid-up coverage.

The Military Coalition is very concerned about the delayed effective date, because the paid-up SBP proposal was initially conceived as a way to grant relief to those who have paid SBP premiums from the beginning. Many of these members entered the program when it was far less advantageous and when premiums represented a significantly higher percentage of retired pay. In partial recognition of this problem, SBP premiums were reduced substantially in 1990, but these older members still paid the higher premiums for up to 18 years. The Coalition believes strongly that their many years of higher payments warrant at least equal treatment under the paid-up SBP option.

The Coalition believes there is a way to provide substantive relief without incurring the mandatory spending problems that have stymied this initiative for so long, and pledges to work with the Subcommittee in hopes of finding a way forward.

The Coalition urges the Subcommittee to seize the opportunity to provide at least one year of relief for the "Greatest Generation" retirees who already have paid nearly 30% more SBP premiums than their successors ever will.

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

Current regulations require the survivor to surrender the final month of retired pay, either by returning the outstanding paycheck or having a direct withdrawal recoupment from his or her bank account. A pro-rata share of the final month's pay is later restored to the survivor, proportional to the number of days in the final month before the member died.

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

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

HEALTH CARE ISSUES

The Coalition very much appreciates the Subcommittee's strong and continuing interest in keeping health care commitments to military beneficiaries. We are particularly grateful for your support last year in refusing to allow the Department of Defense to implement disproportional beneficiary health fee increases and insisting on the establishment of a task force on the future of military medicine. The task force was directed to provide an objective review of the components of and reasons for military health cost growth, an evaluation of the Department's options and efforts to contain that growth within the existing fee structure, the appropriate level of cost-sharing between the government and beneficiaries, and the appropriate methods for any adjustments to that cost-sharing system.

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

It is a great source of regret to the Coalition that there has been substantively less dialogue on the more recent fee increase initiatives. Beneficiary associations were kept in the dark last year until the proposed changes were delivered to Congress. Since that time, the Department has marginalized their discussions with the Military Coalition on these proposed initiatives.

From its actions, it is hard to draw any other conclusion than the Department's sole concern is to extract a specified amount of budget savings from beneficiaries. In part, the savings are intended to come from increased revenues from higher fees. But the vast majority of the savings are based on the assumption that the fee increases will deter hundreds of thousands of beneficiaries from using their earned military health benefits and Medical Treatment facility efficiencies.

To the extent the proposed changes don't achieve the projected savings – which both the Coalition and the Congressional Budget Office believe they will not – the inescapable inference of this budget-setting philosophy is that the Department would then seek further increases to whatever extent necessary to achieve the desired budget savings. As of October 1, 2007, DoD is

free to enact proposed cost saving initiatives not bound by legislative change. Current projected savings are based on DoD's the same as last year's proposals and the Task Forces' recommendations. The Coalition believes this is neither a realistic nor an appropriate basis for setting military benefit levels, and that taking that approach would undermine the whole purpose of providing military health benefits.

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

Full Funding for the Defense Health Program

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

The Defense Department, Congress and The Military Coalition all have reason to be concerned about the rising cost of military health care. But it is important to recognize that the bulk of the problem is a national one, not a military-specific one. To a large extent, military health cost growth is a direct reflection of health care trends in the private sector.

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

Some assert active duty personnel costs have increased 60% since 2001, of which a significant element is for compensation and health costs. But much of that cost increase is due to conscious decisions by Congress to correct previous shortfalls – including easing the double-digit military “pay gap” of that era and correcting the unconscionable situation before 2001 when military beneficiaries were summarily dropped from TRICARE coverage at age 65.

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

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

It is for this reason that the Coalition objects strongly to the Administration's arbitrary reduction of the TRICARE budget submission by \$1.9 billion, on the assumption that Congress will

approve beneficiary fee increases for FY2008 at least as large as those outlined in the second year of the TRICARE fee plan the Department recommended last year.

This is nearly triple the \$735 million reduction tied to fee increases in last year's budget submission. The Coalition deplors this inappropriate budget "brinkmanship", which risks leaving TRICARE significantly under funded, especially in view of statements made last year by leaders of both Armed Services Committees that the Department's proposed fee increases were excessive.

The Coalition understands only too well the very significant challenge such a large and arbitrary budget reduction would pose for this Subcommittee if allowed to stand. If the \$1.8 billion is not made up, the Department almost certainly will experience a substantial budget shortfall before the end of the year. This would then generate supplemental funding needs, further program cutbacks, and likely efforts to shift even more costs to beneficiaries in future years – all to the detriment of retention and readiness.

The Military Coalition strongly urges the Subcommittee to take all possible steps to restore the \$1.8 billion in TRICARE-related budget authority and ensure continued full funding for Defense Health Program needs.

Protecting Beneficiaries Against Cost-Shifting

The Coalition is very grateful for the Subcommittee's insistence on a more comprehensive examination of military health care issues than embodied in last year's defense budget submission. We particularly appreciate your action to require appointment of a Task Force on the Future of Military Health Care.

While we were disappointed that the Secretary of Defense chose not to appoint an active representative of the Coalition to the Task Force, we have had discussions with members of that body and look forward to an opportunity to present the Coalition's views in person before the Task Force later in March.

But we are very concerned that the Defense Department's decision to cut the TRICARE budget by \$1.9 billion on the assumption that the Task Force would recommend fee increases at least as large as those previously posed by the Department. This has had the effect of placing great pressure on the Task Force to do just that – whether they are disposed to do so or not.

People vs. Weapons – Defense officials have provided briefs to Congress indicating that the rising military health care costs are "impinging on other service programs." Other reports indicate that DoD leadership is seeking more funding for weapons programs by reducing the amount it spends on military health care and other personnel needs.

