

Statement of

TANNA SCHMIDLI

Chairman of the Board/Chief Executive Officer

THE NATIONAL MILITARY FAMILY ASSOCIATION

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of the

SENATE ARMED SERVICES COMMITTEE

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

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

NMFA Representatives in military communities worldwide provide a direct link between military families and NMFA staff in the nation's capital. Representatives are the "eyes and ears" of NMFA, bringing shared local concerns to national attention.

NMFA receives no federal grants and has no federal contracts.

NMFA's website is located at <http://www.nmfa.org>.

Tanna K. Schmidli, Chairman of the Board/Chief Executive Officer

Tanna Schmidli has been a military spouse for 29 years and has supported the National Military Family Association (NMFA) since 1983. Upon her husband's assignment in the Washington, DC, area she joined the NMFA headquarters staff as Director of Volunteer Services and Representatives. In the ensuing years she was elected Corporate Secretary for the Association and served on various Board Committees to include: Enlisted Outreach, Operation Purple, Volunteer Services and Representatives Resource, and Governance. She served as Chairman of the Membership Department Board Committee. In 2005, Ms. Schmidli was elected as Chairman of the Board and Chief Executive Officer for NMFA.

A Missouri native, Ms. Schmidli received her B.S. in Education from Central Missouri State University and was a special education teacher in various school systems, including the Department of Defense Dependent Schools in Germany.

As a military spouse Ms. Schmidli served in many volunteer capacities, including: President of three military spouse clubs; Director of Camp Venture, a camp for exceptional children at Fort Stewart, Georgia; Director of Girl Scouts in Wurezburg, Germany; Nominating Chair of the North Atlantic Girl Scouts Board of Governors, Europe; Volunteer Coordinator for ten years with the Department of the Army's Community and Family Support Center Army Family Action Plan Conference. Ms. Schmidli is the wife of a retired Army officer and they have two daughters, Shanon and Erin. The family made fourteen military moves during their active duty years and their daughters each attended nine different schools.

Ms. Schmidli has been awarded the Department of the Army's Patriotic Civilian Service Award; the Department of the Army's Outstanding Civilian Service Award and twice has received the Department of the Army's Commanders Award for Public Service.

Mr. Chairman and Distinguished Members of this Subcommittee, the National Military Family Association (NMFA) would like to thank you for the opportunity to present testimony today on the state of military health care, as well as other quality of life issues affecting service members and their families. Once again, we thank you for your focus on many of the elements of the quality of life package for service members and their families: access to a quality health care benefit, military pay and benefits, and support for families dealing with deployment.

NMFA endorses the recommendations contained in the statement submitted by The Military Coalition, with the exception of those related to increases in TRICARE Prime enrollment fees and TRICARE Standard deductibles. In this statement, NMFA will provide its alternative both to the health care recommendation contained in the Coalition's statement and to the proposals made by the Department of Defense (DoD) in its FY 2007 budget request. We will also briefly address other quality of life issues for military families in the following subject areas:

- I. Military Health Care
 - DoD's Proposal to Increase TRICARE Fees
 - DoD Must Implement More Cost-Saving Measures
 - TRICARE Standard: Not Just Another Insurance Plan!
 - TRICARE Prime and TRICARE Standard
 - Prime Access Standards and Quality of Care
 - Obstetrical and Pediatric Rates
 - Deployment Health for Service Members and Families
 - Wounded Service Members Have Wounded Families
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- II. Family Readiness
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- IV. Families and Transition
 - Transformation, Global Rebasing, and BRAC
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 - Funding for Commissaries, Exchanges, and Other Programs
 - Permanent Change of Station Improvements
 - Adjusting Housing Standards
- VI. Families and Community

Service member readiness is imperative for mission readiness. Family readiness is imperative for service member readiness. Family readiness requires the availability of coordinated, consistent family support provided by well trained

professionals and volunteers; adequate child care; easily available preventative mental health counseling as well as therapeutic mental health care; employment assistance for spouses; and youth programs that assist parents in addressing the concerns of their children during stressful times. However, no issue is more important to family readiness than the military family's ability to access quality health care in a timely manner and at a cost that is commensurate with the sacrifices made by both service members and families.

Military Health Care

NMFA thanks this Subcommittee for its steadfast authorization of a robust military health care system. This system must continue to meet the needs of service members and the Department of Defense (DoD) in times of armed conflict. It must also acknowledge that military members and their families are indeed a unique population with unique duties, who earn an entitlement to a unique health care program.

DoD's Proposal to Increase TRICARE Fees

The proposal by DoD to raise TRICARE fees by exorbitant amounts has resonated throughout the beneficiary population. Seldom has the reaction of service members and families been as strong and strident. Interestingly, this reaction is across the board from all beneficiaries, even though the proposal would only marginally affect current active duty families or retirees over age 64. Beneficiaries see the proposal as a concentrated effort by DoD to change their earned entitlement to health care into an insurance plan. How detrimental this could be to retention is unknown. But the volume of the voices suggests that if the proposals are enacted as presented there will be an effect. In addition, since statistics show the children of veterans are more likely to volunteer for the uniformed services than the children of non veterans, and that the more positive "influencers" of service in the military are military retirees and other military family members, one must also wonder at the effect such proposals could have on recruitment.

NMFA is alarmed DoD has already instructed the TRICARE Managed Care Support Contractors to begin drawing up plans to implement its proposed changes in TRICARE Prime enrollment fees on October 1, 2006. We believe this action is inappropriate given that Congress has not yet had the necessary time to study the proposals and the budget assumptions behind them. We appreciate the many questions Members of Congress are asking about these proposals. We urge Congress to direct DoD—possibly by inserting a provision in the Emergency Supplemental Appropriations Act now being debated—to cease efforts to implement its proposals until Members have had the opportunity to study them more closely.

As part of your review of these proposals, NMFA requests you ask DoD officials which retirees they believe will leave TRICARE and bring about their predicted cost savings. DoD asserts retirees under age 65 are leaving the health insurance offered by their civilian employer and returning to TRICARE. Since the Department has produced no concrete numbers to validate this assertion, it is difficult to comment on, but NMFA does not dispute that some are doing so. However, we also believe the Department is reaping the rewards of its own success.

We suggest TRICARE Prime has improved so significantly that many new retirees are opting to stay in Prime since it has worked well for them on active duty. Anecdotally, NMFA has noticed a profound difference in retiree behavior regarding health care choices over the past decade. The younger retirees, when in an area where Prime is offered, appear overwhelmingly to continue their Prime enrollment into retirement. Older retirees appear more likely either to use Standard as a wrap-around to their employer-provided health insurance or choose to buy a TRICARE supplemental plan and use Standard as their primary benefit. We would be very interested in seeing numbers to learn whether the steady increase in retirees under age 65 enrolled in Prime is due more to the retention of Prime in retirement among recent retirees or if it is indeed the so-called "ghosts" returning.

If most of the increased numbers of retirees using TRICARE are those who are RETAINING their Prime enrollment in retirement, then NMFA questions if many (or any) will migrate to employer-provided health insurance. NMFA believes most families entering retirement will choose to stay with a known system that has worked for them rather than switch to an unknown one. If it is the "ghosts" returning, then NMFA asserts that the current proposal would exacerbate the situation. Retirees who currently use TRICARE Standard as a wrap-around to their civilian employer's health insurance may well opt to buy into TRICARE Prime (where offered) rather than pay for both their civilian health insurance and a TRICARE Standard premium (enrollment fee). NMFA is also concerned that many retirees in this age group may not have access to employer-provided health care as they are self-employed or work for a small business that does not offer health care. These individuals would be penalized for their choice of employment in retirement simply to try to influence the decisions of others.

Active duty families fear for the future of their health care entitlement. Retirees, once they can think beyond their outrage, are frankly perplexed. When TRICARE Prime was first introduced, many retirees could only participate in the option if they enrolled at an MTF. Later, many were told there was no longer room for them at the MTF and they were forced to use Prime in the civilian sector. Retirees who used CHAMPUS or TRICARE Standard seldom could access space available care in MTFs and were forced to buy supplemental policies to guard against high out-of-pocket expenses. Yet, when an inpatient hospitalization loomed and continuity of care with their civilian provider was upper most in their minds, they could be forced back into the MTF via non availability statements. Note this enforced return to the MTF was not for full care, but only for the treatment or surgery required for that particular inpatient episode. Now, retirees see the system does not want them at all! These are the same retirees to whom President Bush referred in a speech before the American Legion Convention on February 24, 2006, when he said: "Our men and women on the front lines are taking inspiration from the valor and courage that you've shown in the field of battle."

