

**Written Testimony on Health Care**

**Reserve Officers Association of the United States  
And  
Reserve Enlisted Association**

**for the**

**House Armed Services Committee  
Subcommittee on Military Personnel**

**March 16, 2011**



*“Serving Citizen Warriors through Advocacy and Education since 1922.”™*



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The Reserve Officers Association of the United States (ROA) is a professional association of commissioned and warrant officers of our nation's seven uniformed services, and their spouses. ROA was founded in 1922 during the drawdown years following the end of World War I. It was formed as a permanent institution dedicated to National Defense, with a goal to teach America about the dangers of unpreparedness. When chartered by Congress in 1950, the act established the objective of ROA to: "...support and promote the development and execution of a military policy for the United States that will provide adequate National Security." The mission of ROA is to advocate strong Reserve Components and national security, and to support Reserve officers in their military and civilian lives.

The Association's 60,000 members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on Active Duty to meet critical needs of the uniformed services and their families. ROA's membership also includes officers from the U.S. Public Health Service and the National Oceanic and Atmospheric Administration who often are first responders during national disasters and help prepare for homeland security. ROA is represented in each state with 55 departments plus departments in Latin America, the District of Columbia, Europe, the Far East, and Puerto Rico. Each department has several chapters throughout the state. ROA has more than 450 chapters worldwide.

ROA is a member of The Military Coalition where it co-chairs the Tax and Social Security Committee. ROA is also a member of the National Military/Veterans Alliance. Overall, ROA works with 75 military, veterans and family support organizations.

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The Reserve Enlisted Association is an advocate for the enlisted men and women of the United States Military Reserve Components in support of National Security and Homeland Defense, with emphasis on the readiness, training, and quality of life issues affecting their welfare and that of their families and survivors. REA is the only Joint Reserve association representing enlisted reservists – all ranks from all five branches of the military.

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## DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers and Reserve Enlisted Associations are member-supported organizations. Neither ROA nor REA have received grants, sub-grants, contracts, or subcontracts from the federal government in the past three years. All other activities and services of the associations are accomplished free of any direct federal funding.

## INTRODUCTION

In answering the call-up, over 800,000 reserves have been mobilized cumulatively since the issuance President Bush's issued Executive Order 13223 on September 14, 2001.

ROA and REA thank the Military Personnel subcommittee for the chance to present testimony on behalf of the 1.1 million Ready Reservists affected by medical readiness, and for the retirees of the National Guard and Reserve who continue to be entitled to health care. Further we would like to thank the committee for expanding the pre-activation TRICARE coverage for recalled Guard and Reserve members prior to reporting for mobilization, and for passage of TRICARE Retired Reserve.

But as the topic of Health Care fees is a focus of today's hearing, let it be mentioned that while increases to retiree TRICARE Prime and Standard fees were prohibited in FY 2011, the premiums for both TRICARE Reserve Select and TRICARE Retired Reserve were overlooked, and increased by the Department of Defense (DoD).

We also commend your committee on working the health care issues for the young men and women who are deployed overseas, and stationed at home. But the transition between health plans is far from seamless. Oftentimes military leadership is encouraging Guard and Reserve members who are returning from mobilization to seek health coverage from the Department of Veteran Affairs rather than utilizing the transitional TRICARE benefit.

## EXECUTIVE SUMMARY

Increasing the cost-share of DoD health care beneficiaries is admittedly an emotional issue. The nation and the Department of Defense are faced with ever increasing health care costs, but this is not simply a budgeting exercise. Because of the dynamics involved, this is an issue that should be resolved by involving all those who are concerned. Here is a summary of the key points as seen by the Reserve Officers Association (ROA) and the Reserve Enlisted Association (REA).

Currently the Secretary of Defense has the authority to make changes in TRICARE fees and copayments without Congressional approval. The prime example of this in FY-2011 was the increase of TRICARE Reserve Select and TRICARE Retired Reserve Premiums.

