NATIONAL
MILITARY FAMILY
ASSOCIATION
Together we're stronger

Statement of

Kathleen B. Moakler
Government Relations Director

NATIONAL MILITARY FAMILY ASSOCIATION

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Personnel

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Military families serve our country with pride, honor, and quiet dedication. The National Military Family Association is the leading nonprofit organization committed to strengthening and protecting the families of the men and women currently serving, retired, wounded or fallen. We provide families of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA with information, work to get them the benefits they deserve, and offer programs that improve their lives. Our 40 years of service and accomplishments have made us a trusted resource for military families and the Nation's leaders.

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

The Association does not have or receive federal grants or contracts.
Our website is: *www.MilitaryFamily.org.*

Kathleen B. Moakler, Government Relations Director

Mrs. Moakler has been associated with the National Military Family Association since 1995 as a member of the headquarters staff. Mrs. Moakler was permanently appointed as Government Relations Director in October 2007. In that position, she monitors the range of issues relevant to the quality of life of the families of the seven uniformed services and coordinates a staff of 4 deputy directors. Mrs. Moakler represents the interests of military families on a variety of advisory panels and working groups, including the DoD/VA Survivors Forum, and the State Department Interagency Roundtable. Mrs. Moakler is co-chair of the Survivors Committee for the Military Coalition (TMC), a consortium of 35 military and veteran organizations and serves on the Retiree Committee. She is often called to comment on issues pertaining to military families for such media outlets as the NY Times, CNN, NBC news , NPR and the Military Times. She writes regularly for military focused publications.

An Army spouse of over 28 years, Mrs. Moakler has served in various volunteer leadership positions in civilian and military community organizations in that time. Through the years, Mrs. Moakler has worked with many military community programs including hospital consumer boards, commanders' advisory boards, family readiness groups, church councils, youth programs, and the Army Family Action Plan at all levels. She believes that communication is paramount in the efficient delivery of services and the fostering of a rich community life for military families. She holds a Bachelor of Science degree in Business Administration from the State University of New York at Albany. Mrs. Moakler has been awarded the Army Commanders Award for Public Service and the President's Volunteer Service Award.

Mrs. Moakler is also a military mom. Her daughter, Megan, is an Army nurse who has served two tours in Iraq and is presently stationed at Ft. Sill, Oklahoma, and son Matthew is an Army major stationed at Ft. Belvoir, Virginia. Her oldest son, Marty, is an aspiring actor in Hollywood, California. Mrs. Moakler and her husband, Colonel Martin W. Moakler Jr. USA (retired), reside in Alexandria, Virginia.

Chairman Webb and Distinguished Members of the Subcommittee, the National Military Family Association would like to thank you for the opportunity to present testimony on the quality of life of military families – the Nation's families. As the war has continued, the quality of life of our service members and their families has been severely impacted. Your recognition of the sacrifices of these families and your response through legislation to the increased need for support have resulted in programs and policies that have helped sustain our families through these difficult times.

We endorse the recommendations contained in the statement submitted by The Military Coalition. In this statement, our Association will expand on several issues of importance to military families:

I. Family Readiness
II. Family Health
III. Family Transitions

I. Family Readiness

The National Military Family Association believes policies and programs should provide a firm foundation for families buffeted by the uncertainties of deployment and transformation. It is imperative full funding for these programs be included in the regular budget process and not merely added on as part of supplemental funding. We promote programs that expand and grow to adapt to the changing needs of service members and families as they cope with multiple deployments and react to separations, reintegration, and the situation of those returning with both visible and invisible wounds. Standardization in delivery, accessibility, and funding are essential. Programs should provide for families in all stages of deployment and reach out to them in all geographic locations. Families should be given the tools to take greater responsibility for their own readiness.

We appreciate provisions in the National Defense Authorization Acts and Appropriations legislation in the past several years that recognized many of these important issues. Excellent programs exist across the Department of Defense (DoD) and the Services to support our military families. There are redundancies in some areas, and times when a new program was initiated before looking to see if an existing program could be adapted to answer an evolving need. Service members and their families are continuously in the deployment cycle, anticipating the next separation, in the throes of deployment, or trying to reintegrate after the service member returns. Dwell times seem shorter and shorter as training, schools, and relocation impede on time that is spent in the family setting.

"My husband will have three months at home with us between deployment and being sent to school in January for two months and we will be PCSing soon afterwards. ....This does not leave much time for reintegration and reconnection." – Army Spouse

We feel that now is the time to look at best practices and at those programs that are truly meeting the needs of families. In this section we will talk about existing programs, highlight best practices, and identify needs.

Child Care

At every military family conference we attended last year, child care was in the top five issues affecting families – drop-in care being the most requested need. Some installations are responding to these needs in innovative ways. For instance, in a recent visit to Kodiak, Alaska, we noted the gym facility provided watch care for its patrons. Mom worked out on the treadmill or elliptical while her child played in a safe carpeted and fenced-in area right across from her. Another area of the gym, previously an aerobics room, had

been transformed into a large play area for "Mom and me" groups to play in the frequently inclement weather. These solutions aren't expensive but do require thinking outside the box.

Innovative strategies are needed to address the non-availability of after-hours child care (before 6 a.m. and after 6 p.m.) and respite care. We applaud the partnership between the Services and the National Association of Child Care Resource and Referral Agencies (NACCRRA) that provides subsidized child care to families who cannot access installation based child development centers. We also appreciate the new SitterCity.com contract that will help military families find caregivers and military subsidized child care providers.

Still, families often find it difficult to obtain affordable, quality care especially during hard-to-fill hours and on weekends. Both the Navy and the Air Force have programs that provide 24/7 care. These innovative programs must be expanded to provide care to more families at the same high standard as the Services' traditional child development programs. The Army, as part of the funding attached to its Army Family Covenant, has rolled out more space for respite care for families of deployed soldiers. Respite care is needed across the board for the families of the deployed and the wounded, ill, and injured. We are pleased the Services have rolled out more respite care for special needs families, but since the programs are new we are unsure of the impact it will have on families. We are concerned, however, when we hear of some installations already experiencing shortfalls of funding for respite care early in the year.

At our *Operation Purple® Healing Adventures* camp for families of the wounded, ill and injured, families told us there is a tremendous need for access to adequate child care on or near military treatment facilities. Families need the availability of child care in order to attend medical appointments, especially mental health appointments. Our Association encourages the creation of drop-in child care for medical appointments on the DoD or VA premises or partnerships with other organizations to provide this valuable service.

We appreciate the requirement in the FY 2010 National Defense Authorization Act calling for a report on financial assistance provided for child care costs across the Services and Components to support the families of those service members deployed in support of a contingency operation and we look forward to the results.

Our Association urges Congress to ensure resources are available to meet the child care needs of military families to include hourly, drop-in, and increased respite care across all Services for families of deployed service members and the wounded, ill, and injured, as well as those with special needs family members.