Finally, the Department is stating two reasons for its proposed exorbitant increases in beneficiary cost shares. One is these cost shares must be put in place to "sustain the benefit." The other is that the Department cannot afford to buy weapons systems and pay for the earned health care entitlement. This mixed

message cannot help but send morale in a downward spiral. Are military retirees buying the next submarine or aircraft or are they supposed to sacrifice their entitlement to preserve the benefit for the future?

NMFA does not believe DoD's estimate of the migration of retirees out of TRICARE is realistic and urges Congress to obtain more information on the economic assumptions used by DoD to formulate its budget proposal. We also urge Congress to ensure adequate authority for DoD health care funding is included in the FY 2007 Budget Resolution and FY 2007 National Defense Authorization Act (NDAA). Because DoD has already directed the TRICARE contractors to begin plans to implement its proposed increases, NMFA requests that Congress insert a provision in the Emergency Supplemental Appropriations bill now being debated to forestall the implementation of any increases until Congress has had more time to study their impact on beneficiaries and to evaluate DoD's cost assumptions.

DoD Must Implement More Cost-Saving Measures

In Section 733 of the FY 2006 National Defense Authorization Act, Congress requested a report on the delivery of health care benefits through the military health system. This report, due to you no later than February 1, 2007, asks key questions that should be answered before DoD attempts to change beneficiary cost shares drastically. Many of the topics required in the report deal with ways DoD could improve efficiencies in delivering the benefit. NMFA believes DoD has many options available to make the military health system more efficient and thus make the need for large increases in beneficiary cost shares unnecessary.

For example, had the Department implemented a marketing plan for the TRICARE Mail Order Pharmacy (TMOP) several years ago, the migration to TMOP might have reduced health care costs significantly. Similarly, if the TRICARE Uniform Formulary had been implemented when first authorized by Congress in the fall of 2000 rather than just starting in March of 2005, additional savings could have been realized. NMFA is aware DoD is attempting to get federal pricing for medications in the TRICARE Retail Pharmacy (TRRx); however, in the meantime, it may have passed up several opportunities to receive significant discounts from pharmaceutical companies.

In recent years at the annual TRICARE conferences and other venues, DoD officials have discussed the benefits of disease management, especially for certain chronic illnesses. These benefits flow to the beneficiaries through better management of their conditions and to DoD through patients' decreased need for costly emergency room visits or hospitalizations. Most MTFs and all of the TRICARE Managed Care Support Contractors have at least one disease management program, offered to beneficiaries in both TRICARE Prime and Standard. However, not all programs are offered everywhere, nor is there an effort to apply disease management programs across the entire system, to include pharmacy. DoD officials say disease management programs can benefit patients and the Department's bottom line and that successful disease management must include medical and

pharmacy components. NMFA was disappointed, therefore, to find no mention of disease management or a requirement for coordination between the pharmacy contractor and Managed Care Support Contractors in the recently-released Request for Proposals for the new TRICARE pharmacy contract. NMFA was pleased to see Congress recognized the importance of improved disease management programs and included the study of the "means of improving integrated systems of disease management, including chronic illness management" in Section 733 of the FY 2006 NDAA.

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

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

NMFA also believes the Managed Care Support Contractors have additional beneficial suggestions that could reduce health care costs through more efficient claims processing, the elimination of redundancies, and the reduction of the number of DoD-unique requirements in the contracts. Because the costs of re-competing and implementing large contracts can be extremely high, NMFA suggests that DoD delay the next round of TRICARE contract competitions for at least a year. Last year's implementation of the T-Nex contracts went more smoothly than many predicted, but beneficiaries and providers still experienced a certain amount of turmoil. Both would benefit from a longer period of stability and anticipated improvements in customer service as the contractors become more familiar with their regions and their implementation tasks. It is probable DoD could better serve its beneficiaries and enhance savings and efficiency if it would take the time to test new concepts for the next contracts through demonstration projects evaluated in the current program rather than implementing them untested in the new contracts. The Department should also ensure the three major issues still

outstanding in the implementation of the current contracts—electronic claims, clean and legible records, and referrals and authorizations—have been solved before launching into another contract round.

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

TRICARE Standard: Not Just Another Insurance Plan!

NMFA thanks Congress for its sustained concern regarding providing information and support to TRICARE Standard beneficiaries. We are hopeful the newer emphasis on this population by DoD and the Managed Care Support Contractors will translate into actual increased support for these beneficiaries. However, we retain the right to come back to Congress if such support does not materialize!

The precursor to TRICARE Standard, the basic benefit provided for care in the civilian sector, was CHAMPUS. CHAMPUS was enacted when the direct military health care system could no longer provide care for all eligible beneficiaries. The relatively high deductibles for the time, 25 percent cost share for doctor visits and extremely high inpatient costs (currently \$535/day in non network hospitals), were included to discourage the indiscriminate use of CHAMPUS when care was available in the direct care system. However, CHAMPUS was then, as TRICARE Standard is now, an extension of the earned entitlement to health care. Charging a premium (enrollment fee) for TRICARE Standard moves the benefit from an earned entitlement to an opportunity to buy into an insurance plan. Active duty families appear to see this proposal from two points of view. First, the security of knowing their earned entitlement to health care would follow them into retirement has just flown out the window; and second, that the constant reference to other health insurance plans and the proposal to tie future increases to the Federal Employees Health Benefit Program (FEHBP) will eventually affect their own cost of health care. NMFA must also note that because TRICARE Prime is not offered everywhere, Standard is the only option for many retirees and their families and survivors who need to access their military health care benefit.

NMFA opposes DoD's proposal to institute a TRICARE Standard enrollment fee and believes Congress should reject this proposal because it changes beneficiaries' entitlement to health care under TRICARE Standard to just another insurance plan. However, we would be remiss if we did not ask the many questions beneficiaries have about how a Standard enrollment fee would be implemented and its implications regarding access to care:

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

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

NMFA strongly asserts DoD’s proposal to change the earned entitlement to health care into an opportunity to buy into an insurance plan breaks both faith and the implied contract with currently serving members and those who have retired. We urge Congress to reject any plan to establish a TRICARE Standard enrollment fee.

TRICARE Prime and TRICARE Standard

In the current debate about whether or not to raise beneficiary fees for TRICARE, NMFA believes it is important to understand the difference between TRICARE Prime and TRICARE Standard and to distinguish between creating a TRICARE Standard enrollment fee and raising the Standard deductible amount. As we have stated above, TRICARE Standard is the successor name for CHAMPUS, and as such is a civilian extension of the basic entitlement to health care originally provided only in military treatment facilities (MTF). At the start of TRICARE in 1995, when TRICARE Standard became the name for CHAMPUS, DoD also introduced an HMO-type benefit called TRICARE Prime. Since Prime offered enhancements to the

health care benefit (lower out-of-pocket costs, access to care within prescribed standards, additional preventive care, assistance in finding providers, and the management of one's health care), enrollment fees for Prime were charged for retirees. These fees, which have not changed since the start of TRICARE, are \$230 per year for an individual and \$460 per year for a family. Below is a general comparison of TRICARE Standard and Prime for retired beneficiaries under the age of 65 when they access care in the civilian sector. Retirees enrolled in Prime with an MTF provider also pay the annual enrollment fee, but do not have a co-payment for outpatient care and only a modest fee for inpatient care received in the MTF.

	Prime	Standard
Enrollment fees	\$230/year for an individual; \$460/year for a family	None
Annual Deductibles	None	\$150/individual; \$300 for a family
Outpatient co-payment (Prime)/cost share (Standard) for individual providers	\$12	25% of allowed charges ^{1,2}
Inpatient co-payment/cost share for individual providers	None	25% of allowed charges ^{1,2}
Daily inpatient hospitalization charge	Greater of \$11 per day or \$25 per admission	Lesser of \$535/day or 25% of billed charges if treated in non-network hospital ³
Emergency Services co-payment/cost share	\$30	25% of allowed charges
Ambulance Services co-payment/cost share	\$20	25% of allowed charges
Preventive Examinations (such as: blood pressure tests, breast exams, mammograms, pelvic exams, PAP smears, school physicals) co-payments/cost shares	None	25% cost share ^{1,2}

¹ Providers may charge 15% above the TRICARE allowable and the beneficiary is responsible for this additional cost, making the potential cost share 40%.

