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Before the

Subcommittee on Personnel

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO RECEIVING TESTIMONY ON
THE HEALTHCARE RECOMMENDATIONS OF THE MILITARY
COMPENSATION AND RETIREMENT MODERNIZATION
COMMISSION

Wednesday, February 25, 2015

Washington, D.C.

ALDERSON REPORTING COMPANY
1155 CONNECTICUT AVENUE, N.W.
SUITE 200
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(202) 289-2260

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Committee on Armed Services

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The subcommittee met, pursuant to notice, at 2:36 p.m. in Room SH-216, Hart Senate Office Building, Hon. Lindsey Graham, chairman of the subcommittee, presiding.

Subcommittee Members Present: Senators Graham [presiding], McCain, Cotton, Tillis, and Gillibrand.

OPENING STATEMENT OF HON. LINDSEY GRAHAM, U.S. SENATOR FROM SOUTH CAROLINA

Senator Graham: Hearing come to order. I apologize for being late.

We have a vote at 2:45, so let's just get started, see how far we can go, and just keep the trains running, here, so we get the testimony we need from this distinguished group.

The Commission has been introduced to the committee about four times. Are y'all still the same people you were before?

Mr. Maldon: We are, Mr. Chairman.

Senator Graham: Okay. If you could just start with the Admiral, here, for the record, announce who you are, then we'll get started. And I'll defer any opening statements to the Senator from New York.

STATEMENT OF HON. KIRSTEN E. GILLIBRAND, U.S. SENATOR FROM NEW YORK

Senator Gillibrand: Mine's really short, but I am just going to say thank you to Senator Graham for his leadership on this committee. I want to join him in welcoming all of you to be our witnesses.

We've already held a full-committee hearing and a Personnel Subcommittee on the Commission's findings and recommendations. And obviously, your work is incredibly important to this committee. Today's hearing will address the Commission's recommendations to improve health benefits for our servicemembers and families. And I'm especially interested in hearing from our witnesses about how these recommendations address the issues of healthcare access, healthcare choice, and healthcare quality for the junior enlisted families and for military families with special needs dependents.

Recent reports indicate that many military service organizations have reservations about these specific recommendations. We will hear from some of these service organizations today during the second panel. I take their concerns seriously and will ensure that their concerns are addressed before we consider any major overhaul of the military healthcare system.

Again, thank you for your excellent effort in this

regard. We're very grateful for your hard work.

Senator Graham: That was well done, and quick.

Senator Gillibrand: Short and sweet.

Senator Graham: Admiral.

Admiral Giambastiani: Good morning, sir. Ed Giambastiani, retired Navy.

Mr. Buyer: Congressman Steve Buyer, Class of '80.

Senator Graham: Go Dogs.

Mr. Maldon: Al Maldon, chairman.

Mr. Higgins: I'm Mike Higgins.

General Chiarelli: Pete Chiarelli.

Senator Graham: Thank you all for your great service. And we'll receive your testimony.

STATEMENT OF HON. ALPHONSO MALDON, JR., CHAIRMAN, MILITARY COMPENSATION AND RETIREMENT MODERNIZATION COMMISSION; ACCOMPANIED BY COMMISSIONERS HON. STEPHEN E. BUYER, MICHAEL R. HIGGINS, GENERAL PETER W. CHIARELLI, USA (RET.), AND ADMIRAL EDMUND P. GIAMBASTIANI, JR., USN (RET.)

Mr. Maldon: Thank you, Mr. Chairman, Ranking Member Gillibrand, distinguished members of the subcommittee. My fellow commissioners and I are honored to be here with you. We thank you for the opportunity to testify before you again today.

As a Commission, we stand unanimous in our belief that the recommendations offered in our report strengthens the foundation of the All-Volunteer Force, it ensures our national security, and it truly honored those who serve and the families who support them. Our recommendations sustain the All-Volunteer Force by maintaining or increasing the overall value of the compensation of benefits for servicemembers and their families, and provide needed options for service personnel managers to design and manage a balanced force. Our recommendations, further, save the government more than $12 billion annually after full implementation.

Today, we specifically address our recommendations to improve the military health benefit. Modernization of the health benefit was one of the most sacred trusts given to

this Commission. There is no benefit more fundamental, nor one more personal, than that which maintains the very health and well-being of our Nation's heroes and their families.