Working with Youth

Older children and teens must not be overlooked. School personnel need to be educated on issues affecting military students and must be sensitive to their needs. To achieve this goal, schools need tools. Parents need tools, too. Military parents constantly seek more resources to assist their children in coping with military life, especially the challenges and stress of frequent deployments. Parents tell us repeatedly they want resources to "help them help their children." Support for parents in their efforts to help children of all ages is increasing, but continues to be fragmented. New federal, public-private initiatives, increased awareness, and support by DoD and civilian schools educating military children have been developed. However, many military parents are either not aware such programs exist or find the programs do not always meet their needs.

Our Association is working to meet this pressing need through our *Operation Purple*® Summer Camps. Unique in its ability to reach out and gather military children of different age groups, Services, and components, our *Operation Purple* program provides a safe and fun environment in which military children feel immediately supported and understood. Now in our seventh year, we have sent more than 30,000 children to camp for free with the support of private donors. This year, we expect to send another 10,000 children to camp at 67 locations in 34 states and Guam, and Germany. We also provided the camp experience to families of the wounded. In 2009, we introduced a new program under our *Operation Purple* umbrella, offering family reintegration retreats in the National Parks. They have been well received by our families and more apply than can attend. We are offering ten retreats this year.

Through our *Operation Purple* camps, our Association has begun to identify the cumulative effects multiple deployments are having on the emotional growth and well being of military children and the challenges posed to the relationship between deployed parent, caregiver, and children in this stressful environment. Understanding a need for qualitative analysis of this information, we commissioned the RAND Corporation to conduct a pilot study in 2007 aimed at the current functioning and wellness of military children attending *Operation Purple* camps and assessing the potential benefits of the *Operation Purple* program in this environment of multiple and extended deployments.

In May 2008, we embarked on phase two of the project – a longitudinal study on the experience of 1,507 families, which is a much larger and more diverse sample than included in our pilot study. RAND followed these families for one year, and interviewed the non-deployed caregiver/parent and one child per family between 11 and 17 years of age at three time points over the year. Recruitment of participants was extremely successful because families were eager to share their experiences. The research addressed two key questions:

How are school-age military children faring?

What types of issues do military children face related to deployment?

In December, the baseline findings of the research were published in the journal *Pediatrics*. Findings showed:

- As the months of parental deployment increased, so did the child's challenges.
- The total number of months away mattered more than the number of deployments.
- Older children experienced more difficulties during deployment.
- There is a direct correlation between the mental health of the caregiver and the well-being of the child.
- Girls experienced more difficulty during reintegration, the period of months readjusting after the service member's homecoming.
- About one-third of the children reported symptoms of anxiety, which is somewhat higher than the percentage reported in other national studies of children.
- In these initial findings, there were no differences in results between Services or Components.

What are the implications? Families facing longer deployments need targeted support – especially for older teens and girls. Supports need to be in place across the entire deployment cycle, including reintegration, and some non-deployed parents may need targeted mental health support. One way to address these needs would be to create a safe, supportive environment for older youth and teens. Dedicated Youth Centers with activities for our older youth would go a long way to help with this. Our Association, as an outgrowth of the study results, will be holding a summit in early May, where we will be engaging with

experts to isolate action items that address the issues surfaced in the study. We will be happy to share these action items with you.

Our Association feels that more dedicated resources, such as youth or teen centers, would be a first step toward addressing the needs of our older youth and teens during deployment.

Families Overseas

Families stationed overseas face increased challenges when their service member is deployed into theater. One such challenge we have heard from families stationed in EUCOM concerns care for a family member, usually the spouse, who may be injured or confined to bed for an extended illness during deployment. Instead of pulling the service member back from theater, why not provide transportation for an extended family member or friend to come from the States to care for the injured or ill family member? This was a recommendation from the EUCOM Quality of Life conference for several years.

Our Association asks that transportation be provided for a designated caregiver to an overseas duty station to care for an incapacitated spouse when a service member is deployed.

Military Housing

In the recent RAND study of military children on the home front commissioned by our Association, researchers found that living in military housing was related to fewer caregiver reported deployment-related challenges. For instance, fewer caregivers who lived in military housing reported that their children had difficulties adjusting to parent absence (e.g., missing school activities, feeling sad, not having peers who understand what their life is like) as compared to caregivers who needed to rent their homes. In a subsequent survey, the study team explored the factors that determine a military family's housing situation in more detail. Among the list of potential reasons provided for the question, "Why did you choose to rent?" researchers found that the top three reasons parents/caregivers cited for renting included: military housing was not available (31%); renting was most affordable (28%), and preference to not invest in the purchase of a home (26%).

Privatized housing expands the opportunity for families to live on the installation and is a welcome change for military families. We are pleased with the annual report that addresses the best practices for executing privatized housing contracts. As privatized housing evolves the Services are responsible for executing contracts and overseeing the contractors on their installations. With more joint basing, more than one Service often occupies an installation. The Services must work together to create consistent policies not only within their Service but across the Services as well. Pet policies, deposit requirements, and utility polices are some examples of differences across installations and across Services. How will Commanders address these variances as we move to joint basing? Our families face many transitions when they move, and navigating the various policies and requirements of each contractor is frustrating and confusing. It's time for the Services to increase their oversight and work on creating seamless transitions by creating consistent policies across the Services.

We are pleased the FY 2010 NDAA calls for a report on housing standards and housing surveys used to determine the Basic Allowance for Housing (BAH) and hope Congress will work to address BAH inequities.

Privatized housing is working! We ask Congress to consider the importance of family well-being as a reason for expanding the amount of privatized housing for our military families.

Commissaries and Exchanges

The commissary is a vital part of the compensation package for service members and retirees, and is valued by them, their families, and survivors. Our surveys indicate that military families consider the commissary one of their most important benefits. In addition to providing average savings of more than 30 percent over local supermarkets, commissaries provide a sense of community. Commissary shoppers gain an opportunity to connect with other military families, and are provided with information on installation programs and activities through bulletin boards and publications. Commissary shoppers also receive nutritional information through commissary promotions and campaigns, as well as the opportunity for educational scholarships.

Our Reserve Component families have benefitted greatly from the addition of case lot sales. We thank Congress again for the provision allowing the use of proceeds from surcharges collected at these sales to help defray their costs. Not only have these case lot sales been extremely well received and attended by family members not located near an installation, they have extended this important benefit to our entire military community.

Our Association continues to be concerned that there will not be enough commissaries to serve areas experiencing substantial growth, including those locations with service members and families relocated by BRAC. The surcharge was never intended to pay for DoD and Service transformation. Additional funding is needed to ensure commissaries are built or expanded in areas that are gaining personnel as a result of these programs.

Our Association believes that additional funding is needed to ensure commissaries are built or expanded in areas that are gaining personnel due to BRAC and transformation.