² If care is accessed from a TRICARE Prime/Extra network provider the cost share is 20%.

³ If care is received in a TRICARE Prime/Extra network hospital the daily hospitalization rate is the lesser of \$250/day or 25% of negotiated charges.

DoD's proposal to increase TRICARE Prime enrollment fees, while completely out-of-line dollar wise, is not unexpected. In fact, NMFA was surprised DoD did not include an increase as it implemented the new round of TRICARE contracts last year. NMFA views enrollment fees for Prime as justified because enrollees enjoy the additional benefits of access guarantees, lower out-of-pocket costs, more preventive care, and management of their health care. In other words, enrollment fees for Prime are not to access the earned entitlement, but for additional services.

NMFA does have concerns about the amount of DoD's proposed increases for TRICARE Prime and the plan to impose a tiered system of enrollment fees and TRICARE Standard deductibles. We believe the tiered system is arbitrarily devised and fails to acknowledge the needs of the most vulnerable beneficiaries: survivors and wounded service members. For example, under the DoD plan an individual retired officer or family member would pay an enrollment fee of \$700 for TRICARE Prime by FY 2008. The surviving spouse of a 2nd Lieutenant who died in Iraq last year will revert to retiree status in terms of health care in 2008. Under the DoD plan, she would pay the \$700 enrollment fee, the same as paid by a retired General Officer. A Marine with just a few years' service who is medically retired after sustaining a serious injury would pay the same premium for his/her family as would a retired E-6 who served twenty years.

Acknowledging that the annual Prime enrollment fee has not increased in more than 10 years and that it may be reasonable to have a mechanism to increase fees, NMFA would like to present an alternative to DoD's proposal should Congress deem some cost increase necessary. NMFA suggests DoD apply the cumulative retiree cost of living adjustment (COLA) to the base annual Prime enrollment fee of \$230 for an individual and \$460 for a family. Using the 31.4 percent cumulative COLA for the years from 1995 through 2006, the annual fee would rise to approximately \$302 for a single service member and \$604 for a family. If DoD thought \$230/\$460 was a fair fee for all in 1995, then it would appear that raising the fees simply by the percentage increase in retiree pay since then is also fair. NMFA also suggests that, to avoid another "sticker shock," fees be raised annually by the same percent as the retiree COLA. NMFA further believes adjusting the current fees over a two-year period would decrease the effect of "sticker shock" and allow families to adjust their budgets. We are aware the current system does require retirees/survivors with smaller incomes to pay a higher percentage of their pension/annuity for Prime than those with higher incomes; however, we believe the benefits of simply updating the current fees are greater for almost all concerned than devising another option, especially an arbitrarily-designed tier system. NMFA also suggests it would be reasonable to adjust the TRICARE Standard deductibles in the same manner: cumulative COLA for the years since 1995 and then tie future increases to the percent of the retiree annual COLA.

NMFA believes its alternative proposal to increase Prime enrollment fees and Standard deductibles using the cumulative retiree Cost of Living Adjustment (COLA) over the past ten years and to tie future increases to the same percent as the retiree COLA is a fair way to increase beneficiary cost shares should Congress deem an increase necessary.

Prime Access Standards and Quality of Care

NMFA remains concerned that prescribed access standards are not being met for enrolled TRICARE Prime beneficiaries at military treatment facilities (MTFs). No one is more cognizant of the need for superior health care to be provided to service members in harm's way than their families. In addition, no one is more willing to change providers or venues of care to accommodate the need for military health care providers to deploy than the families of those deployed. However, a contract was made with those who enrolled in Prime. Beneficiaries must seek care in the manner prescribed in the Prime agreement, but in return they are given what are supposed to be guaranteed access standards. When an MTF cannot meet those standards, appointments within the civilian TRICARE network must be offered. In many cases this is not happening and families are told to call back next week or next month. MTFs must be held as accountable as the Managed Care Support Contractors for meeting stated access standards. In addition, requests for referrals for specialty care must not be held up beyond access standards simply to meet some arbitrary "right of first refusal" standard. MTFs must be as responsive to civilian providers regarding care provided to beneficiaries in the direct care system as the contracts require civilian network providers to be to the MTF for beneficiaries referred within the civilian network. Beneficiaries should not be caught in a bureaucratic "catch 22" when care is needed from both venues.

Because operational requirements have reduced the number of uniformed health care personnel available to serve in the MTF system, a more coordinated approach is needed to optimize care and enable MTFs to meet access standards. Efficient contracting for health care staffing could increase the amount of care provided in the direct care system, thereby reducing the overall cost of care to the military health care system. NMFA suggests Congress direct DoD to reassess the resource sharing program used prior to the implementation of the T-Nex contracts and take the steps necessary to ensure MTFs meet access standards with high quality health care providers.

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

Obstetrical and Pediatric Reimbursement Rates

NMFA thanks the Congress for requiring the Comptroller General to investigate reimbursement levels for obstetrical and pediatric care. We continue to

receive concerns from families that finding providers in these two specialties is extremely difficult in many areas. We look with anticipation to the report and request appropriate legislation if DoD does not propose adequate remedies for the situation.

Deployment Health for Service Members and Families

As service members and families experience numerous lengthy and dangerous deployments, NMFA believes the need for confidential, preventative mental health services will continue to rise. The Services must balance the demand for mental health personnel in theater and at home to help service members and families deal with unique emotional challenges and stresses related to the nature and duration of continued deployments. The good news for family support professionals who believe military families are reluctant to seek help for mental health issues is that many now recognize counseling is an option for them. Families perceive counseling and mental health support as especially helpful if it is confidential and with a professional familiar with the military. One spouse who completed NMFA's recent *Cycles of Deployment Survey* stated:

Three deployments have caused great mental strain on me as the spouse of a service member. Thank goodness for mental health services, which I have used for more than a year now and will continue to use. I have to work daily on managing depression and anxiety, which I feel are a direct result of the deployments.

The Services recognize the importance of educating service members and family members about how to achieve a successful homecoming and reunion and have taken steps to improve the return and reunion process. Information gathered in the now-mandatory post-deployment health assessments may also help identify service members who may need more specialized assistance in making the transition home. Successful return and reunion programs will require attention over the long term. Many mental health experts state that some post-deployment problems may not surface for several months or years after the service member's return. NMFA is especially concerned that not as many services are available to the families of returning Guard and Reserve members and service members who leave the military following the end of their enlistment. Although they may be eligible for transitional health care benefits and the service member may seek care through the Veterans' Administration, what happens when the military health benefits run out and deployment-related stresses still affect the family?

Military OneSource (www.militaryonesource.com) helps returning service members and families access local community resources and receive up to six free face-to-face mental health visits with a professional outside the chain of command. NMFA is pleased DoD has committed to funding the counseling provided under the OneSource contract. This counseling is not medical mental health counseling, but rather assistance for family members in dealing with the stresses of deployment or reunion. It can be an important preventative to forestall more serious problems down the road.

NMFA notes, however, that Military OneSource is only available for members of the four Services under the authority of the Department of Defense. The parent Departments of the Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration (NOAA) operate their own Employee Assistance Programs (EAPs) and provide some of the same information through them as Military OneSource. However, these EAPs may not be equipped with the resources and experience to provide the same type of deployment-related information and assistance as offered by Military OneSource. We ask Members of this Subcommittee to urge the appropriate Committees with jurisdiction over the three uniformed services not part of DoD to work with DoD and ensure deployed members of all uniformed services and their families have access to the same level of deployment-related assistance—including the face-to-face counseling services—provided under Military OneSource.

NMFA remains concerned about access to mental health care, both preventative and therapeutic, for the long haul. Unfortunately the costs of war may linger for service members and their families for many years. It is imperative that whether or not the member remains on active duty and entitled to military health care there are provisions for both service members and their families to access appropriate mental health services paid for by their government.