The Military Coalition continues to assert that such budget-driven trade-offs are misguided and inappropriate. Cutting people programs to fund weapons ignores the much larger funding problem, and only makes it worse.

The Coalition believes strongly that the proposed defense budget is too small to meet national defense needs. Today's defense budget (in wartime) is less than 4% of GDP, well short of the average for the peacetime years since WWII.

The Coalition believes strongly that America can afford to and must pay for both weapons and military health care.

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

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

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

Large Retiree Fee Increases Can Only Hurt Retention – The reciprocal obligation of the government to maintain an extraordinary benefit package to offset the extraordinary sacrifices of career military members is a practical as well as moral obligation. Mid-career military losses can’t be replaced like civilians can.

Eroding benefits for career service can only undermine long-term retention/readiness. Today’s troops are very conscious of Congress’ actions toward those who preceded them in service. One reason Congress enacted TRICARE For Life is that the Joint Chiefs of Staff at that time said that inadequate retiree health care was affecting attitudes among active duty troops.

The current Joint Chiefs have endorsed increasing TRICARE fees only because their political leaders have convinced them that this is the only way they can secure funding for weapons and other needs. The Military Coalition believes it is inappropriate to put the Joint Chiefs in the untenable position of being denied sufficient funding for current readiness needs if they don’t agree to beneficiary benefit cuts.

Those who think retiree health care isn’t a retention issue should recall a quote by the Chief of Naval Operations in the Navy Times last year:

“More and more sailors are coming in married. They talk to me more about medical benefits than I ever thought to when I was in my mid-20s. I believe we’ve got the gold standard...for medical care right now, and that’s a recruiting issue, a recruiting strength, and it’s a retention strength.”

That’s more than backed up by two independent Coalition surveys. A Military Officers Association of America survey drew 40,000 responses last year, including more than 6,500 from active duty members. Over 92% in all categories of respondents opposed the DoD-proposed plan. There was virtually no difference between the responses of active duty members (96%

opposed) and retirees under 65 (97% opposed). A Fleet Reserve Association survey showed similar results.

Reducing military retirement benefits would be penny-wise and pound-foolish when recruiting is already a problem and an overstressed force is at increasing retention risk.

Proposed Increases Far Exceed Inflation Increases – The Administration’s proposed increases are grossly out of line with TRICARE benefit levels originally enacted by Congress, even allowing for interim inflation since current fees were established. Based upon the proposed budget savings we assume the level of fee increases is based on DoD’s proposal from last year.

If the \$460 family Prime enrollment fee had been increased by the same Consumer Price Index (CPI) percentage increase as retired pay, it would be \$612 for FY2008 – far less than \$1,400 envisioned in the FY2008 budget.

If the \$300 deductible for TRICARE Standard were CPI-adjusted for the same period, it would be \$399 by 2008 – one-third the nearly \$1,200 in annual deductible and new fees proposed by DoD in 2006.

Further, the Administration has proposed to make annual fee adjustments after FY2008, based on FEHBP medical inflation, which has been two to three times the inflation-based increase in members’ retired pay. This would ensure that members’ medical costs would consume an ever-larger share of their income with each passing year. The Coalition realizes that this has been happening to many private sector employees, but believes strongly that the government has a greater obligation to protect the interests of its military beneficiaries than private corporations feel for their employees.

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

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

That’s because decades of past budget caps already depressed lifetime retired pay by an average of 10% for military members who retired between 1984 and 2006. For most of the 1980s and 1990s, military pay raises were capped below private sector pay growth, accumulating a 13.5% “pay gap” by 1998-99 – a gap which has been moderated since then but persists at 4% today.

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

As a practical example, a member who retired in 1993 – when the pay gap was 11.5% – continues to suffer an 11.5% retired pay loss today. For an E-7 who retired in 1993 with 20 years of service, that means a loss of \$2,000 this year and every year because the government

chose to cap his military pay below the average American's. An O-5 with 20 years of service loses more than \$4,200 a year.

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

TRICARE for Life (TFL) Trust Fund Accrual Deposit Is Dubious Excuse – Previous analysis by the Congressional Budget Office indicated that most of the growth in defense health spending (56%) was attributable to overall growth in national health care spending. The next largest contributor is beneficiary population growth (23%). Establishment of the accrual accounting methodology for the TFL trust fund (which doesn't affect current outlays) accounts for 18% of the DoD cost growth.

When the Defense Department began arguing three years ago that the trust fund deposit was impinging on other defense programs, the Coalition and the subcommittee agreed that that should not be allowed to happen. When the Administration refused to increase the budget top line to accommodate the statutorily mandated trust fund deposit, Congress changed the law to specify that the entire responsibility for TFL trust fund deposits should be transferred to the Treasury. Subsequently, Administration budget officials chose to find a way to continue charging that deposit against the defense budget anyway.

In the Coalition's view, this represents a conscious and inappropriate Administration decision to cap defense spending below the level needed to meet national security needs. If the Administration chooses to claim to Congress that its defense budget can't meet those other needs, then Congress (which directed implementation of TFL and the trust fund deposit) has an obligation to increase the budget as necessary to meet them.

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

- Promote retaining other health insurance by making TRICARE a true second-payer to other insurance (far cheaper to pay another insurance's copay than have the beneficiary migrate to TRICARE).
- Reduce or eliminate all mail-order co-payments to boost use of this lowest-cost venue.
- Do more to educate beneficiaries and providers about the advantages of mail-order pharmacy.
- Change electronic claim system to kick back errors in real time to help providers submit “clean” claims, reduce delays/multiple submissions.
- Negotiate with drug manufacturers for retail pharmacy discounts (the most costly venue), which DoD has failed to do, or change the law to mandate federal pricing for retail pharmacy network (rather than charging beneficiaries more if drug companies don't agree to federal pricing).
- Eliminate DoD-unique administrative requirements that drive higher overhead fees.