As commissioners, we share the unequivocal belief that a high-quality health benefit is essential for all military constituencies, and we find that the current TRICARE program falls short of this aspiration. TRICARE, as it exists today, is beset by several structural problems that deny our Active Duty families, Reserve-component members, and retirees the high-quality health benefit they deserve.

Low reimbursement rates result in weak healthcare networks, a frustrating referral process that limits access to care unnecessarily. A key medical advancement and modern healthcare management practices are often slow to be adopted. The current TRICARE program limits choice, access, and quality. Conversely, our recommended -- our recommendation on TRICARE Choice program expand all three while increasing the overall value of the health benefit to the servicemember.

Choice and access are important components of a high-quality health benefit, and we believe they can be delivered without undermining the existing MTF structure and the training platform it provides. Current TRICARE beneficiaries already elect MTF-based care through TRICARE Prime, even when other options are available to them. And

the Commission's survey showed that servicemembers strongly prefer a health benefit that both increases choice of civilian providers and ensure continued access to MTF care.

Moreover, our proposed TRICARE Choice offer the same incentives to choose MTF care as DOD's less robust TRICARE reform proposal, and would be expected to result in the same retention of workload at the MTFs. Our recommendations further offer tools to improve medical readiness by attracting new cases into the MTFs, especially those related to combat casualty care.

Currently, there are serious challenges to maintaining joint combat medical capabilities with the typical mix of cases during peacetime. As a result, military medical personnel often rely on just-in-time proficiency training at civilian hospitals, and the services substitute wartime medical personnel requirements with nonoperational family and retiree care specialists during peacetime. Our healthcare recommendations improve the viability of MTFs as a readiness training platform by providing our families and retirees with greater access, choice, and value to their healthcare experience.

Finally, Mr. Chairman, our recommendation on DOD/VA collaboration improves the healthcare experience for transitioning servicemembers. And just one example of insufficient collaboration, drug formularies continue to

differ between DOD and VA, to the detriment of our transitioning servicemembers. Differing formularies often results in uncertainty, tension, and a lack of continuity of care for wounded warriors that should not exist, especially for those managing pain and mental health concerns. Our recommendations ensure proper continuity of care, regardless of the organizational considerations.

In closing, my fellow commissioners and I again thank you for the opportunity to testify here today. It has been our honor and privilege to serve our servicemembers and their families in our role as commissioners, and a particular honor to seek ways to improve and modernize the health benefit. We are confident that our recommendations will serve our servicemembers in a positive, profound, and lasting way.

And we are pleased to answer your question at this time.

Thank you.

[The prepared statement of Mr. Maldon follows:]

Senator Graham: Well, thank you all very much for your hard work. We'll just get right at it.

One of the recommendations is that the amount of money to pay TRICARE bills, past increase on the patient side, is 5 percent. Is that correct?

Mr. Maldon: It's -- that's 5 percent -- there -- it is at 5 percent.

Senator Graham: Okay. So, the bottom line is, of all the -- of the dollar we'll pay for TRICARE, 5 percent comes from those utilizing the service. Is that correct?

Mr. Maldon: That is correct, Mr. Chairman.

Senator Graham: And the norms in the private sector, somewhere in the 20s -- 28? Is that right?

Mr. Maldon: About 28 percent.

Senator Graham: And TRICARE originally was at 28 percent --

Mr. Maldon: 27, I believe.

Senator Graham: 27 percent.

Mr. Maldon: Yes, Mr. Chairman.

Senator Graham: Your recommendation is to get it to 20 percent over 15 years.

Mr. Maldon: That is correct, Mr. Chairman.

Senator Graham: You believe we have to do that to make TRICARE sustainable, no matter what we do.

Mr. Maldon: It is our belief that that is absolutely

correct.

Senator Gillibrand: Congressman Buyer, do you see a way to maintain the 5 percent and keep the program viable?

Mr. Buyer: No.

Senator Graham: Okay.

All right. Now, you've got retirees under 65 who are TRICARE recipients. Will they get a -- an allowance in this new system? How much will their premiums go up beyond the 5 percent? Will their copayments go up? Will their deductibles go up?

Mr. Maldon: Mr. Chairman, they do not. Retirees -- non-Medicare-eligible retirees do not get a basic allowance for healthcare as the Active Duty --

Senator Graham: How much --

Mr. Maldon: -- family would do.

Senator Graham: -- more can the retired force expect to pay if we go to this new system, per person?