The military exchange system, like the commissary, provides valuable cost savings to members of the military community, while reinvesting their profits in essential Morale, Welfare and Recreation (MWR) programs. Our Association strongly believes that every effort must be made to ensure that this important benefit and the MWR revenue is preserved, especially as facilities are down-sized or closed overseas. In addition, exchanges must continue to be responsive to the needs of deployed service members in combat zones and have the right mix of goods at the right prices for the full range of beneficiaries.

As a member of the Defense Commissary Patron Council and a strong proponent of the military exchange system, our Association remains committed to protecting commissary and exchange benefits which are essential to the quality of life of our service members, retirees, families and survivors.

Flexible Spending Accounts

We would like to thank Members of Congress for the Sense of Congress on the establishment of Flexible Spending Accounts for uniformed service members. We hope this Subcommittee will press each of the seven Service Secretaries to establish these important pre-tax savings accounts in a consistent manner. Flexible Spending Accounts would be especially helpful for families with out-of-pocket dependent care and health care expenses. We ask that the flexibility of a rollover or transfer of funds to the next year be considered.

Financial Readiness

Financial readiness is a critical component of family readiness. Our Association applauds DoD for tackling financial literacy head-on with their Financial Readiness Campaign. Financial literacy and education must continue to be on the forefront. We are strong supporters of the Military Lending Act (MLA) and hope Congress will press states to enforce MLA regulations within their state borders. With the

depressed economy, many families may turn to payday lenders. DoD must continue to monitor the MLA and its effectiveness of derailing payday lenders.

Military families are not immune from the housing crisis. We applaud Congress for expanding the Homeowners' Assistance Program to wounded, ill, and injured service members, survivors, and service members with Permanent Change of Station orders meeting certain parameters. We have heard countless stories from families across the nation who have orders to move and cannot sell their home. Due to the mobility of military life, military homeowners must be prepared to be a landlord. We encourage DoD to continue to provide financial education to military service members and their families to help families make sound financial decisions. We also encourage DoD to continue to track the impact of the housing crisis on our military families.

We appreciate the increase to the Family Separation Allowance (FSA) that was made at the beginning of the war. In more than eight years, however, there has not been another increase. We ask that the FSA be indexed to the Cost of Living Allowance (COLA) to better reflect rising costs for services.

Increase the Family Separation Allowance by indexing it to COLA.

II. Family Health

Family readiness calls for access to quality health care and mental health services. Families need to know the various elements of their military health system are coordinated and working as a synergistic system. Our Association is concerned the DoD military health care system may not have all the resources it needs to meet both the military medical readiness mission and provide access to health care for all beneficiaries. It must be funded sufficiently, so the direct care system of Military Treatment Facilities (MTFs) and the purchased care segment of civilian providers can work in tandem to meet the responsibilities given under the TRICARE contracts, meet readiness needs, and ensure access for all military beneficiaries.

Military Health System

Improving Access to Care

In the question and answer period during a hearing of this Subcommittee on June 3, 2009, Senator Lindsey Graham (R-SC) asked panel members to "give a grade to TRICARE." Panel members rated TRICARE a "B" or a "C minus." Our Association's Director of Government Relations stated it was a two- part question and assigned a grade of "B" for quality of care and "C-" for access to care. We welcomed this discussion focused on access issues in the direct care system - our military hospitals and clinics - reinforcing what our Association has observed for years. We have consistently heard from families that their greatest health care challenge has been getting timely care from their local military hospital or clinic.

Our Association continues to examine military families' experiences with accessing the Military Health System (MHS). Families' main issues are: access to their Primary Care Managers (PCM); getting someone to answer the phone at central appointments; having appointments available when they finally got through to central appointments; after hours care; getting a referral for specialty care; being able to see the same provider or PCM; and having appointments available 60, 90, and 120 days out in our MTFs for follow-ups recommended by their providers. Families familiar with how the MHS referral system works seem better able to navigate the system. Those families who are unfamiliar report delays in receiving treatment or sometimes decide to give up on the referral process and never obtain a specialty appointment. Continuity of

care is important to maintain quality of care. The MTFs are stressed from eight years of provider deployments, directly affecting the quality of care and contributing to increased costs. Our Association thanks Congress for requiring, in the FY09 NDAA, a report on access to care and we look forward to the findings. This report must distinguish between access issues in the MTFs, as opposed to access in the civilian TRICARE networks.

Our most seriously wounded, ill, and injured service members, veterans, and their families are assigned case managers. In fact, there are many different case managers: Federal Recovery Coordinators (FRC), Recovery Care Coordinators, coordinators from each branch of Service, TBI care coordinators, VA liaisons, et cetera. The goal is for a seamless transition of care between and within the two governmental agencies, DoD and the VA. However, with so many coordinators to choose from, families often wonder which one is the "right" case manager. We often hear from families, some whose service member has long been medically retired with a 100 percent disability rating or others with less than one year from date-of-injury, who have not yet been assigned a FRC. We need to look at whether the multiple, layered case managers have streamlined the process, or have only aggravated it. Our Association still finds families trying to navigate alone a variety of complex health care systems, trying to find the right combination of care. Individual Service wounded, ill, and injured program directors and case managers are often reluctant to inform families that FRCs exist or that the family qualifies for one. Many qualify for and use Medicare, VA, DoD's TRICARE direct and purchased care, private health insurance, and state agencies. Why can't the process be streamlined?

Support for Special Needs Families

Case management for military beneficiaries with special needs is not consistent because the coordination of the military family's care is being done by a non-synergistic health care system. Beneficiaries try to obtain an appointment and then find themselves getting partial health care within the MTF, while other health care is referred out into the purchased care network. Thus, military families end up managing their own care. Incongruence in the case management process becomes more apparent when military family members transfer from one TRICARE region to another and is further exacerbated when a special needs family member is involved. Families need a seamless transition and a warm handoff between TRICARE regions and a universal case management process across the MHS. Each TRICARE Managed Care Contractor has created different case management processes. The current case management system is under review by DoD and the TRICARE Management Activity.

We applaud Congress and DoD's desire to create robust health care, educational, and family support services for special needs children. But, these robust services do not follow them when they retire. We encourage the Services to allow these military families the opportunity to have their final duty station be in an area of their choice. We suggest the Extended Care Health Option (ECHO) be extended for one year after retirement for those already enrolled in ECHO prior to retirement. If the ECHO program is extended, it must be for all who are eligible for the program. We should not create a different benefit simply based on diagnosis.

There has been discussion over the past years by Congress and military families regarding the ECHO program. The FY09 NDAA included a provision to increase the cap on certain benefits under the ECHO program and the FY10 NDAA established the *Office of Community Support for Military Families with Special Needs*. The ECHO program was originally designed to allow military families with special needs to receive additional services to offset their lack of eligibility for state or federally provided services impacted by frequent moves. We suggest that before making any more adjustments to the ECHO program, Congress should direct DoD to certify if the ECHO program is working as it was originally designed and if it has been

effective in addressing the needs of this population. We need to make the right fixes so we can be assured we apply the correct solutions. This new office will go a long way in identifying and addressing special needs. However, we must remember that our special needs families often require medical, educational and family support resources. This new office must address all these various needs in order to effectively implement change.