- Size and staff military treatment facilities (least costly care option) to reduce reliance on non-MTF civilian providers.
- Promote programs to offer special care management services to beneficiaries with chronic or unusually expensive conditions.
- Change the law to mandate federal pricing for the retail pharmacy network (rather than charging beneficiaries more if drug companies don't provide federal pricing).
- Establish one central DoD facility to order/fill all prescriptions for exceptionally high-cost drugs (AF model has been successful).
- Reduce long-term TRICARE Reserve Select costs by allowing members the option of a government subsidy (at a cost capped below TRS cost) of civilian employer premiums during periods of mobilization.
- Centralize the military treatment facility pharmacy budget/funding process, with emphasis on accountability and cost-shifting.

The Coalition attempted to partner with the Defense Department to investigate and jointly pursue these or other options that offer potential for reducing costs. Department leaders initially indicated an interest in at least some limited joint effort (particularly on educating beneficiaries on mail-order advantages, establishing a central DoD facility to handle high-cost drugs, and optimizing use of military facilities). Subsequently, to the Coalition's great frustration, they refused the offer to partner.

The Coalition appreciates that the Subcommittee has sought to pursue some of these initiatives, such as mandating that DoD develop and implement integrated disease and chronic care management programs.

Ironically, after the Defense Department initially endorsed mandating federal pricing for the retail pharmacy system, the Administration successfully lobbied congressional leaders to drop that initiative from the FY2007 Defense Authorization Act. In the Coalition's view, the Administration has significantly less standing to cite retirees as the cause of health cost growth when it actively opposes initiatives that would save hundreds of millions of dollars a year.

The Coalition also notes that the Defense Department has not complied with the FY2007 Defense Authorization Act conferees' expectation "that the Department of Defense will proceed, under current authority, to eliminate co-payments for generic drugs dispensed through the TRICARE national mail-order program, as a minimum."

TRICARE Still Has Significant Shortcomings – While DoD chooses to focus its attention on the cost of the TRICARE program to the government, the Coalition believes there is insufficient acknowledgement that thousands of providers and beneficiaries continue to experience significant problems with TRICARE. Beneficiaries at many locations, particularly those lacking large military populations, report difficulty in finding providers willing to participate in the program. Doctors complain about the program's low payments and administrative hassles. Withdrawal of providers from TRICARE networks at several locations has generated national publicity.

The Coalition urges the Subcommittee to require DoD to pursue greater efforts to improve TRICARE and find more effective and appropriate ways to make TRICARE more cost-efficient without seeking to "tax" beneficiaries and make unrealistic budget assumptions.

TMC Healthcare Cost Principles

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

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

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

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

- ***Active duty members and families should be charged no fees except retail pharmacy co-payments, except to the extent they make the choice to participate in TRICARE Standard or use out-of-network providers under TRICARE Prime.***
- ***For retired and survivor beneficiaries, the percentage increase in fees, deductibles, and co-payments that may be considered in any year should not exceed the percentage increase beneficiaries experience in their compensation.***
- ***The TRICARE Standard copay should not be increased further for the foreseeable future. At \$535 per day, it already far exceeds inpatient copays for virtually any private sector health plan.***
- ***There should be no enrollment fee for TRICARE Standard, since Standard does not offer assured access to TRICARE-participating providers. An enrollment fee implies enrollees will receive additional services, as Prime enrollees are guaranteed access to providers in return for their fee.***
- ***There should be one TRICARE fee schedule for all retired beneficiaries, just as all legislators, Defense leaders and other federal civilian grades have the same health fee schedule. The TRICARE schedule should be significantly lower than the lowest tier recommended by the Defense Department, recognizing that all retired members paid***

large up-front premiums for their coverage through decades of arduous service and sacrifice.

TRICARE Improvement Needs

TRICARE Standard Enrollment – The Department of Defense has proposed requiring beneficiaries to take an additional step of signing an explicit statement of enrollment in TRICARE Standard. That proposal is based on two main arguments – that enrollment is needed to define the population that will actually use the program and therefore to allow more accurate budgeting for program needs. The Coalition believes neither of these arguments stands up to scrutiny.

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

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

Hard experience is that many thousands of beneficiaries would learn of the requirement only after their TRICARE Standard claims are rejected for failure to enroll. Some would involve cancer, auto accidents and other situations in which it would be unacceptable to deny claims because the beneficiary didn't understand an administrative rule change.

Inevitably, most beneficiaries receive and understand the implications of an enrollment requirement will enroll simply “to be safe” – even if their actual intent is to use VA or employer-provided coverage for primary care.

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

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

To the extent any enrollment requirement may still be considered for TRICARE Standard, such enrollment should be automatic for any beneficiary who files a TRICARE claim. Establishing an enrollment requirement must not be allowed to become an excuse to deny claims for members who are unaware of the enrollment requirement. The Coalition looks forward to DoD's report on the subject due to Congress and the Healthcare Task Force in February 2007.

The Coalition recommends strongly against establishment of any TRICARE Standard enrollment system; to the extent enrollment may be required, any beneficiary filing a claim should be enrolled automatically, without denying the claim.