Mr. Maldon: Today, Mr. Chairman, they're paying about -- roughly $500. And under the new system, the worst-case scenario would be up to about $1760 -- $1,760 -- -69 dollars.

Senator Graham: So --

Senator Gillibrand: That's per year? Is that per year?

Senator Graham: Per year?

Mr. Maldon: Per year.

Senator Graham: Wow. 17- what?

Mr. Maldon: That's 1769. And that's the worst-case scenario.

Senator Graham: Gotcha.

Mr. Maldon: That's out to the --

Senator Graham: I gotcha.

Mr. Maldon: -- the 15 years.

Senator Graham: I gotcha. Oh, so that's after the premium --

Mr. Maldon: That's after the -- that's premium that will take you out to that --

Senator Graham: No, I got you. So, aside from premiums, will their copayments or deductibles go up? Do we know?

Mr. Maldon: There would be some other costs in there. There's copay costs and deductibles, and some of those costs may be there.

Senator Graham: I'll tell you what I want you to do. I want you to give me kind of a summary of what the median would look like. I want the retired force to know, "Here's what it would cost you to make this change."

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Senator Graham: Now, the hope is that, if you make this change, the benefits go up and make it worth the additional investment. That's the goal of this, right, is to give you more choices, better healthcare?

Mr. Maldon: Yes.

Senator Graham: Okay.

Mr. Maldon: Yes, Mr. Chairman.

Senator Graham: All right. Now, Active Duty family members, they'll get a basic allowance, so they'll have no out-of-pocket cost. Is that correct?

Mr. Maldon: That is correct.

Senator Graham: For the median program.

Mr. Maldon: That is correct, Mr. Chairman.

Senator Graham: For the median cost.

Mr. Maldon: Yes.

Senator Graham: Will their deductibles or copayments appreciably go up under TRICARE Choice?

Mr. Maldon: Let me ask --

Senator Graham: Do they have any copayments or deductibles?

Mr. Maldon: Let me ask Commissioner Higgins if he would respond to that question, please.

Mr. Higgins: Senator, today there are copayments that --

Senator Graham: Right.

Mr. Higgins: -- Active Duty people pay. If they remain inside the MTF, obviously those are minimal. But, the key here is that there are two pieces to the basic allowance for healthcare. One is the premium. They --

Senator Graham: Right.

Mr. Higgins: -- pay the 28 percent.

Senator Graham: Right.

Mr. Higgins: And the other piece is the copayments that they are expected, in that median plan, to pay. So, we would project that 85 percent of people would not see a copayment or out-of-pocket expense beyond what they're doing today.

Senator Graham: Okay, that's my question. And I want you to validate that. Eighty-five percent of the people in the current TRICARE system would not expect to see an increase in copayments.

Mr. Higgins: That's correct. They would be fully --

Senator Graham: Everybody's going to expect to see an increase in premiums if we adjust from the 5 percent.

Mr. Higgins: That's, of course, the -- you know, the 5 percent only applies to the --

Senator Graham: Retirees.

Mr. Higgins: -- working-age retiree --

Senator Graham: Yes.

Mr. Higgins: -- not the Active Duty --

Senator Graham: That's -- not Active Duty family members.

Mr. Higgins: Right.

Senator Graham: Okay. So, 85 percent of the people seem to be immune from any copayment increase if they --

Mr. Higgins: That --

Senator Graham: -- go to TRICARE Choice.

Mr. Higgins: That would be our analysis --

Senator Graham: Active Duty --

Mr. Higgins: -- yes, sir.

Senator Graham: Okay. Guard and Reserve, is that still the same?

Mr. Higgins: The Guard and Reserve package is a little bit different. The TRICARE Reserve Select would have a cost share of 25 percent, and that would be, as it is today, fully burdened to the individual.

Senator Graham: How much more would they have to pay, in terms of dollars?

Mr. Higgins: It would be my view, I believe, that there wouldn't be much of an increased cost. We're going to take that percentage --

Senator Graham: Right.

Mr. Higgins: -- and make it a lower percentage burden to the individual, from 28 down to 25.

Senator Graham: Okay. I guess what I'm saying is,

just give me some estimate of out-of-pocket cost, here. You've given me a good estimate from 500 to 1769 over the next 15 years.

Mr. Higgins: Sir, if --

Senator Graham: -- in terms of premiums, in the worst-case scenario. On the copayment side, I'd like some kind of analysis, too.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Mr. Higgins: The --

Senator Graham: That's all I'm asking.