Wounded Service Members Have Wounded Families

Post-deployment transitions could be especially problematic for injured service members and their families. NMFA asserts that behind every wounded service member is a wounded family. We have been pleased the military medical centers are involving Department of Veterans' Affairs (VA) personnel to ease wounded service members' transition to civilian life and care in the VA. The transition between the DoD and the VA health system can be confusing for service members and their families. In the case of the severely disabled, there should be an individual written transition plan that is explained in full to the supporting family members. Robust transition, employment and training programs for wounded/injured service members and their family members are also important for seamless transition to occur. Wounded service members who are medically retired need more information on the full benefit package available to them from both DoD and the VA. They especially need more education about their eligibility for both DoD and VA health care and when it is most appropriate to use each system.

To ease wounded service members' and their families' health care transition and reduce their out-of-pocket costs in the years immediately following their injury, we urge Congress to allow wounded/injured service members who are medically retired and their families to be treated as active duty family members in terms of TRICARE costs and access to care at military hospitals for three years following the service members' retirement. This change would mirror the three-year transitional status provided to surviving spouses of active duty deaths.

Family Assistance Centers (FACs) established at Walter Reed and other major medical centers have proved invaluable in assisting families of wounded service

members and in providing a central location to filter community offers of help. NMFA is hearing the Services are now sending more wounded service members back to their home installations sooner to receive care at their home installation MTF—which could be a community hospital rather than a medical center. Therefore, NMFA believes Family Assistance Centers are urgently needed in every MTF that treats injured service members. In addition to the recreation, travel, and emergency support these centers provide, they also assist the family in dealing with the service member's transition back home.

NMFA applauds recent provisions in FY 2006 NDAA that require standards for assisting wounded and injured service members. NMFA strongly encourages the Services to cooperate and expedite the standardization of programs. NMFA has heard from families of wounded service members that they are not offered the "same services." An injured Soldier, Airman, Sailor, or Marine should be offered access to the same services as the Soldier, Airman, Sailor, or Marine recuperating in the bed next to them in a military hospital. We continue to ask that the role of the DoD and the VA be clearly explained and delineated and joint efforts between all the Services and the VA, in support of the service member and family, continue to be the priority.

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

Health Care for Survivors

NMFA thanks Congress for including Section 715 in the FY 2006 NDAA, which allows surviving children of active duty deaths to be treated as active duty family members for purposes of enrolling in TRICARE Prime until they age out of TRICARE. We and the surviving families who contact us are waiting—slightly impatiently—for word from DoD on how this important benefit change will be implemented. To date, we have not received this information.

This year, we ask for consideration of several other proposals to ease the health care transition for survivors of active duty deaths. First, we ask Congress to update the survivor benefit to enable survivors of active duty deaths to enroll in TRICARE Prime Remote during the time they are treated as active duty family members for health care—three years for the spouse. Some survivors may immediately relocate to the area where their parents live for the security and support they need. Others may remain for their one year entitlement in government quarters and then relocate to family or for the necessity of employment. In these cases, the area to which the survivors have relocated may not be one in which TRICARE Prime is offered. It seems reasonable these survivors should be able to qualify for the Prime Remote option during the period when they are treated as active duty family members in terms of TRICARE to minimize their out of pocket costs during this traumatic transition time.

National Guard and Reserve families may choose to keep their employer sponsored health and dental care when their service member is activated and deployed. The family's eligibility for this care may cease if the service member is killed on active duty. Legislative changes are needed to enable these family members to take advantage of their survivor benefit for coverage under the TRICARE Dental Program (TDP), the dental insurance for active duty families. As the law is currently written, with limited exceptions, only those families enrolled in the TRICARE Dental Program (TDP) at the time of the service member's death are eligible to continue enrollment and receive premium-free dental insurance for three years. NMFA recommends, in cases where the family has employer sponsored dental insurance, survivors be treated as if they had been enrolled in the TRICARE Dental Program at the time of the service member's death.

Survivors of those who die on active duty or in retirement justly lose their entitlement to DoD benefits to include access to commissaries, exchanges, MWR benefits, and health care when they remarry. Survivors eligible for the Veterans' Administration CHAMPVA program are eligible for health care reinstatement if their second marriage ends, but NOT those previously eligible for DoD-provided health care, even though their entitlement for all other benefits is reinstated. NMFA requests this inequity be removed and these survivors have their health care entitlement restored.

In cases where the family of a deceased service member has been enrolled in an employer-sponsored dental plan, NMFA recommends survivors be treated as if they had been enrolled in the TRICARE Dental Program at the time of the service member's death. We also recommend that Congress update the TRICARE benefit provided in the period following the service member's death in which the surviving spouse and children are treated as their active duty family members and allow them to enroll in TRICARE Prime Remote.

National Guard and Reserve Health Care

NMFA also asks for an update to the TRICARE Prime Remote eligibility rules for some National Guard and Reserve families. While Guard and Reserve families in remote locations may be eligible for Prime Remote while their service member is on active duty, they lose their eligibility once the service member is demobilized and is eligible for the 180-day Transitional Assistance Management Program (TAMP) benefit. We believe, for the sake of continuity of care as well as the family's financial stability during the Guard or Reserve member's transition back to civilian life, the service member and family should retain eligibility for Prime Remote during the TAMP period.

NMFA thanks Congress for extending the ability to buy into TRICARE to members of the Selected Reserve, but is concerned the "one shoe fits all" solution does not translate into continuity of care for all their families when the member is mobilized. Certainly those with no access to health care insurance will benefit from the ability to buy into TRICARE and thus ensure their families have continuity of care when they are mobilized. However, a large segment of this population has

employer-provided health insurance and for their families continuity of care would best be achieved by a DoD subsidy of this insurance when they are mobilized. Having to change health care plans and possibly providers when the member is going in harm's way are not conducive to family readiness!

We also ask you to monitor the process by which DoD determines rates for TRICARE Reserve Select. We were just as surprised as the Reserve Select beneficiaries when DoD chose to increase premiums for this program so soon after its implementation. NMFA was also concerned at the percentage increase in the premium, which was tied to the premium increase for the standard option Blue Cross/Blue Shield plan offered under the Federal Employees Health Benefits Program (FEHBP).

To promote continuity of care for families of mobilized Guard and Reserve members, NMFA asks that Congress authorize DoD to subsidize the cost of family coverage under the member's employer-sponsored health insurance while the service member is mobilized. NMFA also asks Congress to monitor the premium-setting process used by DoD for TRICARE Reserve Select.

Pharmacy

NMFA applauds DoD's proposal to encourage migration to the TRICARE Mail Order Pharmacy (TMOP) by removing cost shares for generic medications. NMFA and other associations have long encouraged DoD to launch a concentrated marketing effort to promote use of the TMOP, as it provides significant savings to beneficiaries as well as huge savings to the Department. The proposed beneficiary cost share increases in the pharmacy retail network program (TRRx) are not as exorbitant as the proposals for increases in Prime enrollment fees, the premium to access TRICARE Standard, or the increase in Standard deductibles, but do represent a 67 percent increase for all beneficiaries. If some additional cost share for TRRx is instituted, NMFA believes it should not be implemented until all of the medications available through TRRx are also available through TMOP and DoD joins the associations in actively and strongly promoting use of the TMOP.

NMFA is most grateful to Congress for establishing the Beneficiary Advisory Panel to review and comment on the recommendations of the Pharmacy and Therapeutics Committee for the Uniform Formulary. It appears as though the process has been beneficial to both groups and a good working relationship has been established. However, NMFA has several concerns. First, even when the majority of the panel recommends against a Pharmacy and Therapeutics Committee recommendation, there is no feedback on why its comments were rejected by the final decision maker, the Director of the TRICARE Management Agency. While NMFA would certainly not suggest the Director "report" to the Panel, in the spirit of collegiality, a direct communication to the Panel on why their recommendations were rejected would enhance the working relationship. Second, NMFA and our fellow associations were initially assured few drugs would move to the nonformulary or third co-payment tier. Yet in the first year of the process, 41 drugs out of 131 considered have been moved to the third tier. Third, the law clearly states

Congressional intent that beneficiaries were to have access to nonformulary drugs; they just had to pay more for them. However, an internal DoD policy currently appears to require MTF providers to write prescriptions only for drugs that are available on that MTF's formulary, unless medical necessity has been determined. Hence, beneficiaries treated at an MTF are precluded from accessing nonformulary drugs at either the TRRx or the TMOP, even if they are willing to pay the higher cost share. Finally, it is well understood, and NMFA has no great argument with the premise, that the process of establishing a Uniform Formulary was to provide clinically appropriate drugs at a cost savings to the Department. We believe information must be gathered to determine if the Uniform Formulary process is meeting the desired goals.