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

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

The Coalition recommends Congress modify the law restricting private employer TRICARE incentives to explicitly exempt employers who offer only cafeteria plans (i.e., cash payments to all employees to purchase care as they wish) and employers who extend cash payments (e.g., \$100 per month) to any employee who uses health coverage other than the employer plan (e.g., FEHBP, TRICARE, or commercial insurance available through a spouse or previous employer).

TRICARE Standard Improvements – The Coalition very much appreciates the Subcommittee’s continuing interest in the specific problems unique to TRICARE Standard beneficiaries. In particular, we applaud your efforts to expand TRICARE Standard provider surveys and establish Standard support responsibilities for TRICARE Regional Offices. These are needed initiatives that should help make it a more effective program. We remain concerned, however, that more remains to be done. TRICARE Standard beneficiaries need assistance in finding a provider that can provide healthcare services within a reasonable time and distance from their home. This will become increasingly important with the expansion of TRICARE Reserve Select, as these individuals are most likely not living within a Prime Service Area.

Provider Participation Adequacy – The provider surveys are a first step and should provide a wealth of additional information. The question is what use will be made of the information.

The Coalition is concerned that DoD has not established any standard for the adequacy of provider participation. Participation by half of the providers in a locality may suffice if there is not a large Standard beneficiary population. The Coalition would prefer to see an objective participation standard (perhaps number of beneficiaries per provider) that would help shed more light on which locations have participation shortfalls of Primary Care Managers and Specialists that require positive action.

We are also concerned about whether the Standard surveys actually measure what they purport to measure. In particular, we are perplexed that DoD survey results for some locations do not conform to (admittedly anecdotal) inputs that beneficiary associations have received from some of the same localities. Coalition discussions with those who processed the surveys yielded acknowledgements that health care providers may give different answers to the surveyors than they give to beneficiaries – if only because the beneficiaries may ask different questions of them than the survey-takers do. The Coalition believes it would be useful and appropriate to conduct independent surveys of TRICARE Standard beneficiaries, so that beneficiary inputs could be correlated with provider inputs for a given area.

The Coalition urges the Subcommittee to establish requirements for TRICARE Standard beneficiary surveys and a definition of what level of provider participation shall be deemed to require positive action to increase it.

Administrative Deterrents to Provider Participation – The Coalition is pleased that Congress has directed DoD to modify current claims procedures to be identical to those of Medicare. We look forward to implementation with the next generation of Managed Care Support Contracts. Feedback from providers indicates TRICARE imposes additional administrative requirements on providers that are not required by Medicare or other insurance plans. On the average, about 50 percent of a provider's panel is Medicare patients, whereas only 2 percent are TRICARE beneficiaries. Providers are unwilling to incur additional administrative expenses that affect only a small number of patients. Thus, providers are far more prone to non-participation in TRICARE than in Medicare.

One problem is that TRICARE requires that each provider be identified by each physical location where he or she performs services. If a clinic has 50 providers that have privileges at 10 different addresses in a clinic group, TRICARE requires 500 unique provider numbers. Medicare and most commercial insurers are moving to embrace a National Provider Indicator. TRICARE has been reluctant to change because of concerns for identifying fraud, but Medicare has been successful in fraud identification using one unique provider identification number.

Another problem is that, TRICARE still requires submission of a paper claim to determine medical necessity on a wide variety of claims for Standard beneficiaries. This thwarts efforts to encourage electronic claim submission and increases provider administrative expenses and delays receipt of payments. Examples include speech therapy, occupational/physical therapy, land or air ambulance service, use of an assistant surgeon, nutritional therapy, transplants, durable medical equipment, and pastoral counseling.

Another source of claims hassles and payment delays involve cases of third party liability (e.g., auto insurance health coverage for injuries incurred in auto accidents). Currently, TRICARE requires claims to be delayed pending receipt of a third-party-liability form from the beneficiary. This often delays payments for weeks and can result in denial of the claim (and non-payment to the provider) if the beneficiary doesn't get the form in on time. Recently, a major TRICARE claims processing contractor recommended that these claims should be processed regardless of diagnosis and that the third-party-liability questionnaire should be sent out after the claim is processed to eliminate protracted inconvenience to the provider of service.

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

TRICARE Reimbursement Rates – Physicians consistently report that TRICARE is virtually the lowest-paying insurance plan in America. Other national plans typically pay one-quarter to one-third higher rates. In some cases the difference is even higher.

While TRICARE rates are tied to Medicare rates, TRICARE Managed Care Support Contractors make concerted efforts to persuade providers to participate in TRICARE Prime networks at a further discounted rate. Since this is the only information providers receive about TRICARE, they see TRICARE as lower-paying than Medicare.

This is exacerbated by annual threats of further reductions in TRICARE rates due to the statutory Medicare rate-setting formula. Doctors are unhappy enough about reductions in Medicare rates, and many already are reducing the number of Medicare patients they see.

But the problem is far more severe with TRICARE, because TRICARE patients typically comprise a small minority of their beneficiary caseload. Physicians may not be able to afford turning away large numbers of Medicare patients, but they're more than willing to turn away a small number of patients who have low-paying, high-administrative-hassle TRICARE coverage.

Congress has acted to avoid Medicare physician reimbursement cuts for the last four years, but the failure to provide a payment increase for 2006 and 2007 is another step in the wrong direction according to physicians. Further, Congress still has a long way to go in order to fix the underlying reimbursement determination formula.

Correcting the statutory formula for Medicare and TRICARE physician payments to more closely link adjustments to changes in actual practice costs and resist payment reductions is a primary and essential step. We fully understand that is not within the purview of this Subcommittee, but we urge your assistance in pressing the Ways and Means and Finance Committees for action.