National Guard and Reserve Member Family Health Care

National Guard and Reserve families need increased education about their health care benefits. We also believe that paying a stipend to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan while the service member is deployed may work out better for many families in areas where the TRICARE network may not be robust.

Grey Area Reservists

Our Association would like to thank Congress for the new TRICARE benefit for Grey Area Reservists. We want to make sure this benefit is quickly implemented and they have access to a robust network.

TRICARE Reimbursement

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. As the 111th Congress takes up Medicare legislation, we request consideration of how this legislation will impact military families' health care, especially our most vulnerable service, access to mental health.

National provider shortages in the mental health field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographic challenges - for example large populations in rural or traditionally underserved areas. Many mental health providers are willing to see military beneficiaries on a voluntary status. However, these providers often tell us they will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. More must be done to persuade these providers to participate in TRICARE and become a resource for the entire system, even if that means DoD must raise reimbursement rates.

Pharmacy

We caution DoD about generalizing findings of certain beneficiary pharmacy behaviors and automatically applying them to our Nation's unique military population. We encourage Congress to require DoD to utilize peer-reviewed research involving beneficiaries and prescription drug benefit options, along with performing additional research involving military beneficiaries, before making any recommendations on prescription drug benefit changes, such as co-payment and tier structure changes for military service members, retirees, their families, and survivors.

We appreciate the inclusion of federal pricing for the TRICARE retail pharmacies in the FY 2008 NDAA. However, we still need to examine its effect on the cost of medications for both beneficiaries and DoD. Also, we will need to see how this potentially impacts Medicare, civilian private insurance, and the National Health Care Reform affecting drug pricing negotiations.

We believe it is imperative that all medications available through TRICARE Retail Pharmacy (TRRx) should also be available through TRICARE Mail Order Pharmacy (TMOP). Medications treating chronic conditions, such as asthma, diabetes, and hypertension should be made available at the lowest level

of co-payment regardless of brand or generic status. We agree with the recommendations of *The Task Force on the Future of Military Health Care* that over-the-counter (OTC) drugs be a covered pharmacy benefit and there be a zero co-pay for TMOP Tier 1 medications.

The new T3 TRICARE contract will provide TRICARE Managed Care Contractors and Express-Scripts, Inc. the ability to link pharmacy data with disease management. This will allow for better case management, increase compliance, and decrease cost, especially for our chronically ill beneficiaries. However, this valuable tool is currently unavailable because the T3 contract is still under protest and has not yet been awarded.

National Health Care Proposal

Our Association is cautious about current rhetoric by the Administration and Congress regarding National Health Care Reform. We request consideration of how this legislation will also impact TRICARE.

The perfect storm is brewing. TMA will hopefully be instituting the new T3 contract in 2011. Currently, there is the possibility that two out of three TRICARE Managed Care Contractors could change. This means that the contracts of 66 percent of our TRICARE providers would need to be renegotiated. Add the demands and uncertainties to providers in regards to health care reform and Medicare reimbursement rate changes. This leads to our concern regarding the impact on providers' willingness to remain in the TRICARE network and the recruitment of new providers. The unintended consequences may be a decrease in access to care due the lack of available health care providers.

DoD Must Look for Savings

We ask Congress to establish better oversight for DoD's accountability in becoming more cost-efficient. We recommend:

- Requiring the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality health care in a cost-effective manner;
- Creating an oversight committee, similar in nature to the Medicare Payment Advisory Commission, which provides oversight to the Medicare program and makes annual recommendations to Congress. *The Task Force on the Future of Military Health Care* often stated it was unable to address certain issues not within their charter or the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.
- Establishing a Unified "Joint" Medical Command structure, which was recommended by the Defense Health Board in 2006 and 2009.

Our Association believes optimizing the capabilities of the facilities of the direct care system through timely replacement of facilities, increased funding allocations, and innovative staffing would allow more beneficiaries to be cared for in the MTFs, which DoD asserts is the most cost effective. The Task Force made recommendations to make the DoD MHS more cost-efficient which we support. They conclude the MHS must be appropriately sized, resourced, and stabilized; and make changes in its business and health care practices.

We suggest additional funding and flexibility in hiring practices to address MTF provider deployments.

Our Association recommends a one year transitional active duty ECHO benefit for all eligible family members of service members who retire.

We believe that Reserve Component families should be given the choice of a stipend to continue their employer provided care during deployment.

Behavioral Health Care

Our Nation must help returning service members and their families cope with the aftermath of war. DoD, VA, and state agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs. Partnering will also capture the National Guard and Reserve member population, who often straddle these agencies' health care systems.

Full Spectrum of Care

As the war continues, families' need for a full spectrum of behavioral health services—from preventative care and stress reduction techniques, to counseling and medical mental health services—continues to grow. The military offers a variety of psychological health services, both preventative and treatment, across many agencies and programs. However, as service members and families experience numerous lengthy and dangerous deployments, we believe the need for confidential, preventative psychological health services will continue to rise. It will remain high, even after military operations scale down. Our study on the impact of the war on caregivers and children found the mental health of the caregiver directly affects the overall well-being of the children. Therefore, we need to treat the family as a unit rather than as individuals because the caregiver's health determines the quality of life for the children.

Access to Behavioral Health Care

Our Association is concerned about the overall shortage of mental health providers in TRICARE's direct and purchased care network. DoD's *Task Force on Mental Health* stated timely access to the proper psychological health provider remains one of the greatest barriers to quality mental health services for service members and their families. The Army Family Action Plan (AFAP) identified mental health issues as their number three issue for 2010. While families are pleased more mental health providers are available in theater to assist their service members, they are disappointed with the resulting limited access to providers at home. Families are reporting increased difficulty in obtaining appointments with social workers, psychologists, and psychiatrists at their MTFs and clinics. The military fuels the shortage by deploying some of its child and adolescent psychology providers to combat zones. Providers remaining at home report they are overwhelmed by treating active duty members and are unable to fit family members into their schedules. This can lead to provider compassion fatigue, creating burnout and exacerbating the provider shortage problem.

We have seen an increase in the number of mental health providers joining the purchased care side of the TRICARE network. However, the access standard is seven days. We hear from military families after accessing the mental health provider lists on the contractors' websites that the provider is full and no longer taking TRICARE patients. The list must be up-to-date in order to handle real time demands by families. We need to continue to recruit more mental health providers to join the TRICARE network and we need to make sure we specifically add those in specialty behavioral health care areas, such as child and adolescence psychology and psychiatrists.

Families must be included in mental health counseling and treatment programs for service members. Family members are a key component to a service member's psychological well-being. Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. We recommend an extended outreach program to service members, veterans, and their families of available mental health resources, such as DoD, VA, and State agencies. We appreciate the VA piloting programs that incorporate active duty service members and their families into their newly established

OIF/OEF health care clinics. The family is accessed as a "unit" and educated about the VA's benefits and services. These initiatives need to be expanded throughout the VA and fully funded.