Mr. Higgins: If I could, Mr. Chairman, when we look at retirees today, the working-age retiree, we have determined that their out-of-pocket costs are approximately -- a little over $2,000, on average.

Senator Graham: Okay.

Mr. Higgins: Many pay much less if they stay within the military treatment facility. But, many are paying dental premiums, many are paying for adult-child coverage that is quite expensive. So, on average, the retiree -- working-age retiree -- is about $2,000. And final end state, 15 years from now, we would project that that retiree, who's going to get the adult child in their healthcare plan under TRICARE Choice, is going to be out-of-pocket somewhere around $3500. So, we're looking at a increase of less than two times.

Senator Graham: Okay, thank you.

Senator Gillibrand.

Senator Gillibrand: Thank you.

One of my concerns is the needs of families with special needs. Your report says that there should be a DOD program available to assist families with a high-cost chronic condition or a catastrophic event or illness with medical expenses until they reach their health plans'

catastrophic caps or are no longer required to pay out-of-pocket costs. Active Duty families should apply for the -- to this program for additional funding to cover copayments that substantially exceed their basic allowance for healthcare. How do you envision this operating?

Mr. Maldon: Thank you, Senator, for the question. I'm going to ask Commissioner Buyer to respond to that question, please.

Mr. Buyer: In our report, I'll refer you to pages 265 through 267. And what we seek to do is to mitigate the financial risks of the chronic and catastrophic illnesses to the Active-Duty-family households. So, when you take about the average median plan, and you're about -- around the 995s, say just under 1,000. You know, we -- back -- when we did -- prior to Medicare Part D, we used to talk about the "donut hole," with drug costs. There's kind of a hole here, also, meaning you're covered to 1,000, but, when you get to 2,000, that's the cap, and then you're triggered into a fund. And so, we've come up with a calculation that we believe that funding the program with about $50 million annually will allow for the complete coverage of expenses for that family in excess of $2,000.

Senator Gillibrand: Okay. Who will be in charge of deciding who receives the additional funding and how to define "chronic" and "catastrophic" conditions?

Mr. Buyer: You know, you've got the plans. So, the -- each of the plans -- you know, when you have a family member that -- with a particular condition for which they're being treated, if, in fact, it's chronic, and you've got catastrophic coverage. I mean, my gosh, it could -- it could be -- catastrophic could be any form of -- type of an illness or an accident. When those costs exceed 2,000, it triggers into the fund.

Senator Gillibrand: Okay. And --

Admiral Giambastiani: If I could, the Secretary of Defense or Department of Defense would determine that.

Senator Gillibrand: Okay.

And how -- would families with special-needs dependents be automatically enrolled, or do they need to figure this out?

Mr. Maldon: Yes. Commissioner Higgins, I'm going to ask you to respond to that question.

Mr. Higgins: We don't envision an enrollment, per se, although I think a family with a special-needs individual in the family would be well-recognized in the system, and there would be an acknowledgment that, after the first year or two, that there would be -- it would be consistent to consider them a special category, and there wouldn't be an -- a very arduous kind of administrative process.

Senator Gillibrand: Okay. And how did you assess the

$50 million fund? How did you assess that that would be the right amount of money?

Mr. Higgins: We calculated what the out-of-pocket costs would be today, where that -- the basic allowance for healthcare would take -- the allowance for out-of-pocket costs would take them. And where that line crossed, we considered what the costs would be for all the population beyond the crossing lines. And that was calculated to be $50 million. You could add money to that, obviously, and push that line back. That would be perhaps a decision the Congress might want to consider. But, we believe that we have the right analysis, on $50 million after the crossing lines, where you have out-of-pocket costs match each other.

Mr. Maldon: And, Senator, that's based on 5 percent, too, I thought, just to be sure. It was 5 percent of the people we thought that would fall within that category.

Senator Gillibrand: Now, it's not clear, would this program also apply to family of military retirees, or is this just for Active Duty?

Mr. Maldon: It's Active Duty, Senator.

Senator Gillibrand: Okay. And so, did you assess possible costs for medically retired wounded warriors having access to these kinds of funds to pay for medical expenses for any special-needs dependents they have?

Mr. Maldon: No, we did not. I mean, no, it will not.

Senator Gillibrand: Okay.