NMFA requests the Government Accountability Office be asked to conduct a review to see if the Uniform Formulary process is producing the savings projected and the extent, if any, beneficiaries believe they have been denied medications they and their provider believe would be more clinically appropriate for them.

Health Care for Special Needs Family Members/ECHO

On September 1, 2005, the TRICARE Management Activity (TMA) at last implemented the Enhanced Care Health Option (ECHO), which was authorized in the FY 2002 NDAA as the replacement for the Program for Persons with Disabilities (PFPWD). ECHO is intended to provide additional benefits to active duty family members with a qualifying mental or physical disability, generally defined as: moderate or severe mental retardation; a serious physical disability; or an extraordinary physical or psychological condition of such complexity that the beneficiary is homebound. The program recognizes the additional challenges faced by active duty families because of the service member's deployment or frequent relocations that often make accessing services in the civilian community difficult.

ECHO offers services and supplies beyond the basic TRICARE benefit covered in Prime and Standard, up to a maximum of \$2,500 per eligible family member per month, a \$1,500 increase over the Program for Persons with Disabilities' (PFPWD). Additionally, some beneficiaries may qualify for ECHO Home Health Care (EHHC), which provides medically-necessary skilled services to eligible homebound beneficiaries. Families registered in ECHO pay a rank-based monthly cost share. They must be enrolled in their Service Exceptional Family Member Program (EFMP) in order to receive ECHO services.

Active duty families with a special needs family member had eagerly awaited the often-delayed implementation of ECHO. While the numbers of eligible beneficiaries for ECHO is much smaller than for the PFPWD because certain services covered by the PFPWD have now been moved to the basic TRICARE benefit, there have been numerous problems with the transition to the new program. These problems generally fall into three areas: information about ECHO eligibility and how to access services, obtaining covered respite care, and changes in TRICARE coverage for Applied Behavioral Analysis (ABA) therapy.

In the early months of ECHO implementation beneficiaries generally reported confusion about eligibility for ECHO services, what services are covered, and how to obtain the needed authorization for these services. Because of the relatively-small numbers of eligible beneficiaries, the TRICARE contractors generally chose to manage the information flow through its case managers rather than through its TRICARE Service Centers or customer service lines. Beneficiaries who grew frustrated with a lack of answers to their questions had to learn from each other to ask for a case manager or someone familiar with ECHO when seeking assistance.

Respite care is a new benefit under ECHO that was not available under the PFPWD and was probably the most anticipated of all ECHO benefits. There are two types of respite care benefits: the ECHO respite care benefit of 16 hours per month when receiving other ECHO services and the ECHO Home Health Care “sleep benefit” of 8 hours per day for 5 days each week. Because of some confusion about what other services are covered under ECHO or a difficulty in accessing these services, many beneficiaries found they were not eligible for the ECHO respite care benefit. Families had looked forward to this service because it would give the parents the opportunity to spend time together or with their other children without worrying about the care of the special needs child. Beneficiaries have also told NMFA they and their TRICARE contractors have been confused about the type of provider qualified to provide the respite care services. Often, local home health agencies are geared toward providing care for the elderly and not for children. In some locations, there are not enough agencies available to meet the demand for these services.

Beneficiaries who cannot obtain respite care services note a benefit isn't a benefit if you can't access it. Complaints of a hollow benefit have been heard most often in connection with the provision of Applied Behavior Analysis (ABA) services for children with autism. ABA is a type of educational therapy that has been effective for some children with types of autism. In recent years, DoD paid for ABA therapy under the PFPWD and promised it would continue as a benefit under ECHO. Unfortunately, many military children who received ABA therapy under the PFPWD lost these services when they were transitioned to ECHO. With the implementation of ECHO, DoD chose to change its standards for authorizing and paying ABA providers. At issue is who provides the hands-on, in-home therapy that is the key to effective ABA therapy. Currently, the industry standard for treatment in ABA therapy is that certified ABA therapists develop the treatment plan and train and supervise tutors who provide the hands-on therapy, often several times each week. Formerly, DoD paid for therapy following this standard. With the implementation of ECHO, DoD announced it would only pay for ABA therapy when it was done by the board-certified therapist and not by a tutor operating under the therapist's supervision.

DoD has argued this change is necessary to ensure therapy is provided by qualified providers. Unfortunately, there are not enough board-certified therapists in the field to meet the demand for this therapy and as a result military families are reporting their children are losing ground in their ability to learn and function because their services have been scaled back or curtailed. Of course NMFA believes

DoD should have high quality standards for all providers; however, we are concerned the Department is ignoring industry standard and is opting to eliminate a benefit promised under ECHO rather than devise a more reasonable way to ensure quality. We find it ironic that DoD officials talk about the need for highly trained providers but yet have suggested parent training in ABA therapy as a viable alternative to paying for trained tutors working under the supervision of certified providers. NMFA does not disagree that parents should be knowledgeable about the therapy in order to reinforce the work done by the tutor during the home visits. However, parents should not be the DoD-authorized replacements for trained therapists!

NMFA requests this Subcommittee direct DoD to meet military families' needs for promised services under ECHO and to revise policies that would deny special needs family members access to these services.

Retiree Dental Insurance

NMFA frequently hears from individuals in the two categories of TRICARE-eligible beneficiaries who were not included in the list of eligibles in the legislation creating the TRICARE Retiree Dental Plan. We recommend Congress add military retirees and their families who live overseas as well as TRICARE-eligible former spouses to the list of eligible beneficiaries for this plan. Since the TRICARE Retiree Dental Plan is not subsidized by DoD, there is no cost to the Department to include these otherwise TRICARE eligible beneficiaries.

NMFA requests TRICARE eligible former spouses and military retirees and their family members who live overseas be allowed to participate in the TRICARE Retiree Dental Plan.

Health Care Implications of Transformation, Global Rebasing, and BRAC

NMFA believes it imperative the full spectrum of health care be available to families at losing or closing installations until the last family has left and also be in place before the first new family arrives at a gaining installation. NMFA is fully aware this cannot be accomplished solely through the direct care system. However, the Managed Care Support Contractors must be required to meet the need when the direct care system cannot and to do so within the Prime access standards. In communities experiencing an increase in active duty population, this may mean they will need to recruit more family practice providers, pediatricians, and OB/GYNs for their networks. Because of housing patterns in affected communities, more network providers may be needed in locations farther from the installations than are currently required. For example, the North region contractor has already had to recruit additional network providers in the Syracuse, New York, area because families of service members stationed at Fort Drum have been forced to find housing there. The contractors must also be prepared to work together to ease the transition of large numbers of active duty members and their families from installation to installation, in many cases across regional boundaries.

In addition, NMFA is concerned about other beneficiaries, to include those who are medically retired and survivors, who may be left without access to an MTF

at closing or downsizing installations. At a minimum, Prime must continue to be an option in BRAC areas and a robust network of providers, to include all relevant specialists, must be in place before an MTF downsizes or closes. In areas where military hospitals are being downsized to outpatient clinics, every effort must be made to ensure continuity of care for beneficiaries needing to move back and forth between the direct care and purchased care segments of the military health system. DoD must ensure the contractors develop adequate hospital networks to replace care now provided in the direct care system.

Family Readiness

NMFA recognizes and appreciates the continued focus all the Services are placing on family readiness. Family readiness affects a service member's entire career from recruitment to retention to retirement. DoD must continue to refine and improve family readiness programs not only because it is the right thing to do, but also to retain highly trained and qualified service members.

In NMFA's recent *Cycles of Deployment Survey*, respondents' comments paint a picture of both successes and failures in the family support/readiness arena. A common theme was the desire for a "purple" family support system. As an active duty Army spouse stated: *"We are all in this together—it doesn't matter the branch of service."* What matters to the family is that the information and support that they are promised is provided in a consistent manner. Accessing the right information when they need it continues to be a critical issue for Guard and Reserve families who generally have very limited access to military installations. Like the families in our survey, NMFA believes family support agencies must reach out to all families located in their geographical area regardless of Service affiliation.