In the meantime, the rate freeze for 2006 and 2007 makes it even more urgent to consider some locality-based relief in TRICARE payment rates, given that doctors see TRICARE as even less attractive than Medicare. Additionally, the Medicare pay package that was enacted in Public Law 109-432 included a provision for Doctors to receive a 1.5 percent bonus next year if they report a basic set of quality-of-care measures. The TRICARE for Life beneficiaries should not be affected as their claims are submitted directly to Medicare and should be included in the physicians' quality data. For those under age 65 TRICARE Standard users this could present a major problem. If no such bonus payment is made for TRICARE Standard patients then TRICARE will definitely be the lowest payer in the country and access could be severely decreased.

The Department must ensure physicians have the same incentive to see Standard patients as Medicare.

The TRICARE Management Activity has the authority to increase the reimbursement rates when there is a provider shortage or extremely low reimbursement rate for a specialty in a certain area and providers are not willing to accept the low rates. In some cases a state Medicaid reimbursement for a similar service is higher than that of TRICARE. To date, this authority has been used only in Alaska. One concern, as mentioned previously, is that the Department has been reluctant to establish a standard for adequacy of participation.

There are specialties that do not fall cleanly within the Medicare reimbursement rates. Obstetrical and pediatric services have been a constant source of aggravation for military beneficiaries and the Managed Care Support Contractors. We applaud Congress' requirement for a Comptroller General report on obstetrical and pediatric reimbursement levels to ensure the adequacy of a quality network. We look forward to its findings and in the meantime encourage DoD to make full use of its authority to set higher rates for these specialties.

The Coalition urges the Subcommittee to exert what influence it can to persuade the Ways and Means/Finance Committees to reform Medicare/TRICARE statutory payment formula. To the extent the Medicare rate freeze continues, we urge the Subcommittee to encourage the Defense Department to use its reimbursement rate adjustment authority as needed to sustain provider acceptance.

The Coalition urges the Subcommittee to require a Comptroller General report on the relative propensity of physicians to participate in Medicare vs. TRICARE, and the likely effect on such relative participation of a further freeze in Medicare/TRICARE physician payments along with the affect of an absence of bonus payments.

Minimize Medicare/TRICARE Coverage Differences – DoD submitted a report to Congress last year indicating the coverage differences between Medicare and TRICARE. The report showed that there are at least a few services covered by Medicare that are not covered by TRICARE. These include an initial physical at age 65, chiropractic coverage, respite care, and certain hearing tests. We believe TRICARE coverage should at least equal Medicare's in every area. Our military retirees have made sacrifices far and above those who have not served and deserve no less coverage than is provided to other federal beneficiaries.

The Coalition urges the Subcommittee to align TRICARE coverage to at least match that offered by Medicare in every area.

National Guard and Reserve Healthcare

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

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

Setting the TRICARE Reserve Select (TRS) Premium – The Coalition believes the premium-setting process for this important benefit needs to be improved. Currently, the Defense Department adjusts TRS premiums based on annual adjustments to the basic FEHBP insurance option. This adjustment mechanism has no relationship either to the Department's military health care costs or to increases in eligible members' compensation.

The Coalition believes we have a higher obligation to restrain health cost increases for Selected Reserve members who are periodically being asked to leave their families and lay their lives on the line for their country. These members deserve better than having their health premiums raised arbitrarily by a formula that has no real relationship to them. The 8% TRS fee increase already imposed last year represents a percentage increase equivalent to several years' worth of basic pay increases.

As a matter of principle, the Coalition believes that TRS premiums should not be increased in any year by a percentage that exceeds the percentage increase in basic pay. In this regard, the Coalition believes there should be no further increase in the TRS fee at least until the cumulative basic pay increase, beginning with the FY06 across the board pay raise, has exceeded 8%.

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

The Coalition recommends that the percentage increase in TRS premiums should not exceed the percentage increase in military basic pay, and that there should be no increases for at least two years in light of the 8% increase imposed in 2006. The Coalition further recommends that the Subcommittee request a report from the Department of Defense on options to assure TRS enrollees' access to TRICARE-participating providers.

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

We appreciate Congress' action in requiring a GAO review of this issue and look forward to the report due in April 2007.

We hope that report will address not only the current wartime situation, but the longer-term peacetime scenario. Over the long term, when Guard and Reserve mobilizations can be expected at a considerably lower pace, the Coalition believes subsidy of employer coverage during mobilizations periods offers considerable savings opportunity.

In fact, the Department could calculate a maximum monthly subsidy level that would represent a cost savings to the government, so that each member who elected that option would reduce TRICARE costs.

The Coalition recommends developing a cost-effective option to have DoD subsidize premiums for member's private insurance as an alternative to TRICARE Reserve Select coverage.

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

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

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

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

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

Reserve Dental Coverage – The Coalition remains concerned about the dental readiness of the Reserve forces. Once these members leave active duty, the challenge increases substantially, so the Coalition believes the services should at least facilitate correction of dental readiness issues identified while on active duty. DoD should be fiscally responsible for dental care to Reservists to ensure service members meet dental readiness standards when DoD facilities are not available within a 50 mile radius of the members’ home for at least 90 days prior and 180 days post mobilization.

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

Consistent Benefit

As time progresses and external changes occur, we are made aware of pockets of individuals who for one reason or another are denied the benefits that they should be eligible for. DoD and all its health contractors were leaders in modifying policy and procedures to assist Katrina victims. Additionally, Congress’ action to extend eligibility for TRICARE Prime coverage to children of deceased active duty members was truly the right thing to do.