Frequent and lengthy deployments create a sharp need in mental health services by family members and service members as they get ready to deploy and after their return. There is also an increase in demand in the wake of natural disasters, such as hurricanes and fires. We need to maintain a flexible pool of mental health providers who can increase or decrease rapidly in numbers depending on demand on the MHS side. Currently, Military Family Life Consultants and Military OneSource counseling are providing this type of service for military families on the family support side. The recently introduced web-based TRICARE Assistance Program (TRIAP) offers another vehicle for non-medical counseling, especially for those who live far from counselors. We need to make the Services, along with military family members, more aware of resources along the continuum. We need the flexibility of support in both the MHS and family support arenas, as well as coordination of support between these two entities. We must educate civilian network providers about our culture. Communities along with nongovernment organizations are beginning to fulfill this role, but more needs to be done.

Availability of Treatment

Do DoD, VA and State agencies have adequate mental health providers, programs, outreach, and funding? Better yet, where will the veteran's spouse and children go for help? Many will be left alone to care for their loved one's invisible wounds resulting from frequent and long combat deployments. Who will care for them when they are no longer part of the DoD health care system?

The Army's Mental Health Advisory Team (MHAT) IV report links reducing family issues to reducing stress on deployed service members. The team found the top non-combat stressors were deployment length and family separation. They noted soldiers serving a repeat deployment reported higher acute stress than those on their first deployment and the level of combat was the major contribution for their psychological health status upon return. Our study on the impact of deployment on caregivers and children found it was the cumulative time deployed that caused increased stress. These reports demonstrate the amount of stress being placed on our troops and their families.

Our Association is especially concerned with the scarcity of services available to the families as they leave the military following the end of their activation or enlistment. Due to the service member's separation, the families find themselves ineligible for TRICARE, Military OneSource, and are very rarely eligible for health care through the VA. Many will choose to locate in rural areas lacking available mental health providers. We need to address the distance issues families face in finding mental health resources and obtaining appropriate care. Isolated service members, veterans, and their families do not have the benefit of the safety net of services and programs provided by MTFs, VA facilities, Community-Based Outpatient Centers and Vet Centers. We recommend:

- using alternative treatment methods, such as telemental health;
- modifying licensing requirements in order to remove geographic practice barriers that prevent psychological health providers from participating in telemental health services outside of a VA facility;
- educating civilian network psychological health providers about our military culture as the VA incorporates Project Hero; and
- encouraging DoD and VA to work together to provide a seamless "warm hand-off" for families, as well as service members transitioning from active duty to veteran status and funding additional transitional support programs if necessary.

National Guard and Reserve Members

The National Military Family Association is especially concerned about fewer mental health care services available for the families of returning National Guard and Reserve members. Some are eligible for TRICARE Reserve Select but, as we know, National Guard and Reserve members are often located in rural areas where there may be fewer mental health providers available. Policy makers need to address the distance issues that families face in linking with military mental health resources and obtaining appropriate care. Isolated National Guard and Reserve families do not have the benefit of the safety net of services provided by MTFs and installation family support programs. Families want to be able to access care with a provider who understands or is sympathetic to the issues they face. We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture. We urge DoD to expand information outreach about the new TRIAP program, which provides access to non-medical counseling via phone and web through the TRICARE managed care support contractors. We hear the National Guard Bureau's Psychological Health Services (PHS) is not working as designed to address members' mental health issues. This program needs to be evaluated to determine its effectiveness.

Children

Our Association is concerned about the impact deployment and/or the injury of the service member is having on our most vulnerable population, children of our military service member and veterans. Our study on the impact of the war on caregivers and children found deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not "rock the boat." They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve members face unique challenges since there are no military installations for them to utilize. They find themselves "suddenly military" without resources to support them. School systems are generally unaware of this change in focus within these family units and are ill prepared to lookout for potential problems caused by these deployments or when an injury occurs. Also vulnerable are children who have disabilities that are further complicated by deployment and subsequent injury of the service members. Their families find stress can be overwhelming, but are afraid to reach out for assistance for fear of retribution to the service member's career. They often choose not to seek care for themselves or their families. We appreciate the inclusion of a study on the mental health needs of our children in the FY10 NDAA.

The impact of the wounded, ill, and injured on children is often overlooked and underestimated. Military children experience a metaphorical death of the parent they once knew and must make many adjustments as their parent recovers. Many families relocate to be near the treating MTF or the VA Polytrauma Center in order to make the rehabilitation process more successful. As the spouse focuses on the rehabilitation and recovery, older children take on new roles. They may become the caregivers for other siblings, as well as for the wounded parent. Many spouses send their children to stay with neighbors or extended family members, as they tend to their wounded, ill, and injured spouse. Children get shuffled from place to place until they can be reunited with their parents. Once reunited, they must adapt to the parent's new injury and living with the "new normal." We appreciate the inclusion of a study to assess the impact on children of the severely wounded in the FY10 NDAA.

We encourage partnerships between government agencies, DoD, VA and State agencies and recommend they reach out to those private and non-governmental organizations who are experts on

children and adolescents. They could identify and incorporate best practices in the prevention and treatment of mental health issues affecting our military children. We must remember to focus on preventative care upstream, while still in the active duty phase, in order to have a solid family unit as they head into the veteran phase of their lives. School systems must become more involved in establishing and providing supportive services for our nation's children.

Caregiver Burnout

In the eighth year of war, care for the caregivers must become a priority. There are several levels of caregivers. Our Association hears from the senior officer and enlisted spouses who are so often called upon to be the strength for others. We hear from the health care providers, educators, rear detachment staff, chaplains, and counselors who are working long hours to assist service members and their families. They tell us they are overburdened, burnt out, and need time to recharge so they can continue to serve these families. These caregivers must be afforded respite care, given emotional support through their command structure, and be provided effective family programs.

Education

The DoD, VA, and State agencies must educate their health care and mental health professionals of the effects of mild Traumatic Brain Injury (mTBI) in order to help accurately diagnose and treat the service member's condition. They must be able to deal with polytrauma—Post-Traumatic Stress Disorder (PTSD) in combination with multiple physical injuries. We need more education for civilian health care providers on how to identify signs and symptoms of mild TBI and PTSD.

The families of service members and veterans must be educated about the effects of TBI, PTSD, and suicide in order to help accurately diagnose and treat the service member/veteran's condition. These families are on the "sharp end of the spear" and are more likely to pick up on changes attributed to either condition and relay this information to their health care providers. Programs are being developed by each Service. However, they are narrow in focus targeting line leaders and health care providers, but not broad enough to capture our military family members and the communities they live in. As Services roll out suicide prevention programs, we need to include our families, communities, and support personnel.