Evidence of this need for outreach by strong, well-coordinated programs was seen in the confusion and frustration experienced by so many uniformed service families in the wake of Hurricane Katrina and in the responses initiated by their Services. In the wake of the disaster and in response to calls from families and family support providers alike, NMFA worked quickly to compile contact and support information for all agencies and Services in order to be able to provide accurate and timely advice to families. While we were happy to provide a one-stop information portal for families from all the uniformed services and while the individual Services ended up offering a wide variety of information and support resources, we just kept thinking how nice it would have been if military leaders had focused more from the beginning on working together to meet families' needs.

NMFA applauds the various initiatives designed to meet the needs of service members wherever they live and whenever they need them. DoD must have the flexibility to meet emerging needs, the mandate to reach out to families, and the resources to ensure continuation of the "bedrock" support programs. Whenever possible, these programs should focus on a joint solution and reach out to all family members, including parents of single service members.

Caring for Military Children and Youth

Frequent deployments and long work hours make the need for quality affordable and accessible child care critical. We thank Congress for making additional funding available for child care since the beginning of the Global War on Terror. We were pleased that DoD has requested military construction for eight child development centers for FY 2007. The communities slated to receive these centers desperately need them. Currently, DoD estimates it has a shortage of 31,000 child care spaces within the system, not counting the demand from the mobilized Guard and Reserve community. While efforts are being made to bridge this gap, thanks in part to Congressional funding for child care over the past few years, additional innovative strategies are needed. Programs such as *Military Child Care in Your Neighborhood* and *Operation Military Child Care*, which assist military families in finding and paying for child care, are welcome pieces of the solution, but are insufficient to completely meet all the need.

Older children and teens cannot be overlooked. Parents tell us repeatedly they want resources to “help them help their children.” NMFA is working to meet this need through programs such as our Operation Purple summer camps and a pilot after school program for children of deployed service members. We also applaud the partnership between DoD and Johns Hopkins School of Public Health to assist school personnel in helping military children deal with frequent moves or the deployment of a parent. We urge Congress to increase its funding for schools educating large numbers of military children. This supplement to Impact Aid is vital to these districts, which have shouldered the impressive burden of ensuring military children receive a quality education despite the stresses of military life.

Schools serving military children, whether DoD or civilian schools, need the resources to meet military parents' expectation that their children receive the highest quality education possible. Because Impact Aid funding from the Department of Education is not fully funded and has remained flat in recent years, NMFA recommends increasing the DoD supplement to Impact Aid to \$50 million to help districts better meet the additional demands caused by large numbers of military children, deployment-related issues, and the effects of military programs and policies such as family housing privatization. Initiatives to assist parents and to promote better communication between installations and schools should be expanded across all Services.

Spouse Employment

In recent years, DoD has sponsored a variety of programs, including a partnership with Monster.com, to promote spouse employment. However, with 700,000 active duty spouses, the task of enhancing military spouse employment is too big for DoD to handle alone. NMFA encourages more private employers to step up to the plate and form partnerships with local installations and DoD. We ask DoD to reach out to potential employers and acquaint them with the merits of hiring the members of this talented and motivated work force.

Despite greater awareness of the importance of supporting military spouse career aspirations, some roadblocks remain. State laws governing unemployment compensation vary greatly regarding eligibility for military spouses who have moved because of a service member's government ordered move. NMFA is appreciative of DoD's efforts to work with states to promote the award of unemployment compensation to military spouses, eligibility for in-state tuition, and reciprocity for professional licenses.

NMFA asks Congress to promote federal and state coordination to provide unemployment compensation for military spouses as a result of Permanent Change of Station (PCS) orders. State governments should be encouraged to look at ways to make college credits and fees more easily transferable and also explore paths towards national standards or reciprocity for licensing and professional certification. DoD and private sector employers who protect employment flexibility of spouses and other family members impacted by deployment should be applauded and used as role models for others to follow. Last, but not least, military spouses should be encouraged to use all available resources to educate themselves about factors to consider regarding employment benefits, to include investments, health care, portability and retirement.

Families and Deployment

In July of 2004, NMFA published ***Serving the Home Front: An Analysis of Military Family Support from September 11, 2001 through March 31, 2004.*** This report noted progress made to the military's support of its families during the first eighteen months of the Global War on Terror. Understanding the need for further research and information on the long-term effects of repeated deployments and the reunion and reintegration of both active and reserve component families, NMFA developed its ***Cycles of Deployment*** survey. This survey was active on the NMFA website between April and November 2005 and received 1,592 responses. The message from military families came through loud and clear: families cannot nor should they have to make it through a deployment alone. They expect family support to be available to all, regardless of their Service component or where the family lives. Respondents acknowledged they had a role to play in their own family readiness; however they looked to their commands, their unit volunteers, and their communities to recognize their sacrifice and help them make it through deployments.

NMFA could not agree more. We are pleased to note the progress made on innovative ways in which families can communicate with command and family readiness/support groups. The Army Virtual Family Readiness Group (VFRG) has just recently gone live and will soon be able to connect up to 800 battalions with family members and significant others, to include spouses, children, fiancés, parents, and extended family members. VFRGs should be a tremendous help in meeting the needs of geographically-dispersed service members, Guard and Reserve members, and individual augmentees and their families who feel left "out of the communication loop" and consistently ask: "who's my group?"

As deployments have continued, the Services have refined programs dealing with the return and reunion process. Families worry about how the reunion will go even as they are worrying about the service member's safety in theater. Attention also needs to be placed on how children, at varying stages of their lives, reconnect with a parent who in all likelihood will be deployed again sometime soon.

Families need to be better educated in how to deal with problems that could surface months after the service member returns.

Multiple deployments are no longer the exception but rather the norm. Families experiencing a second or third deployment never start from the same place. Along with skills acquired during the first deployment, there are unresolved anxieties and expectations from the last. New families are entering the cycle, whether they are new recruits, service members deploying with new units, or families whose life situations have changed since the last deployment. More families seem willing to seek mental health care and counseling but it is not always readily available. Many of our survey respondents called for counselors to be assigned to unit family readiness groups, as well as on-call professionals who would be available to deal with troubled families or the emergency situations currently being thrust on often inadequately trained volunteers. NMFA applauds the Soldier and Family Life Consultants Program, which is used by the Army to provide additional preventative counseling support to Soldiers and their family members, especially following Soldiers' return from deployments. The number of Army installations using this program is growing; services have also been provided to the Marine Corps Reserve for returning units. NMFA recommends increased funding for this program and for DoD to provide the option to expand it to all Services.

Higher stress levels caused by open-ended and multiple deployments require a higher level of community support. We ask Congress to ensure the Services have sufficient resources to provide robust quality of life and family support programs during the entire deployment cycle: pre-deployment, deployment, post-deployment, and in that critical period between deployments. Programs must also address the specific needs of family volunteers, who make up the front line of family readiness.

Families and Transition

Transitions are part of the military life. For the individual military family, transitions start with the service member's entrance in the military and last through changes in duty station until the service member's separation or retirement from the service. Another transition comes with the injury or death of the service member. National Guard and Reserve families face a transition with each call-up and demobilization of the member. The transition to a restructured military under Service transformation initiatives, Global Rebasing, and Base Realignment and Closure (BRAC) will affect service members, their families, and their communities.

Transformation, Global Rebasing, and BRAC

As the Global Rebasing and the BRAC process are implemented, military families look to Congress to ensure key quality of life benefits and programs remain accessible. Members of the military community, especially retirees, are concerned

about the impact base closures will have on their access to health care and the commissary, exchange, and MWR benefits they have earned. They are concerned that the size of the retiree, survivor, Guard, and Reserve populations remaining in a location will not be considered in decisions about whether or not to keep commissaries and exchanges open. In the case of shifts in troop populations because of Service transformation initiatives, such as Army modularity and changes in Navy home ports, or the return of service members and families from overseas bases, community members at receiving installations are concerned that existing facilities and programs may be overwhelmed by the increased populations.

NMFA cannot emphasize enough the urgency for DoD and Congress to allocate resources now to support communities involved in movements of large numbers of troops. Increased visibility of issues such as the smooth transition of military children from one school to another and a military spouse's ability to pursue a career means that more family members will expect their leadership to provide additional support in these areas.

Army transformation has already had an impact in some communities. Installations such as Fort Drum, Fort Campbell, and Fort Lewis and their surrounding communities expect strains on housing availability—both on and off-base—health care access, and school capacity. Fort Riley and Fort Carson are already seeing the troops arriving from overseas installations being downsized. The latest news is that the Army will move approximately 7,200 soldiers and 11,000 family members from Germany to stateside installations during FY 2006. Over the next five or six years, U.S. Army Europe will reduce from 62,000 soldiers to 24,000. Several communities in Europe will also grow, as the remaining troops are consolidated into fewer locations. The Department of Defense must do more now to ensure that communities have the resources to support these increased populations.