**Congress must maintain an oversight over DoD health care, preventing capricious fee increases to beneficiaries.**

### **TRICARE Prime:**

- The proposed \$30 increase for individuals and \$60 for families is a modest proposal.
- If indexed, adjustments to the enrollment fee should be population based rather than industry-based.
- It is important to independently verify the current total cost of DoD health care benefits. Such an audit will permit Congress to validate proposals based on cost-sharing percentages.
- Annual increases should **not** be tied to the market-driven Federal Employee Health Benefits Plan (FEHBP) or a commercial plan.

**On Pharmacy Co-payments:**

- ROA and REA believe higher retail pharmacy co-payment should not apply on initial prescriptions, but on maintenance refills only.
- ROA and REA support DoD efforts to enhance the mail-order prescription benefit.

**Sole Community Hospitals:**

- Fee adjustments must be approached with caution because of inconvenience to beneficiaries.

**US Family Health Plan – Medicare coverage:**

- ROA and REA support continuation of the Medicare coverage as part of USFHP.
- To maintain the program, a mandatory Part “B” payment might be considered.

**Reserve Health Care Initiatives:**

- Improve continuity of health care for all drilling Reservists and their families by:
  - o Auditing the assumptions used for TRICARE Retired Reserve premiums
  - o Providing Continuing Health Benefit Plan to traditional Drilling Reservists who are beneficiaries of TRICARE Reserve Select but are separated from the Selected Reserve to provide COBRA protections.
  - o Permitting active members in the Individual Ready Reserve (IRR) to buy-into TRICARE Reserve Select.
  - o Allowing demobilized Retirees and Reservists involuntarily returning to IRR to qualify for subsidized TRS coverage.
  - o Providing TRS coverage to mobilization ready IRR members; levels of subsidy would vary for different levels of readiness.
  - o Improving post deployment medical and mental health evaluations and access to care for returning Reserve Component members.
  - o Providing an option for Reservists where DoD pays a stipend to employers.
- Extend military coverage for restorative dental care following deployment to 90 days.
- Permit beneficiaries of Federal Employee Health Benefit plan the option of subscribing to TRICARE Reserve Select.

<b>DISCUSSION</b>
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**MILITARY HEALTH CARE – a shaky foundation.**

The Global War on Terror is a protracted engagement that will not end with the withdrawal of troops from Iraq and Afghanistan. Overseas Contingency Operations (OCO) will continue, as will military response to crisis spots such as Libya. Yet, at the same time the Fiscal Year 2011 (FY-2011) Defense Budget may be reduced.

Included in the Budget release is a statement that the president has moved \$73 billion from the OCO to the base budget (pg 61). While the budget at \$553 billion appears as a gross increase of \$22 billion above FY-2010, this shift from OCO to the base budget is a de facto cut of \$51 billion with spending on certain items being trimmed down from the FY-2010 base budget.

In addition, the political atmosphere is focusing debate on correcting the growing National Deficit. "Our national debt is our biggest national security threat," said Admiral Mike Mullen, Chairman of the Joint Chiefs of Staff at a "Tribute to the Troops" breakfast, last summer."

And there are members on both sides of the aisle that are saying if cuts are made then Defense should not be exempt. Lawmakers are talking openly about TRICARE fees not having been increased since 1995.

For a number of years, the Pentagon has spoken out about the rising costs of health care and the need for reform. This can be noted by statements illustrating that military health costs have increased such as "DoD medical costs have shot up from \$19 billion in FY 2001 to \$52.5 billion in FY 2012," as made by Deputy Secretary of Defense William J. Lynn, III at a Senate Budget hearing this month, or hyped by statements such as "Healthcare costs are eating the Defense Department alive," as said by Secretary of Defense Robert M. Gates.