So, what would they -- so, someone who is a veteran, who is -- wounded warrior who has a child with autism, what do they do? They just don't get coverage through this system, or there's no extra money if they do have catastrophic-care requirements?

Mr. Maldon: Commissioner Higgins, would you respond to the question?

Mr. Higgins: Senator, I'm assuming you're talking about somebody that qualified for a disability retirement.

Senator Gillibrand: Yeah.

Mr. Higgins: They would be covered in the same way as a working-age retiree would be covered.

Senator Gillibrand: But, you said retirees aren't covered -- their families aren't covered.

Mr. Higgins: I'm sorry. The --

Senator Gillibrand: So, I'm asking about dependents of retirees or medically wounded -- wounded warriors. So, let's say you're Active Duty, you have an autistic child, you're trying to get the medical necessities for your child --

Mr. Higgins: I see.

Senator Gillibrand: -- to develop. You get wounded in Afghanistan. You are -- must retire, for -- due to that injury. What does that dependent do? Are -- is there any

coverage for them? Have you assessed cost? What happens?

Mr. Higgins: I believe I would like to correct that, then. They would not be covered, because this would be an Active Duty benefit. And I -- if I do understand you correctly now. So, a wounded --

Mr. Maldon: Yes, let us take that, Senator Gillibrand --

Senator Gillibrand: Just --

Mr. Maldon: -- for the record.

Senator Gillibrand: Just analyze that fact pattern for me.

Mr. Maldon: Okay.

[The information referred to follows:]

Senator Gillibrand: Because it's real. It's the kind of thing that happens.

Mr. Buyer: But, I think it's also -- it's also worthy -- you've brought up a scenario that we didn't think about.

Senator Gillibrand: Yeah.

Mr. Buyer: And I want to thank you for that. But, it's also worthy for you to improve our work product. So, if you have the consideration that, "You know what? I think this fund, for these special needs" -- because this is really narrow population that you've defined, here --

Senator Gillibrand: Yes.

Mr. Buyer: -- because the VA's not going to cover that dependent, and whether they access into this fund is probably a worthwhile recommendation, and it's right in your jurisdiction to do.

Senator Gillibrand: Okay.

Admiral Giambastiani: When I was on Active Duty, I thought the Exceptional Family Member Program was working and that we were sending people where they could get the medical care they needed. When we went around to posts, camps, and stations and talked to servicemen all across the country, we found out it is not working, according to spouses, that many of them are sent to places where they cannot get critical care.

Senator Gillibrand: Right.

Admiral Giambastiani: And I honestly believe that this program would increase the access to that care for the Active-component --

Senator Gillibrand: Now, are you --

Admiral Giambastiani: -- soldier.

Senator Gillibrand: Did you do any analysis about whether a stigma would be created for people who access this fund? Or was that not an issue raised? Meaning, you may not want your commander to know that your wife has a chronic condition that -- whatever. It may be personal. It may be something that -- so, is it known -- is it known by your commander unit that you're accessing this fund, or does it stay --

Admiral Giambastiani: Well --

Senator Gillibrand: -- confidential under healthcare?

Admiral Giambastiani: I remember the day I could no longer go and pick up my wife's medical records at the MTF, when HIPAA went into play -- in play. So, I believe that that would --

Senator Gillibrand: It would stay confidential.

Admiral Giambastiani: -- that would be confidential under HIPAA, which the military follows very, very strictly.

Senator Gillibrand: Okay. Because we -- you know, we -- I worked a lot on special --

I'm over time.

Senator Graham: No, take your time.

Senator Gillibrand: I worked a lot on getting funding for special-needs treatment specifically under TRICARE. And so, that work gets vitiated to a significant degree if other options are now available. I just don't want to lose the access that we were trying to develop for special-needs kids if a servicemember gets injured, which happens all the time. So, we just want to make sure this population has services.

Admiral Giambastiani: I -- if I could just add, we -- as General Chiarelli said, we spent a lot of time looking at exceptional family members on the Active Duty side. We did not spend as much time on the --

Senator Gillibrand: On retirees.

Admiral Giambastiani: -- veteran side.

Senator Gillibrand: Okay.

Mr. Buyer: But, the medically retired, I think it's awesome. I mean, you went right to something very narrow and specific. And if you try to define that population --

Senator Gillibrand: It's going to be --

Mr. Buyer: -- it might be 12.

Senator Gillibrand: Yeah, it's going to be --

Mr. Buyer: I mean, it's going to be --

Senator Gillibrand: -- specific.