Most of the Army installations expecting an increase in population have already privatized their housing or expect to do so soon. Privatization contracts were structured to deal with those installations' housing needs at the time the contracts were signed, and not in anticipation of the arrival of several thousand service members and their families. At most of these installations, waiting lists for housing on the installation are common now. What will happen when the troops arrive from overseas? Where will their families live? The Services generally deem the amount of housing in the area surrounding an installation is adequate if enough exists within a forty-mile radius of the installation. Forcing military families, especially those of junior enlisted service members, to live that far from the installation will increase their financial hardships because of transportation costs, as well as their isolation from the military community.

We ask you to seek information from the Services on housing capacity, not just on the installations anticipating growth, but also in the surrounding communities. We also ask you to encourage DoD to re-negotiate housing privatization contracts or authorize more military construction funding where appropriate to increase the housing stock on affected installations and to look for

other innovative ways to meet housing demands caused by these troop movements. We urge you to pay particular attention to the effect of the influx of service members and families on local housing costs to ensure that sufficient funding is provided for Basic Allowance for Housing (BAH) in these communities.

We also urge Congress to remember that, as families are forced to seek housing farther from the installation, they lose some of their connection with other military families and the military community. The installation is the focal point for the military family. When families are scattered in towns and subdivisions miles from the installation, they lose not only their link to that focal point but also find it more difficult to access the support services—commissaries, exchanges, health care, youth programs, chapel programs, family readiness activities—offered on the installation. The challenge to the installations experiencing growth will be to reach out to isolated families and let them know they remain a part of the community. Leaders will also have to answer the question of what MWR programs and family support services must be available for families regardless of their location and which can be offered only to families who can or choose to access them on an installation on a regular basis. Will additional subsidies be available for child care slots at civilian facilities? Should family center personnel operate satellite facilities or do outreach to areas farther from an installation? How valuable is a commissary or exchange benefit if a young family must drive 45 miles to reach it? How can DoD help these families located far from an installation access their benefits?

We are pleased Congress has directed DoD to report on the impact of troop and family movements on schools. We thank Congress for providing funds to assist schools in meeting the additional costs that come with the arrival of large numbers of military students. We believe this DoD funding—\$7 million appropriated for this year vice \$10 million authorized—will be needed in larger amounts for several years until districts are able to secure resources from other federal, state or local resources. Because many incoming families may be forced to find housing farther away from the installation than families now live, they may find themselves in school districts that have little experience with military children. Nevertheless, they will expect these schools to have the resources needed to educate their children properly. Schools must have at least 20 percent military student enrollment to qualify for additional funds for schools experiencing an increase in student population due to transformation, rebasing, or BRAC, according to Section 572 of the FY 2006 NDAA. That means schools with the least experience with military children, who potentially could see significant increases in their military population, will not qualify for assistance from DoD. What message does this send to these communities and to the military families who must move there about DoD's concern about the quality of education there?

Quality of life issues that affect service members and families must be considered on an equal basis with other mission-related tasks in any plan to move troops or to close or realign installations. Regarding the DoD funding for schools experiencing an increase in the number military children, NMFA recommends eligibility be based on increases in population alone and not on the percentage of military children already in the district.

DoD must provide support for all districts facing a large influx of military children, those facing rising enrollments of military students for the first time as well as those currently educating a high percentage. We want these districts to welcome military children and not blame them for cutbacks in services because the schools could not receive DoD funds to assist them in supporting these children.

Survivors

NMFA believes the obligation as articulated by President Lincoln, "...to care for him who shall have borne the battle and for his widow and his orphan," is as valid today as it was at the end of the Civil War. We are most grateful to Members of this Committee for your advocacy in providing the increased death gratuity of \$100,000 to survivors of all active duty deaths as part of the FY 2006 NDAA. NMFA would also like to thank Senator Carl Levin, Ranking Member of the full Committee, for requesting budget authority for \$45 million to provide the same enhanced death gratuity to the survivors of certain service members who died between May 12, 2005 and August 31, 2005. A gap between the language of the FY 2005 Emergency Supplemental and that of the FY 2006 NDAA inadvertently denied the enhanced death gratuity to these survivors. NMFA hopes this situation can be fixed as soon as possible.

NMFA also appreciates the work done this year by DoD and the Services to improve the education of casualty assistance officers and to make sure survivors are receiving accurate information in a timely manner. A new DoD publication will soon be available for each surviving spouse and/or parent outlining the benefits available to them. It is an on-line document and can be easily updated as changes occur. It will be supplemented by Service-specific information. NMFA also looks forward to the results of the GAO study on the casualty notification and assistance process.

DoD and the VA have formed a committee to examine procedures and review complaints that they hear about the present casualty notification and assistance process and have included stakeholders like the Gold Star Wives, the Transition Assistance Program for Survivors (TAPS), the military relief societies, and NMFA. These initiatives provide a response to the recent language included in the FY 2006 NDAA, which requires DoD to develop and implement a comprehensive casualty assistance program that offers training of casualty assistance officers, centralized case management, personalized benefits information for survivors, financial counseling, and liaison with VA and Social Security. While we still hear from some widows that they received wrong or incomplete information from their casualty assistance officer, these problems are quickly resolved when surfaced to the higher headquarters. We are concerned, however, about the widows or parents who still do not know who to call when there is a problem.

An area that NMFA feels could still be addressed is the need for specific training in bereavement and other counseling for family readiness group leaders, ombudsmen, and key volunteers. Many widows say they suddenly felt shut out by their old unit or community after the death of their service member. Often the

perceived rejection is caused by a lack of knowledge on the part of other families about how to meet the needs of the survivors in their midst. Because they find contact with survivors difficult, they shy away from it. In some communities, support groups outside the unit family support chain have been established to sustain the support of the surviving families in the days and months after the death of the service member. Fort Hood, Texas, for example, has a special command-sponsored support group for the widows in the surrounding area. We have been especially pleased to note the development of the "Care Team" concept at a growing number of installations. Care Teams are family volunteers who receive special training to assist survivors immediately after the casualty notification. Key in making the Care Teams effective is the extensive training received by the volunteers and the de-briefing of these volunteers by chaplains or other trained counselors that occurs after their contact with the surviving family members.

NMFA believes the benefit change that will provide the most significant long term advantage to the surviving family's financial security would be to end the Dependency Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP). DIC is a special indemnity (compensation or insurance) payment that is paid by the VA to the survivor when the service member's service causes his or her death. It is a flat rate monthly payment of \$1,033 for the surviving spouse and \$257 for each surviving child. The SPB annuity, paid by the Department of Defense (DoD) reflects the longevity of the service of the military member. It is ordinarily calculated at 55% of retired pay.

Surviving active duty spouses can make several choices, dependent upon their circumstances and the ages of their children. Because SBP is offset by the DIC payment, the spouse may choose to waive this benefit and select the "child only" option. In this scenario, the spouse would receive the DIC payment and her children would receive the full SBP amount until the last child turns 18 (23 if in college), as well as the individual child DIC until each child turns 18 (or 23 if in college). Once the children have left the house, this leaves the spouse who has chosen this option with an annual income of \$12,396. In each case, this is a significant drop in income from what the family had been earning while on active duty. The percentage of loss is even greater for survivors whose service members had served longer. Those who give their lives for their country deserve more fair compensation for their surviving spouses. We urge Congress to intensify efforts to eliminate this unfair "widow's tax" this year.

As part of the standardization and improvement of the casualty assistance process, more effort needs to be placed on supporting the long-term emotional needs of survivors and of communities affected by loss. NMFA recommends that the DIC offset to SPB be eliminated. Doing so would recognize the length of commitment and service of the career service member and spouse and relieve the spouse of making hasty financial decisions at a time when he or she is emotionally vulnerable. To ensure the VA continues to meet survivors' long-term needs, NMFA recommends the establishment of a Survivor Office within the VA to provide long-term information and support for surviving spouses and

children and offer individualized information about each surviving family's benefit package.