In February, Admiral Mullen told the House Armed Services Committee as a whole that people costs account between 60 to 70 percent of the Pentagon budget. The Hill newspaper also quotes Mullen as saying that "the military is 'on track to almost be immobilized' by healthcare and benefits costs. Yet it has been calculated that personnel costs will be \$244 billion in 2010, just under 40 percent of the \$636 billion appropriated to DoD.

Health care costs now consume nine percent of the DoD budget. Yet comparisons of health care costs are distorted by beginning with a peacetime starting point followed by a decade of war. Still judging from what has been said to both Congress and the press, it would seem that many in the Pentagon are attributing the increases in military health care to its retirees, especially those working second careers.

Unfortunately, many retirees are blaming much of this additional health care costs on National Guard and Reserve members for being included under TRICARE.

The Pentagon's public campaign for health care reform has undercut its credence by serving members, retirees and beneficiary associations in what has been said, what has been budgeted, and what still might be planned.

## **HEALTH CARE COST DISCUSSION**

The Reserve Officers Association and the Reserve Enlisted Association are disappointed in how the Department of Defense Health Affairs has in the past attempted to address such an emotionally laden issue unilaterally. While this year, the Pentagon has made efforts to meet with beneficiary associations, these gatherings have been more briefings rather than discussions to seek solutions. ROA and REA would like to thank Congress for its continued involvement on DoD health care issues and hope it remain a leading partner on these issues.

ROA and REA applaud the efforts by Congress to address the issue of increasing Department of Defense health care costs and its interest to initiate dialogue and work with both the Pentagon and

the beneficiary associations to find the best solution. The time has come to examine the cost of TRICARE and the level of beneficiary contribution.

It is important to sustain the DoD health care as a deferred benefit for our serving Active and Reserve Component members and their families. While retired, these beneficiaries have accepted risks and made sacrifices in their earlier military careers that have not been asked of the remaining 99 percent of the nation's population. TRICARE fulfills an on-going promise by the government for continued health care to those who have served or are serving.

ROA and REA are committed to our membership to sustain this health care benefit. We fear that Congress will be unable to continue prohibitions on health care fees. DoD, Congress and the beneficiary associations need to work together to find a fair and equitable solution that protects our beneficiaries and ensures the financial viability of the military health care system for the future. Some associations seek to continue a freeze on premium fees permanently; others are joining ROA and REA by admitting that some increases are necessary.

Conversely, the Department of Defense and this nation cannot afford to carry the full burden of health care costs. The operational Active and Reserve force and their families deserve the best, both while serving and into retirement. To preserve the top health care program in the nation as a DoD benefit, ROA and REA are open to discussions on cost-sharing.

Beneficiary medical expense totals have not yet been provided by DoD. Congress should ask the Pentagon for a financial breakdown. An independent audit by the Government Accountability Office (GAO) or another agency would allow Congress an opportunity to validate proposals based on financial benchmark.

**ROA and REA agree that the proposed \$30 increase for individuals and \$60 for families is a modest proposal, and can accept this as a first step.**

Of concern is a proposal to index future increases. Having some formula in place seems appropriate, following a similar approach to what was taken by Congress to calculate cost of living allowances (COLA) for social security and military retirement pay. But the challenge is, **What index to select?**

ROA and REA agree with other beneficiary associations that it should not be a Medicare Index, because a Medicare-based index penalizes those retirees under age 65 who don't suffer from the same ailments as retirees in the older age group.

ROA also found that contracted commercial indexes tend to maximize health care growth, likely justifying the higher premium increases associated with commercial health insurance and should not be used. Comparisons between commercial and military health care plans are not justified.

ROA is continuing to explore indices, but the challenge is that even government matrixes are based on an industry and not actual beneficiary health care costs.

ROA and REA share the concern that any process used should be a fair and equitable approach where retiree's won't be overburdened. Should an index be agreed upon, it should be codified.