Mr. Buyer: -- really small.

Senator Gillibrand: Yeah.

Mr. Buyer: So, adding that to access this fund, I think, is probably -- is well worthy of your consideration.

Senator Gillibrand: Thank you.

Senator Graham: With that, we're going to just recess. We're going to go vote. We've got back-to-back votes. And so, we'll stand in recess. And when Senator Tillis gets back, tell him, please, to just go ahead and chair the hearing, and we'll be right back.

Thank you.

Senator Gillibrand: Thank you.

[Recess.]

Senator Tillis [presiding]: Thank you all. If we can come back to order.

I think the Chair and the Ranking Member will be back momentarily, but, since I'm probably the only other one that was going to ask questions of this panel, we'll go ahead and proceed.

I'd like to start with kind of normalizing the first numbers, Chairman Maldon, that you and Senator Graham discussed, and that was the 500-to-1700 number. I'm just trying to normalize that, because I think we need to make sure it's communicated properly, because -- are you saying that the $500, in today's dollars with the new program design at year 15, is at $1700?

Mr. Maldon: Yes, Senator Tillis, it's at the -- today

it's $500 -- roughly $500. And what we are saying is that, 15 years from today, that cost would have -- would be 1769 --

Senator Tillis: Could you go --

Mr. Maldon: -- approximately.

Senator Tillis: Could you go on to discuss if -- let's just say we keep current state, and the number under the current state is $500 -- what the projection would be 15 years from now if you did nothing. Has there been math on that?

Mr. Maldon: We did some math on it. I honestly don't remember exactly what those numbers might be at this point in time. I'll ask my colleagues, here, if anybody might remember. If not, I'll --

Senator Tillis: Okay. If it's --

Mr. Maldon: -- take it for the --

Senator Tillis: -- not readily available, if we could ask you to --

Mr. Maldon: I'll take it for the record. Let me take it for the record.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Senator Tillis: Because I think that that's -- it's very important for people to understand that this is not added purely because of the change in program design, that some of these are rising costs of insurance, healthcare, and a number of other factors over a 15-year period.

Mr. Maldon: Yeah. We will do that. It is constant dollars that we're talking about. But --

Senator Tillis: All right.

Mr. Maldon: -- we'll definitely take that for the record, and I can get back to you on this.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Senator Tillis: Okay.

Mr. Maldon: Okay?

Senator Tillis: Something else that was in the -- I think, the opening paragraph of your opening statement, was the $12 billion that would, I think, be saved. The -- typically, the leap one would make, who may be a stakeholder in this, is that $12 billion comes at the expense of something less than they're going to receive. I'm assuming, similar to the pension strategy, it may come from efficiencies and other things. Can you talk about the key sources of the -- the sources of that $12 billion in savings?

Mr. Maldon: Yes, Mr. Chairman. I'm going to ask Commissioner Higgins to start off talking about it, and then we'll have others talk about it, as well.

Mr. Higgins: Senator, the 12 billion that you refer to has three parts. One would be the savings from just moving to an accrual system for the working-age retiree. And that has budgetary savings of 4 billion. So, just looking at the healthcare components of all this, of what we propose, we would suggest that the cost shares are going to produce roughly $2 billion in savings. Better utilization, better management of the program is going to develop about $5.2 billion of savings there. So, we are increasing cost shares for the working-age retiree. And, as a result, they

are part of the savings, obviously.

Senator Tillis: So, some of that is as a result of the cost share, but not all of it. And you're saying somewhere on the order of 5 billion of the 12 billion?

Mr. Higgins: Is the purely utilization management that the private sector is going to bring to the program. And -- for example, we're going to put 4.5 billion of those total savings back into the system, in terms of your choice, in terms of the improved network, in terms of that healthcare management, that quality management that's going to produce quality healthcare for people. We believe that we're pushing back into that system about 4.5 billion. So, the net savings, just looking at the healthcare aspect alone, is about 2.7 billion.

Senator Tillis: Do you have any sense where some of the increased cost comes with a benefit of increased value? Where -- to the extent there's going to be more -- or is there something, as you're talking to the stakeholders -- I know that the choice becomes a factor which seems to rate pretty highly among many that would be a part of the plan. But, can you give me some sense of, you know, how much of that -- the additional costs or the cost share is somehow compensated for by much higher value for the money?