Compensation and Benefits

NMFA appreciates the military pay raises set above the Economic Cost Index (ECI) for the past several years. They serve as both an acknowledgement of service and recognition of the need for financial incentives as a retention tool. As DoD prepares its Quadrennial Review of Military Compensation, NMFA hopes Congress, in evaluating its recommendations, considers their effects on the whole pay and compensation package. Changes in individual elements of that package can have unintended consequences on other elements or on the package as a whole. And, while pay raises are important, equally important is the need to maintain the non-pay benefit package that makes up such a vital part of military compensation.

Funding for Commissaries, MWR and other Programs

Commissaries, exchanges, recreational facilities and other Morale, Welfare, and Recreation (MWR) programs are an integral part of military life and enhance the overall quality of life for service members and their families. Respondents to NMFA's recent survey on military benefits spoke emphatically about the value of commissaries, exchanges, and MWR programs. Almost three-quarters of the respondents stated the commissary benefit was important to their family; more than half voiced a similar opinion about military exchanges. The majority of respondents used at least one MWR activity monthly. Families also value their installation family centers. Delegates at the recent Army Family Action Plan Conference, for example, rated Army Community Services as their most valued service.

NMFA urges Congress to strengthen and protect these benefits during the upheavals and troop movements over the next few years. We are concerned about the timeline for the closure of commissaries and exchanges overseas and the ability of stores at installations experiencing growth to handle the increased demand. We understand the Army and Air Force Exchange Service (AAFES) earns approximately 50 percent of its profits at overseas stores, many of which will close or downsize as troops and families move back to CONUS installations. When these stores are gone, what will be the future of the MWR programs funded by these profits? Are the Army and Air Force examining their program needs, developing a plan, and identifying alternate funding sources to maintain vital programs despite a projected increase in exchange revenues?

Permanent Change of Station Improvements

NMFA is grateful for recent increases in Permanent Change of Station (PCS) weight allowances for senior enlisted members included in the FY 2006 NDAA. Weight allowances for these ranks were dramatically out of sync with the expected accumulation of goods over the course of a career and with the responsibility shouldered by these service members. These increases, while still below the levels NMFA believes are appropriate, will ease the financial burden for many service members and their families when the government orders them to move. NMFA asks

Congress to continue reviewing the weight allowance tables and increase them to better reflect the needs and responsibilities of today's force.

While applauding this much needed change in weight allowances, families still wait for what they view as the most important improvement to the PCS process: full replacement value reimbursement for household goods lost or damaged in a government-ordered move. In the FY 2004 NDAA, based on promises that the DoD household goods re-engineering initiative, "Families First," would be implemented in the fall of 2004, Congress authorized full replacement value reimbursement for military moves, but tied its implementation to the implementation of the re-engineering project. Unfortunately for families, "Families First" has not yet been implemented. The Military Surface Deployment and Distribution Command, the agency in charge of the household goods move process, announced last fall that, after many other delays, the implementation of "Families First" is in a "strategic pause." NMFA finds it disappointing that families have been anything but first in DoD's efforts to improve the move process. The delay to implement these improvements has gone on long enough. We believe DoD must have this program in place before the bulk of the overseas rebasing and BRAC moves occur. Military families want and deserve a program that works and have waited long enough.

NMFA asks Congress to press DoD to implement "Families First" and begin paying full replacement value reimbursement as promised more than two years ago.

The shipment of a second vehicle for all uniformed services members moving to an OCONUS assignment (including Alaska and Hawaii) has been a major quality of life issue for service members and their families stationed overseas. With service members' long work hours in support of the mission, having only one car available to the family limits a spouse's employment options and family members' access to commissaries, children's schools and activities, and installation support programs. NMFA hopes Congress will address this concern and authorize and fund the costs of shipping a second vehicle for overseas PCS moves.

PCS mileage reimbursement rates are no more than 20 cents per mile and then, only if four persons are in the vehicle. The official explanation for this rate is that the Monetary Allowance in Lieu of Transportation (MALT) and PCS rates were never intended to reimburse the transportation costs for driving a car; they are based on commercial fares and are a payment instead of providing the member or employee with Government-procured transportation. The MALT/PCS mileage rates do not reflect the price of gasoline. As we all know, commercial carriers are raising their rates because of the increased price of fuel. NMFA feels an increase in the PCS mileage rates would reflect the increase in the commercial rate and provide a more realistic reimbursement for mileage to service members and families as they relocate.

Adjusting Housing Standards

Increased funding for Basic Allowance for Housing over the past six years has been a quality of life success story for military families. This funding has cut families' out-of-pocket costs tremendously, especially in high cost of living areas. DoD's claims that out-of-pocket costs for military families living off the installation have been "zeroed out" only apply, however, to averages. Many service members' BAH still does not cover their families' total housing costs. This disparity is due in part to the housing standard tied to a service member's rank.

The trend in housing construction on military installations, whether through military construction or the privatization contracts, has been to construct larger homes that meet so-called "community standards." The standard on the installation for assigning or offering housing is based on rank and the number of family members. If an E-5 with three dependents is lucky enough to live on the installation in privatized housing, they may be living in a three-bedroom duplex or townhouse. Yet, if that E-5's family is forced to live off the installation in the community, the rate of BAH they receive is based on the DoD E-5 standard of a two bedroom townhouse. Service members needing a larger home off-base cover the additional rental costs out of their own pockets. An enlisted member must be an E-9 before "earning" sufficient BAH to rent a single family dwelling.

NMFA believes it is time to revisit and possibly revamp the housing standards used to determine Basic Allowance for Housing to better reflect the "community standards" used in constructing housing on military installations and the responsibilities placed on service members.

Families and Community

Military families are members of many communities. Communities small and large in every corner of the United States now have military families, due to the increased deployment and utilization of National Guard and Reserve members since the beginning of the Global War on Terror. NMFA has heard how these communities want to help the military families in their midst. They want to be better informed on how to provide this help. How can this be accomplished?

As the sacrifice of service members and families continues in the Global War on Terror, many states have implemented military family friendly programs and passed legislation to support families. NMFA applauds the states assisting service members and their families with in-state tuition, unemployment compensation for spouses, licensing reciprocity, and education and sports provisions for military children. The DoD State Liaison office works to promote these policies and publicizes them on the DoD website *USA4MilitaryFamilies.org*, a web forum for sharing information about state and local initiatives to support military families. Of special importance is the work this office is doing to improve community-based support for disabled service members. It is also working to deter the payday lenders, check cashing stores, title loan companies, and other financial predators that plague service members. DoD is promoting financial literacy programs to insure stability for the members and their families. NMFA has worked closely with

the State Liaison Office on several state initiatives concerning spouse unemployment compensation, predatory lending, and in-state tuition.

Many states recognize the financial difficulties facing some National Guard and Reserve families. Some have instituted state-coordinated emergency funds financed through corporate and individual donations or through state residents' designations on their state income tax forms. Others pay the differential between state employees' military and civilian pay when the employee is mobilized or pay the health insurance premiums to enable the Guard or Reserve member's family to maintain continuity of health care. New Mexico pays the Servicemembers' Group Life Insurance (SGLI) premium for the deployed National Guard and Reserve members from their state.

Concern for deployed service members from North Carolina and compassion for their loved ones left behind prompted the creation of a unique partnership to help the combatants' families, particularly those in remote areas. The Citizen-Soldier Support Program (CSSP) is a collaborative effort, funded by Congress through a DoD grant, and coordinated by the University of North Carolina at Chapel Hill. CSSP is designed to mobilize communities and make them aware of the needs of local military families so people can reach out and help when help is needed. The program is designed as a preventative measure, as opposed to a crisis-response structure, to help with little things before they become big things. The support program uses existing agencies within counties and communities to broadcast the needs of military families. Liaisons also seek help from representatives of Rotary Clubs, Lions Clubs, the American Legion, and Veterans of Foreign War units who are interested in helping military families. Other states have expressed interest in starting similar programs. We hope North Carolina will be the training center to expand the program to other states and communities.

NMFA recommends increased funding for community-based programs, including the North Carolina Citizen-Soldier Support Program, to reach out to meet the needs of geographically dispersed service members and their families.

In conclusion, NMFA would like to thank the many dedicated people who serve our military families. We again express our extreme gratitude for the actions of this Subcommittee, which has consistently supported the needs of our nation's warriors and their families, both while on active duty and in retirement. You too are part of the tapestry of support. By keeping military families strong, you are ensuring the force will remain strong.