## HEALTH CARE REFORM DISCUSSION

The beneficiary associations were invited to the Pentagon for a meeting with Dr. Clifford L. Stanley, Under Secretary of Defense for Personnel and Readiness about the health reform proposals. At this meeting it was stated that the FY-2012 proposal was enough to cover what was needed in the FY-12 budget, and if more was needed the next year, DoD would submit additional proposals.

During the first week of March, the Pentagon also announced that John Baldacci, former governor of Maine, has been hired into in a newly created position to recommend to Dr. Stanley “necessary reforms for the military health care system.”

Statements like these combined with the DoD public relations health care costs campaign makes both retirees and beneficiary associations nervous.

In anticipation of less modest proposals in the future ROA and REA include the following:

### **TRICARE:**

- Catastrophic Cap of \$3000 should not be changed, nor indexed.

### **TRICARE Standard:**

- ROA and REA do not endorse an annual enrollment fee for either DoD or VA beneficiaries.
- Should DoD suggest increasing deductible levels, the total cost of Standard needs to be evaluated, because...
- Standard has large co-payments of 25 percent after the deductible, and the cost of TRICARE standard automatically adjust to changes in medical costs.
- For individuals or families relying on Standard for medical treatment, it is a more expensive health plan than TRICARE Prime.

### **TRICARE Reserve Select (TRS)**

- DoD should stop viewing TRS as a health insurance, but as a health program.
- TRICARE standard deductible increases should not be rolled over into TRS.

### **TRICARE Retired Reserve (TRR)**

- Premiums are too high, and for TRR to be viable, premiums need to be reduced.

## RESERVE COMPONENT HEALTH CARE DISCUSSION

The Pentagon views TRICARE as a health care plan, and Reserve TRICARE as a health care insurance. Because words create paradigm, Reserve health care is treated by DoD entirely different than active duty health care. The differences are easily noted: Active duty members enroll in a benefit with deductibles and co-payments; Guard and Reserve members “purchase” a premium based health plan. The following are suggested improvements.

**1. ROA and REA hold concerns over the implementation of TRICARE for gray area retirees.** Because DoD treated Reserve gray area retirees as a separate health care risk group, health care premiums proved higher than expected. Because of the expense, enrollment is low. It is likely just being used by those with health care problems, who can't afford health care from other sources. If the program is not changed it will have a similar success to mobilization insurance.

**ROA and REA hope that the committee will request a Government Accountability Office review of the process that determined the published premium levels.**

**2. Seamless Transition.** Service members should not have to navigate through bureaucracy to receive care or benefits. Every time a Reserve Component member transitions into a new category of health care, he or she is required to reenroll in the new program. Even those who are beneficiaries of TRICARE Reserve Select (TRS) need to do an administrative transition between TRS, TRICARE once mobilized, into Transitional Assistance Management Program (TAMP) and back onto TRS. And once retired, there is additional transition into TRICARE Retired Reserve, and the latter TRICARE retiree health care. Add to this the additional health care provided by the Department of Veteran Affairs, and there are gaps in health care as a Reserve Component or family member moves between programs.

**3. Access to TAMP.** It has come to ROA's attention that some Guard and Reserve members who have returned from deployment may not be provided TAMP coverage. In one particular case, an individual who was placed in a wounded warrior company, after being found fit, was told that she would not qualify for transitional health care upon discharge because of how her orders were written while a wounded warrior.

**ROA and REA feel that all members being separated from Active Duty should qualify for TAMP.**

**4. Sustaining Reserve Health Care.** *Continued Health Care Benefit Plan* continues to be shown as only allowing members of the Selected Reserve who have had a tour of active duty within the previous 18 months by DoD. This is denying COBRA protections for TRS beneficiaries who haven't be activated, and doesn't support the Secretary of Defense's directive to mobilize National Guard and Reserve members one year out of six, which would be a dwell time of 60 months. There is little cost as the beneficiary pays a premium of 102 percent of TRICARE Cost.