Reintegration Programs

Reintegration programs become a key ingredient in the family's success. Our Association believes we need to focus on treating the whole family with programs offering readjustment information; education on identifying mental health, substance abuse, suicide, and traumatic brain injury; and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties. We appreciate the inclusion in the FY10 NDAA for education programs targeting pain management and substance abuse for our families.

Successful return and reunion programs will require attention over the long term, as well as a strong partnership at all levels between the various mental health arms of DoD, VA, and State agencies. DoD and VA need to provide family and individual counseling to address these unique issues. Opportunities for the entire family and for the couple to reconnect and bond must also be provided. Our Association has recognized this need and successfully piloted family retreats in the National Parks promoting family reintegration following deployment.

We recommend an extended outreach program to service members, veterans, and their families of available psychological health resources, such as DoD, VA, and State agencies.

We encourage Congress to request DoD to include families in its Psychological Health Support survey; perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members).

We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.

Caregivers must be afforded respite care; given emotional support through their command structure; and, be provided effective family programs.

Wounded Service Members Have Wounded Families

Our Association asserts that behind every wounded service member and veteran is a wounded family. It is our belief the government, especially the DoD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded, ill, and injured service member must also consider the needs of the spouse, children, parents of single service members and their siblings, and the caregivers. DoD and VA need to think proactively as a team and one system, rather than separately; and addressing problems and implementing initiatives upstream while the service member is still on active duty status.

Reintegration programs become a key ingredient in the family's success. For the past two years, we have piloted our *Operation Purple® Healing Adventures* camp to help wounded service members and their families learn to play again as a family. We hear from the families who participate in this camp, as well as others dealing with the recovery of their wounded service members that, even with Congressional intervention and implementation of the Services' programs, many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes we need to focus on treating the whole family with DoD and VA programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process. We must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

Brooke Army Medical Center (BAMC) has recognized a need to support these families by expanding in terms of guesthouses co-located within the hospital grounds and a family reintegration program for their Warrior Transition Unit. The on-base school system is also sensitive to issues surrounding these children. A warm, welcoming family support center located in guest housing serves as a sanctuary for family members. The DoD and VA could benefit from looking at successful programs like BAMC's, which has found a way to embrace the family unit during this difficult time.

The Vet Centers are an available resource for veterans' families providing adjustment, vocational, and family and marriage counseling. The VA health care facilities and the community-based outpatient clinics (CBOCs) have a ready supply of mental health providers, yet regulations have restricted their ability to provide mental health care to veterans' families unless they meet strict standards. Unfortunately, this provision hits the veteran's caregiver the hardest, especially if they are the parents. We recommend DoD

partner with the VA to allow military families access to mental health services. We also believe Congress should require the VA, through its Vet Centers and health care facilities to develop a holistic approach to care by including families when providing mental health counseling and programs to the wounded, ill, and injured service member or veteran.

The Defense Health Board has recommended DoD include military families in its mental health studies. We agree. We encourage Congress to direct DoD to include families in its Psychological Health Support survey; perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members). We appreciate the FY10 NDAA report on the impact of the war on families and the DoD's Millennium Cohort Study including families. Both will help us gain a better understanding of the long-term effects of war on our military families.

Transitioning for the Wounded and Their Families

Transitions can be especially problematic for wounded, ill, and injured service members, veterans, and their families. The DoD and the VA health care systems, along with State agency involvement, should alleviate, not heighten these concerns. They should provide for coordination of care, starting when the family is notified that the service member has been wounded and ending with the DoD, VA, and State agencies working together, creating a seamless transition, as the wounded service member transfers between the two agencies' health care systems and, eventually, from active duty status to veteran status.

Transition of health care coverage for our wounded, ill, and injured and their family members is a concern of our Association. These service members and families desperately need a health care bridge as they deal with the after effects of the injury and possible reduction in their family income. We have created two proposals. Service members who are medically retired and their families should be treated as active duty for TRICARE fee and eligibility purposes for three years following medical retirement. This proposal will allow the family not to pay premiums and be eligible for greater access to care at certain MTFs and for certain benefits offered to active duty families for three years. Following that period, they would pay TRICARE premiums at the rate for retirees. Service members medically discharged from service and their family members should be allowed to continue for one year as active duty for TRICARE benefits and then move into the Continued Health Care Benefit Program (CHCBP) if needed.

Caregivers

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded service members and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DoD and VA health care providers because they tend to the needs of the service members and the veterans on a regular basis. And, their daily involvement saves DoD, VA, and State agency health care dollars in the long run. Their long-term psychological care needs must be addressed. Caregivers of the severely wounded, ill, and injured service members who are now veterans have a long road ahead of them. In order to perform their job well, they will require access to mental health services.

The VA has made a strong effort in supporting veterans' caregivers. The DoD should follow suit and expand their definition. We appreciate the inclusion in FY10 NDAA of compensation for service members with assistance in everyday living. However, our Association believes this provision does not go far enough. In order to perform their job well, caregivers must be taught the skills to be successful.

Compensation of caregivers should be a priority for DoD and the Secretary of Homeland Security. Caregivers must be recognized for their sacrifices and the important role they play in maintaining the quality

of life of our wounded service members and veterans. Financial compensation must be established for caregivers of injured service members and veterans that begin while the hospitalized service member is still on active duty and transitions seamlessly to a VA benefit. Current law creates a potential gap in compensation during transition from active duty to veteran status. Our Association proposes that compensation should reflect the types of medical and non-medical care services provided by the caregiver. The caregiver should be paid directly for their services. Non-medical care should be factored into a monthly stipend tied to severity of injury –cognitive and physical injury and illness—and care provided. In order to perform their job well, caregivers must be taught the skills to be successful. This will require the caregiver to be trained through a standardized, certified program. Compensation for medical care should be an hourly wage linked to training and certification of the caregiver paid for by the VA and transferrable to employment in the civilian sector if the care is no longer needed by the service member or veteran.

Consideration should also be given to creating innovative ways to meet the health care and insurance needs of the caregiver, with an option to include their family. Current proposed legislation does not include a "family" option. Additional services caregivers need are: respite care, such as 24 hour in-home care, mental health services, and travel and lodging expenses when accompanying service members and veterans for medical care.

There must be a provision for transition benefits for the caregiver if the caregiver's services are no longer needed, chooses to no longer participate, or is asked by the veteran to no longer provide services. The caregiver should still be able to maintain health care coverage for one year. Compensation would discontinue following the end of services/care provided by the caregiver. Our Association looks forward to discussing details of implementing such a plan with Members of this Subcommittee.

The VA currently has eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. DoD should evaluate these pilot programs to determine whether to adopt them for caregivers of service members still on active duty. Caregivers' responsibilities start while the service member is still on active duty.

Relocation Allowance and Housing

Active Duty service members and their spouses qualify through the DoD for military orders to move their household goods when they leave the military service. Medically retired service members are given a final PCS move. Medically retired married service members are allowed to move their family; however, medically retired single service members only qualify for moving their own personal goods.