Restoration of TRICARE for Widows – One group of individuals that has earned the TRICARE benefit is now being closed out and needs to be brought back into the fold. When a TRICARE-eligible widow/widower remarries, he/she loses TRICARE benefits. When that individual’s second marriage ends in death or divorce, the individual has eligibility restored for military ID card benefits, including SBP coverage, commissary/exchange privileges, etc. – with the sole exception that TRICARE eligibility is not restored.

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

Military survivors deserve equal treatment.

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

TRICARE Prime Remote exceptions – We thank Congress for the FY2006 Defense Authorization Act provision allowing the Secretaries to waive the requirement for the spouse to reside with the service member for purposes of TRICARE Prime Remote eligibility if the service

determines special circumstances warrant such coverage. We remain concerned about the potential for inconsistent application of eligibility.

With longer deployments and sea/shore and overseas assignment patterns families are faced with some tough decisions. A spouse and children may find it easier and more supportive to reside with or around relatives during extended separations from their Active Duty spouse. The special authority is a step in the right direction, but there is a wide variety of circumstances that could dictate a family separation of some duration, and the Coalition believes each family is in the best situation to make its own decision.

The Coalition recommends removal of the requirement for the family members to reside with the active duty member to qualify for the TRICARE Prime Remote Program.

BRAC, Re-Basing, and Relocation – Relocation from one geographic region to another brings multiple problems. A smooth health care transition is crucial to a successful relocation. And that means ensuring a robust provider network and capacity is available as long as members and families remain in either losing or gaining locations affected by BRAC and Global Re-basing. A major effort is essential by the Department and its Managed Care Support Contractors to ensure smooth beneficiary transition from one geographic area to another.

It also is important to sustain Prime networks at closing locations to protect health care access for Guard/Reserve and retired members and families remaining in the area. We stress the importance of coordination of construction and funding in order to maintain access and operations while the process takes place.

The Coalition recommends codifying the requirement to provide TRICARE Prime in BRAC-affected areas and ensuring, via a report from DoD, that adequate health resources are available to provide care within access standards for those affected by re-basing plans.

Mental Health

We sincerely appreciate the continued effort the Subcommittee made in the 2007 National Defense Authorization Act to address the issues of the mental health of service members and their families. The additional elements of assessment provided the Task Force on Mental Health will further articulate the best recommendations to improve current policies and identify best practices in the treatment of mental health disorders. We look forward to the task force report to Congress due in May and pledge to partner with DoD as appropriate.

Our deepest concern in this area remains Post Traumatic Stress Disorder (PTSD) prevention, identification and treatment. We are impressed and gratified by the scope of efforts to deal with this issue by the development and implementation of an additional Post deployment survey and provider examination 3 to 6 months after returning from theater, partnership between DoD and VA. But the results of good intentions and great efforts can be undermined if they are not governed by a systemic, coordinated approach by DoD and the VA.

We believe that the magnitude of the problem may well be greater than current statistics indicate. The cultures of the respective armed forces tend to cause a reluctance to report symptoms and seek help, because doing so is perceived among some leaders and peers to be a weakness in

terms of the warrior ethic. This unfortunate and counterproductive view is most prevalent among those who carry the brunt of the fight and live in harm's way consistently.

Education of service members, their organizational leadership, and family members is essential to remove the sense of stigma, to recognize symptoms and to acquire coping skills to deal with combat related stress before it advances to a permanent life threatening disorder.

One key issue is that the multiple ongoing initiatives among the components have varying approaches that increase the possibility of losing service members in need of treatment through the proverbial "crack" as they transition from the combat zone to home or civilian status.

The trauma each service member experienced in war zones will be with them as long as they live. Army Chief of Staff Peter Schoomaker and Marine Commandant James Conway recently told Congress that the pressures and stresses on service members and their families are intensifying, not easing. This directly affects members' and families' ability to work, cope, and succeed in all aspects of their lives.

The Coalition believes we need standardized pre- and post-deployment mental health screening instruments that are reliable and valid to ensure service members and their families in need of mental health care are referred to and receive appropriate interventional services.

We must train and sustain more trained mental health professionals with the special skills needed to work through the range of mild to severe PTSD veterans who experience being shot at, seeing bodies or human remains, have been attacked or ambushed, had someone in their unit killed or seriously injured, or have seen women and children they were unable to help. Each of these experiences is a searing wound to the psyche. It cannot be left untended.

We must recognize that many cases will require longer-term treatment and services.

Without a congruent and overarching strategic plan involving integrated organizational leadership across DoD and VA health care spectrums nothing will occur in the effective diagnosis and treatment of mental health conditions.

The Coalition strongly recommends requiring DoD and the VA to work in concert to ensure a unified strategy to address PTSD and other mental health problems, providing consistent guidance, coordination of efforts, and cross-feed of results of segmented studies, task forces and programs that are currently underway among military services and the two departments.

Pharmacy

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

Pharmacy Co-payment Changes – The Coalition thanks the Subcommittee for freezing pharmacy co-payments for FY07. The Coalition believes strongly that uniformed services beneficiaries deserve more stability in their benefit levels, and that DoD has not performed due diligence in exploring other ways to reduce pharmacy costs without shifting such increased expense burdens to beneficiaries.

In fact, the Department has rejected Coalition offers to work jointly in developing a coordinated plan to educate beneficiaries on savings possibilities and motivate them to use the TRICARE mail-order pharmacy (TMOP) rather than the more expensive retail system. As noted above, the Administration has actively opposed at least one major initiative that would have reduced retail pharmacy costs by several hundred million dollars a year.