As even discharged active service members have the benefit of the Continuing Health Care Benefit Plan, those Guard and Reserve members who have signed up for TRICARE Reserve Select need to have protections when they leave the Selected Reserve.

**ROA and REA encourage Congress to work with the Pentagon to open up Reserve Component member access to the Continued Health Care Benefit Plan to any TRICARE Reserve Select beneficiary separating from the Selected Reserve under conditions that are not punitive in nature.**

**5. Employer health care option:** DoD pays a stipend to employers of deployed Guard and Reserve members to continue employer health care during deployment. G-R family members are eligible for TRICARE if the members' orders to Active Duty are for more than 30 days; but some families would prefer to preserve the continuity of their own health insurance. Being dropped from private sector coverage as a consequence of extended activation adversely affects family

morale and military readiness and discourages some from reenlisting. Many G-R families live in locations where it is difficult or impossible to find providers who will accept new TRICARE patients. This stipend would be equal to DoD's contribution to Active Duty TRICARE.

**ROA and REA continue to support an option for individual Reservists where DoD pays a stipend to employers**

**6. Dental Readiness.** Currently, dental readiness has one of the largest impacts on mobilization. The action by Congress in the FY-2010 NDAA was a good step forward, but still more needs to be done.

The services require a minimum of Class 2 (where treatment is needed, however no dental emergency is likely within six months) for deployment. Current policy relies on voluntary dental care by the Guard or Reserve member. Once alerted, dental treatment can be done by the military, but often there isn't adequate time for proper restorative remedy.

**ROA and REA continues to suggest that the services are responsible to restore a demobilized Guard or Reserve member to a Class 2 status to ensure the member maintains deployment eligibility.**

Because there are inadequate dental assets at Military Treatment Facilities for active members, active families, and reservists, **ROA and REA further recommend that dental restoration be included as part of the six month TAMP period following demobilization.** DoD should cover full costs for restoration, but it could be tied into the TRICARE Dental program for cost and quality assurance.

**7. Utilization of TRS: ROA and REA support efforts by the Pentagon to encourage enrollment in TRICARE Reserve Select.** We share a concern that the numbers being published by the Pentagon understate the actual level of participation by Guard and Reserve members who are eligible. A survey should be taken of TRICARE contractors to compare their participation measures with those of DoD.

**8. IRR Access to TRS:** Not everyone who drills is eligible for TRS. All services offer drilling for points without pay. These members are in the IRR. The Navy has Voluntary Training Units. The Air Force and Army have non-paid Individual Mobilization Augmentees (IMA). The Army also has a group within the IRR body that has agreed to mobilization during their first two years.

The Army, the Marine Corps and the Navy have mobilized Reservists out of the Individual Ready Reserve. Under current law, unless these RC members are given an opportunity to join the Selected Reserve, they are not eligible to purchase TRS.

ROA and REA feel that IRR members should be eligible for TRS. They could qualify if they sign an agreement of continued service and complete a satisfactory year of training and satisfy physical standards. A satisfactory year could be defined either by points or by training requirements, as defined by each Reserve Chief.

**ROA and REA recommend legislation to allow IRR buy-in to TRICARE Reserve Select.**

## **CONCLUSION**

ROA and REA reiterate their profound gratitude to the subcommittee for addressing the health care issues. The process that we develop and what we decide upon this year for TRICARE fees and sustained benefits reflects not only our recognition of retired members for their service to the nation, but is a dedication to the warriors of the future.

Service members deserve the best medical care that the nation can offer. Health care services are vital to keeping the nation's military force strong and ready. As a deferred benefit, it serves as a recruiting as well as a retention tool, as the willingness of the young to serve will depend on how they perceive the treatment and appreciation given to earlier veterans.

When a nation puts members of its military at physical risk from disease and traumatic injury it absolutely owes them health care not health insurance.

ROA and REA strongly urge that when all cost-sharing is finally taken into account, our beneficiaries must receive the DoD provided health care for which they are entitled.