Our Association suggests that legislation be passed to allow medically retired single service members the opportunity to have their caregiver's household goods moved as a part of the medical retired single service member's PCS move. This should be allowed for the qualified caregiver of the wounded service member and the caregiver's family (if warranted), such as a sibling who is married with children or mom and dad. This would allow for the entire caregiver's family to move, not just the caregiver. The reason for the move is to allow the medically retired single service member the opportunity to relocate with their caregiver to an area offering the best medical care, rather than the current option that only allows for the medically retired single service member to move their belongings to where the caregiver currently resides. The current option may not be ideal because the area in which the caregiver lives may not be able to provide all the health care services required for treating and caring for the medically retired service member. Instead of trying to create the services in the area, a better solution may be to allow the medically retired service member, their caregiver, and the caregiver's family to relocate to an area where services already exist.

The decision on where to relocate for optimum care should be made with the Federal Recovery Coordinator (case manager), the service member's medical physician, the service member, and the caregiver. All aspects of care for the medically retired service member and their caregiver shall be considered. These include a holistic examination of the medically retired service member, the caregiver, and the caregiver's family for, but not limited to, their needs and opportunities for health care, employment, transportation, and education. The priority for the relocation should be where the best quality of services is readily available for the medically retired service member and his/her caregiver.

The consideration for a temporary partial shipment of caregiver's household goods may also be allowed, if deemed necessary by the case management team.

Medical Power of Attorney

We have heard from caregivers of the difficult decisions they have to make over their loved one's bedside following an injury. We support the *Traumatic Brain Injury Task Force* recommendation for DoD to require each deploying service member to execute a Medical Power of Attorney and a Living Will.

Provide medically-retired wounded, ill and injured service members and their families a bridge of extended active duty TRICARE eligibility for three years, comparable to the benefit for surviving spouses.

Service members medically discharged from service and their family members should be allowed to continue for one year as active duty for TRICARE and then start the Continued Health Care Benefit Program (CHCBP) if needed.

Caregivers of the wounded, ill and injured must be provided with opportunities for training, compensation and other support programs because of the important role they play in the successful rehabilitation and care of the service member.

The National Military Family Association is requesting the ability for medically retired single service members to be allowed the opportunity to have their caregiver's household goods moved as a part of the medically retired single service member's PCS move.

DoD should require each deploying service member to execute a Medical Power of Attorney and a Living Will.

Senior Oversight Committee

Our Association is appreciative of the provision in the FY2010 NDAA establishing a DoD Task Force on the Care, Management, and Transition of Recovery, Wounded, Ill, and Injured Members of the Armed Forces to access policies and programs. We understand the Office of Wounded Warrior Care and Transition Policy (WWCTP), a permanent structure for the Senior Oversight Committee, is in the process of being established and manned. This Task Force will be independent and in a position to monitor DoD and VA's partnership initiatives for our wounded, ill, and injured service members and their families, while this organization is being created.

The National Military Family Association encourages the all Committees with jurisdiction over military personnel and veterans matters to talk on these important issues. We can no longer continue to create policies in a vacuum and be content on focusing on each agency separately because this population moves too frequently between the two agencies, especially our wounded, ill, and injured service members and their families.

We would like to thank you again for the opportunity to provide information on the health care needs for the service members, veterans, and their families. Military families support the Nation's military missions. The least their country can do is make sure service members, veterans, and their families have consistent access to high quality mental health care in the DoD, VA, and within network civilian health care systems. Wounded service members and veterans have wounded families. The caregiver must be supported by providing access to quality health care and mental health services, and assistance in navigating the health care systems. The system should provide coordination of care with DoD, VA, and State agencies working together to create a seamless transition. We ask Congress to assist in meeting that responsibility.

III. Family Transitions

Survivors

In the past year, the Services have increased their outreach to surviving families. In particular, the Army's SOS (Survivor Outreach Services) program makes an effort to remind these families that they are not forgotten. DoD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need, through all of VA's venues. New legislative language governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement or grief counseling. The goal is the right care at the right time for optimum treatment effect. DoD and the VA need to better coordinate their mental health services for survivors and their children.

We thank Congress for extending the TRICARE active duty family dental insurance benefit to surviving children. The current TRICARE Management Activity policy directive allows for the surviving children of Reserve Component service members who had not previously been enrolled to be eligible for the expanded benefit. We ask that eligibility be expanded to those active duty family members who had not been enrolled in the active duty TRICARE Dental insurance program prior to the service member's death.

Our Association recommends that eligibility be expanded to active duty survivors who had not been enrolled in the TRICARE Dental Program prior to the service member's death. We also recommend that grief counseling be more readily available to survivors.

Our Association still believes the benefit change that will provide the most significant long-term advantage to the financial security of all surviving families would be to end the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP). Ending this offset would correct an inequity that has existed for many years. Each payment serves a different purpose. The DIC is a special indemnity (compensation or insurance) payment paid by the VA to the survivor when the service member's service causes his or her death. The SBP annuity, paid by DoD, reflects the longevity of the service of the military member. It is ordinarily calculated at 55 percent of retired pay. Military retirees who elect SBP pay a portion of their retired pay to ensure that their family has a guaranteed income should the retiree die. If that retiree dies due to a service-connected disability, their survivor becomes eligible for DIC.

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 the children would receive the full SBP amount until each child turns 18 (23 if in college), as well as the individual child DIC until each child turns 18 (23 if in college). Once the children have left the house, this choice currently leaves the spouse with an annual income of $13,848, a significant drop in income from what the family had been earning while the service member was alive and on active duty. The percentage of loss is

even greater for survivors whose service members served longer. Those who give their lives for their country deserve more fair compensation for their surviving spouses.

We believe several other adjustments could be made to the Survivor Benefit Plan. Allowing payment of the SBP benefits into a Special Needs Trust in cases of disabled beneficiaries will preserve their eligibility for income based support programs. The government should be able to switch SBP payments to children if a surviving spouse is convicted of complicity in the member's death.

We believe there needs to be DIC equity with other federal survivor benefits. Currently, DIC is set at $1,154 monthly (43% of the Disabled Retirees Compensation). Survivors of federal workers have their annuity set at 55% of their Disabled Retirees Compensation. Military survivors should receive 55% of VA Disability Compensation. We are pleased that the requirement for a report to assess the adequacy of DIC payments was included in the FY 2009 NDAA. We are awaiting the overdue report. We support raising DIC payments to 55% of VA Disability Compensation. When changes are made, ensure that DIC eligibles under the old system receive an equivalent increase.

We ask the DIC offset to SBP be eliminated to recognize the length of commitment and service of the career service member and spouse. We also request that SBP benefits may be paid to a Special Needs Trust in cases of disabled family members.

We ask that DIC be increased to 55% of VA Disability Compensation.