For several years in a row, Congress rightfully has rejected Administration proposals to double VA pharmacy co-payments for certain categories of non-disabled veterans. The Chairman of the House Budget Committee has asserted that a similar proposal for FY2008 will be rejected as well. This year, the VA increased co-payments by \$1 for those categories, a much more reasonable adjustment that would not have happened without Congressional intervention. Military beneficiaries deserve no less protection.

One important consideration in the mail-order-vs.-retail discussion is that some medications are simply not available through the TMOP.

The Coalition recommends no increases to the co-payment rates until all medications are available in the mail order program. The Coalition further recommends that the percentage of any future pharmacy co-payment increase should be limited to the percentage increase in retired pay since the last co-payment increase, rounded down to the next lower dollar.

Mail-Order Pharmacy – To date, DoD has not complied with the Armed Services Committees' expectation that DoD would eliminate the co-payment for generic drugs received through the TRICARE Mail Order Program. The Department has ignored what the Coalition believes would create the most powerful incentive for beneficiaries to shift from the more costly retail program to the mail order program – eliminating mail-order copays. While modest already, mail-order co-payments entail considerable processing expense for the contractor and DoD. For generics, the processing expense approaches the value of the co-payment.

Marketers know that offering something for free is a powerful economic incentive. The Coalition believes that eliminating mail-order co-payments for all mail-order drugs would send a strong economic and educational message to beneficiaries on the advantages of the mail-order system, and that the government would realize very large savings from this change.

The average of the 50 highest cost drugs purchased in the mail-order system saves the government \$175 per prescription relative to providing the drug through the retail system. If all mail-order co-payments would be eliminated, the savings for these 50 high cost drugs would still be at least \$166 per prescription (in fact, savings would be larger, since the government would no longer pay contractors to process co-payments). Elimination of mail-order copays should save the government \$20 million for each 1% of prescriptions that migrate from the retail to the mail-order pharmacy system.

The Coalition recommends eliminating beneficiary co-payments in the mail-order pharmacy system for generic and preferred brand name medications to incentivize use of this lowest-cost venue and generate substantial cost savings.

Rapid Expansion of “Third Tier” Formulary – The Coalition very much appreciated the efforts of the Subcommittee to protect beneficiary interests by establishing a statutory

requirement for a Beneficiary Advisory Panel (BAP) to give beneficiary representatives an opportunity in a public forum to voice our concerns about any medications DoD proposes moving to the third tier (\$22 co-pay). We were further reassured when, during implementation planning, Defense officials advised the BAP that they did not plan on moving many medications to the third tier.

Unfortunately, this has not been the case. To date, DoD has moved over 55 medications to the third tier. While the BAP did not object to most of these, the BAP input has been universally ignored in the small number of cases when it recommended against a proposed reclassification. The Coalition is also concerned that the BAP has been denied access to information on relative costs of the drugs proposed for reclassification and the Defense Department has established no mechanism to provide feedback to the BAP on why its recommendations are being ignored.

The Coalition believes the Subcommittee envisioned that the BAP would be allowed substantive input in the Uniform Formulary decision process, but that has not happened.

The Coalition urges the Subcommittee to monitor DoD's consideration of Beneficiary Advisory Panel input in future Uniform Formulary decisions and reassert its intent that the Panel should have a substantive role in the process, including access to meaningful data on relative drug costs in each affected class.

Drug Therapy – The Coalition believes DoD should take full advantage of the benefits of drug therapy as a means of cutting long-term health care costs and more expensive treatment methods. Actions taken on the Uniform Formulary should focus on these potential long term savings. Chronic disease management coupled with appropriate drug therapy lower costs in the long run, and multiple drug therapies should be evaluated for appropriateness in disease management and patient safety.

TRICARE Prime and MCSC Issues

DoD and its health contractors are continually trying to improve the level of TRICARE Prime service. We appreciate their inclusion of our associations in their process improvement activities and will continue to partner with them to ensure the program remains beneficiary-focused and services are enhanced, to include: beneficiary education, network stability, service level quality, uniformity of benefit between regions (as contractors implement best business practices), and access to care.

Referral and Authorization System – There has been much discussion and consternation concerning the Enterprise Wide Referral and Authorization (EWRAS) system. Much time, effort and money have been invested in a program that has not come to fruition. Is adding to the administrative paperwork requirements and forcing the civilian network providers into a referral system really accomplishing what DoD set out to do? Rather than forcing unique referral requirements on providers, perhaps DoD should look at expanding its Primary care base in the Prime Service Areas and capture the workload directly.

The Coalition recommends that Congress require a cost analysis report concerning the referral process within DoD and reliance on Civilian Network Providers within an MTF's Prime Service Area.

DoD/VA Health Care

For decades, there has been strong congressional interest on improving the DoD and VA relationship to gain greater efficiency in the services provided to beneficiaries of each system. Today, Congress is focusing even more attention on the need to improve the transition process for returning war veterans.

While both departments are making sincere efforts, the results still fall far short of the current and rapidly growing OEF/OIF need. The same concerns that were highlighted in previous year's testimony remain issues today – but with an even more pressing urgency as backlogs continue to rise.

Congress and TMC agree that our Nation's servicemen and women have earned first class health care, during and following separation from the military. DoD and VA have critical, complementary roles in that transition process.

Unfortunately, the pace of the two departments' collaborative efforts has been slowed by bureaucratic and parochial barriers as they struggle to bridge the gap between the departments. Time and again, progress continues to be stymied despite senior leaders' statements on expedited improvement efforts. Four years into a major war, the hand-off between the departments for those with the greatest need is still hardly "seamless."

The Coalition believes the basic problem is one of bureaucratic stove piping in each department. While each is making efforts to cooperate, there is no joint activity whose primary mission is to plan and execute the seamless transition strategy and exercise leadership from a single point of origin. There's a DoD effort and a VA effort, but no true joint synchronized effort.