Education of Military Children

The National Military Family Association would like to thank Congress for including a "Sense of Congress" in regards to the *Interstate Compact on Educational Opportunity for Military Children* in last year's National Defense Authorization Act. The Compact has now been adopted in twenty-seven states and covers over 80% of our military children. The Interstate Commission, the governing body of the Compact, is working to educate military families, educators, and states on the appropriate usage of the Compact. The adoption of the Compact is a tremendous victory for military families who place a high value on education.

However, military families define the quality of that education differently than most states or districts that look only at issues within their boundaries. For military families, it is not enough for children to be doing well in their current schools, they must also be prepared for the next location. The same is true for children in underperforming school systems. Families are concerned that they will lag behind students in the next location. With many states cutting educational programs due to the economic downturn, this concern is growing. A prime example is Hawaii, which opted to furlough teachers on Fridays, cutting seventeen days from the school calendar. With elementary schools already on a shortened schedule for Wednesday, these students are only getting three-and-a-half days of instruction a week. In addition, the recent cuts have made it increasing hard for schools to meet IEP requirements for special needs students. Furthermore, Hawaii is requiring parents to pay more for busing, and the cost of school meals have gone up 76%. Our Association believes that Hawaii's cuts are just the "tip of the iceberg" as we are beginning to see other states make tough choices as well. Although Hawaii's educational system has long been a concern for military families, many of whom opt for expensive private education, Hawaii is not the only place where parents have concerns. The National Military Family Association believes that our military children deserve to have a good quality education wherever they may live. However, our Association recognizes that how we provide that quality education may differ in each location.

We urge Congress to encourage solutions for the current educational situation in Hawaii and recognize that service members' lack of confidence that their children may receive a quality education in an assignment location can affect the readiness of the force in that location.

While our Association remains appreciative for the additional funding Congress provides to civilian school districts educating military children, Impact Aid continues to be under-funded. We urge Congress to provide appropriate and timely funding of Impact Aid through the Department of Education. In addition, we urge Congress to increase DoD Impact Aid funding for schools educating large numbers of military children to $60 million for FY 2011. We also ask Congress to include an additional $5 million in funding for special needs children. The DoD supplement to Impact Aid is critically important to ensure school districts provide quality education for our military children.

As increased numbers of military families move into new communities due to Global Rebasing and BRAC, their housing needs are being met further and further away from the installation. Thus, military children may be attending school in districts whose familiarity with the military lifestyle may be limited. Educating large numbers of military children will put an added burden on schools already hard-pressed to meet the needs of their current populations. We urge Congress to authorize an increase in this level of funding until BRAC and Global Rebasing moves are completed.

Once again, we thank Congress for passing the Higher Education Opportunity Act of 2008, which contained many new provisions affecting military families. Chief among them was a provision to expand in-state tuition eligibility for military service members and their families, and provide continuity of in-state rates if the service member receives Permanent Change of Station (PCS) orders out of state. However, family members have to be currently enrolled in order to be eligible for continuity of in-state tuition. Our Association is concerned that this would preclude a senior in high school from receiving in-state tuition rates if his or her family PCS's prior to matriculation. We urge Congress to amend this provision.

We ask Congress to increase the DoD supplement to Impact Aid to $60 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. We also ask Congress provide $5 million for school districts with Special Needs children.

Support for Military Voters

The National Military Family Association would like to thank Congress for passing the Military and Overseas Voter Empowerment (MOVE) Act which was included in the FY2010 National Defense Authorization Act. As a member of the Alliance for Military and Overseas Voting Rights (AMOVR), our Association worked hard to pass this important legislation which resolves many of the absentee voting issues for our military service members and their families. The passage of the MOVE ACT was a tremendous victory for our military community whose very service helps protect the right to vote.

Spouse Education & Employment

Our Association wishes to thank Congress for recent enhancement to spouse education opportunities. In-state tuition, Post 9/11 G.I. bill transferability to spouses and children, and other initiatives have provided spouses with more educational opportunities than previous years.

Since 2004, our Association has been fortunate to sponsor our Joanne Holbrook Patton Military Spouse Scholarship Program, with the generosity of donors who wish to help military families. Our 2010 application period closed on January 31, 2010. We saw a 33% increase in applications from previous years

with more than 8,000 military spouses applying to our program. Military spouses remain committed to their education and need assistance from Congress to fulfill their educational pursuits.

We have heard from many military spouses who are pleased with the expansion of the Military Spouse Career Advancement Accounts, now called MyCAA. Unfortunately the abrupt halt of the program on February 16, 2010 has created a financial burden and undue stress for military spouses. Spouses who have established accounts and those who planned to set-up accounts in the future have been barred for accessing funds. The MyCAA system only permitted users to request financial assistance 30 days prior to a class start date. Many, who had planned on the funding, will not receive it, if they didn't have a start date entered into the system by February 16th. We ask Congress to push DoD to restart this critical program and find a way to assist spouses who have been abruptly cut-off from receiving funding. We also ask Congress to fully fund the MyCAA program, which is providing essential educational and career support to military spouses. The MyCAA program is not available to all military spouses. We ask Congress to work with the appropriate Service Secretary to expand this funding to the spouses of Coast Guard, the Commissioned Corps of NOAA and U.S. Public Health Service.

Our Association thanks you for establishing a pilot program to secure internships for military spouses with federal agencies. Military spouse are anxious for the program to launch and look forward to enhanced career opportunities through the pilot program. We hope Congress will monitor the implementation of the program to ensure spouses are able to access the program and eligible spouses are able to find federal employment after successful completion of the internship program.

To further spouse employment opportunities, we recommend an expansion to the Workforce Opportunity Tax Credit for employers who hire spouses of active duty and Reserve component service members, and to provide tax credits to military spouses to offset the expense in obtaining career licenses and certifications when service members are relocated to a new duty station within a different state.

The Services are experiencing a shortage of medical, mental health and child care providers. Many of our spouses are trained in these professions or would like to seek training in these professions. We think the Services have an opportunity to create portable career opportunities for spouses seeking in-demand professions. In addition to the MyCAA funding, what can the Services do to encourage spouse employment and solve provider shortages? We would like to see the Services reach out to military spouses and offer affordable, flexible training programs in high demand professions to help alleviate provider shortages.

Our Association urges Congress to recognize the value of military spouses by fully funding the MyCAA program, and by creating training programs and employment opportunities for military spouses in high demand professions to help fill our provider shortages.

Military Families - Our Nation's Families

We thank you for your support of our service members and their families and we urge you to remember their service as you work to resolve the many issues facing our country. Military families are our Nation's families. They serve with pride, honor, and quiet dedication. Since the beginning of the war, government agencies, concerned citizens and private organizations have stepped in to help. This increased support has made a difference for many service members and families, yet, some of these efforts overlap while others are ineffective. In our testimony, we believe we have identified improvements and additions that can be made to already successful programs while introducing policy or legislative changes that address the ever-changing needs of our military families. Working together, we can improve the quality of life for all these families