On the plus side, the VA has established an office for seamless transition and it is a catalyst in VA's outreach efforts, focused on providing our service members a smooth transition. However, without DoD as an integral partner in this effort, options for success remain stunted.

The Coalition believes it is essential to establish a joint or federal transition office, to which DoD and VA personnel are permanently assigned to work together to provide oversight, direction and implementation of the Joint Executive Council's strategic plan. This office's responsibilities should include:

Joint In-Patient Electronic Health Record – We applaud DoD and VA leaders for making a firm commitment to accomplish this long awaited initiative, one that both Congress and TMC have been seeking for years. A reality by 2012 is too long to wait. Congress must press DoD and VA to speed delivery of an interoperable, bi-directional and standards based electronic medical record. We must see concrete timelines and milestones for action. This medical record is a key goal to ensure we meet seamless transition requirements for wounded moving from DoD care into VA care.

Joint DoD/VA Physical – A "one stop" separation physical supported by an electronic separation document (DD214) is a cost saving initiative that once again feeds into the seamless transition model. Although it has been accomplished in some DoD facilities it has yet to be an accepted practice throughout the two departments. The Coalition once again recommends continued oversight by the Committees to ensure that this important program be implemented

promptly and effectively at all sites. It should become the "gold standard" of effective and efficient transitions.

Special Needs Health Care – Polytrauma Rehabilitation Centers were established to meet the specialized clinical care needs of polytrauma patients. They provide comprehensive inpatient rehabilitation services for individuals with complex cognitive, physical and mental health sequelae of severe disabling trauma. These centers require special oversight in order to ensure the required resources are available to include specialized staff, technical equipment and adequate bed space. This oversight should be a joint effort since it provides a significant piece of the health care continuum for severely injured service members.

Traumatic Brain Injury (TBI) – TBI is the signature injury of OIF/OEF, its impact range from mild to severe. Recognizing the severity of brain injury and developing effective evidence based practices for its diagnosis and treatment is necessary to include research on the long-term consequences of mild TBI. The goal of achieving optimal function of each individual TBI patient requires improved interagency coordination between DoD and VA. Service members should be afforded the best rehabilitation services available and the opportunity to achieve maximum activities of daily living so they can reenter either active duty, become a productive member of society, or at a minimum achieve stability of their activities of daily living in order to function in an appropriate setting.

Access to Care – Lack of timely access to care in VA facilities has been a constant refrain for years. In response HR 92 has been proposed that will establish timely access standards. However, the reality is without additional assets and a coordinated plan with DoD to facilitate a seamless transition little will change to help returning service members ability to access VA health care.

Joint Research – Combined Research Initiatives would further enhance the partnership between VA and DoD. Since many of the concerns are shared research crosses agency lines and once again collaboration of effort should enable research dollars to go much further. Furthermore, research must be performed jointly and results shared among all branches of military service and other practicing healthcare professionals to ensure timely integration of these findings in the diagnosis and treatment of TBI patients.

The Military Coalition recommends that Congress mandate a single Joint Transition Office, permanently staffed with personnel from both VA and DoD and having primary responsibility for top-down planning and execution of all "seamless transition" initiatives, including a joint in-patient electronic health record; joint DoD/VA physical; traumatic brain injury, PTSD, and special needs care; coordinated access to care (including long-term support services), and joint research.

Health-Related Tax Law Changes

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

Many uniformed services beneficiaries pay annual enrollment fees for TRICARE Prime, TRICARE Reserve Select, and premiums for supplemental health insurance, such as a TRICARE supplement, the TRICARE Dental and Retiree Dental Plans, or for long-term care insurance. For most military beneficiaries, these premiums are not tax-deductible because their annual out-of-pocket costs for healthcare expenses do not exceed 7.5% of their adjusted gross taxable income.

In 2000, a Presidential directive allowed Federal employees who participate in FEHBP to have premiums for that program deducted from their pay on a pre-tax basis. Similar legislation for all active, reserve, and retired military and federal civilian beneficiaries would restore equity with private sector workers, many of whom already can pay their health premiums with pre-tax dollars. Tax incentives will help offset the cost of these important coverages, promote enrollment, and reduce members' liability for catastrophic expenses.

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

CONCLUSION

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

Colonel Steven P. Strobridge, USAF (Retired)

Director, Government Relations, Military Officers Association of America (MOAA); and
Co-Chairman, The Military Coalition

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

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

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

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

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

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

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

Joseph L. Barnes

National Executive Secretary, FRA; and
Co-Chairman, The Military Coalition

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

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

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

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

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

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

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

Joyce Wessel Raezer
Chief Operating Officer
National Military Family Association

Joyce Raezer joined the staff of the Government Relations Department of the National Military Family Association as a volunteer in September 1995. In February 1998, she was selected for the paid position of Senior Issues Specialist for the Association and subsequently served as the Department's Deputy Associate Director and Associate Director 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, including the Department of Defense Education Activity (DoDEA), the U.S. Army Community and Family Support Center, and the TRICARE Management Activity (TMA). She has been a member of the Defense Commissary Agency (DeCA) Patron Council since February 2001. 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. 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. From June 1999 to June 2001, Joyce served on the first national Board of Directors for the Military Child Education Coalition. In 2004, she 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 serves as a member of the expert panel for the federally-funded Maternal and Child Health Library, sponsored by Georgetown University.

Joyce 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 (PA) 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 (KY) Community Schools Board of Education in 1993, serving until August 1995. She is an active volunteer parent in her son's school in Fairfax County, Virginia, and sings in her church choir.