Mr. Higgins: Mr. Chairman, you want to --

Mr. Maldon: Yeah. One of the things that takes place,

Mr. Chairman, is that there's an expense in --

Senator Tillis: He's back. It was a fleeting moment.

[Laughter.]

Mr. Maldon: Okay, I apologize. Okay.

Senator, is the -- there's an expansion of the network, you know, that takes place there. And then, in terms of just the program management, in itself, just bringing about efficiencies and streamlining the processes of the way the work is done, of some of that. And also, just in increasing the value of the services that they were to get with regard to the doctors, themselves -- I mean, the medical professionals, and -- because now you're talking about the people that would not be reimbursed at the reimbursement rate or lower rate, so you've got increased quality that would hopefully come with that, as well.

General Chiarelli: I would argue that -- also, that I don't think that there's a single one of the groups that'll follow us that would argue they don't want to see the best possible medical care for servicemembers when deployed into harm's way. And central to our recommendations is that, ensuring that our doctors are trained in a way that, as I've said before, on the first day of battle, they can provide the same kind of care they have after 13 years of battle. And that's a critical piece. As these -- as the services get smaller, the number of dependents gets smaller, we need

to find ways that attract additional people into the MTFs, but also the right kind of caseload into the MTFs, so that we have that critical, critical combat medical readiness.

Senator Tillis: And then, the last thing -- sorry, Mr. Chair, if I may -- just, again, going back to initial reactions by stakeholder groups, either those who would be in the plan or the providers. What sense do you have of their reaction? We're going to hear, I think, shortly, but what sense do you have, in terms of the challenge that we would have to, you know, convince those who are -- would be beneficiaries of other changes, that it's the appropriate path?

Mr. Maldon: I'm going to ask Commissioner Buyer to respond to your question.

Mr. Buyer: So, if I may, Mr. Chairman, right now in TRICARE, we have very limited networks. Okay? The networks are limited because of the reimbursement rates. So, in order for me -- you're a doctor, I'm one of the TRICARE contractors. I want you in my network, but I want to make money, too. So, I get you in my network, but I'm going to pay you below -- below Medicare rates.

Now, you look at your practice, and you say, "Okay, of my practice, I can only take so much Medicare, so much Medicaid," right? You make these decisions. You say, also, "I may be a veteran. I'm going to do this because of the

flag, my patriotism," but you can only do that for so long, right?

So, here's what I'd like you to see. You say, "Well, how does the family really feel about this?" Well, access is pretty important, right, to a health network. And in TRICARE, our networks are very limited. So, take for example -- we'll go to Fayetteville, Fort Bragg. So, for orthopaedic surgery -- you blew out your knee, right, or your son or daughter has, in an athletic event, and you need to see an orthopaedic surgeon. In the TRICARE network around Fort Bragg, you get access to only 15 orthopaedic surgeons. If you are in the BlueCross/BlueShield plan, under TRICARE Choice -- you chose the BlueCross/BlueShield -- you get access to 163 orthopaedic surgeons. How come only 15 out of the 136 are in the network? Because of the low reimbursement rates, right? So, those rates are going to begin to limit the choice.

So, when you say, "How does it impact the family?" You know, you want the access to the very best of healthcare, and, in order for someone to qualify as a provider under a BlueCross/BlueShield plan, they don't select just anybody, they have to meet their own qualifications to be a provider within their plan. They want the best. They don't -- and what does TRICARE do? Does TRICARE have any specialty requirements in order to be in their plan? No. It's just

you'll accept below-Medicare rates.

This is incredibly important when you begin to see the differences from family practice, OB-GYN -- you can go down a lot of different specialties and you'll be able to see how these limited networks limit the access and choice and access to good quality healthcare.

Senator Tillis: Thank you. That chart reminds me that I need to enroll in vision care, now that I'm here in the Senate.

[Laughter.]

Senator Tillis: But, thank you, Mr. Chair.

Mr. Buyer: And the reason I have the GEHA plan, there, the Government Employees Health Plan, is -- that's about the median.

Senator Graham [presiding]: Right.

Mr. Buyer: We couldn't find an actual plan in the marketplace to say what would be the median. So, Mr. Chairman, you talked about the median --

Senator Graham: Right.

Mr. Buyer: -- early on. That's about it.

Senator Graham: And that's 87? What number is that?

Mr. Buyer: And so -- yes, that would be 87 or in the GEHA plan, which is about the median.

Senator Graham: Okay.

Mr. Buyer: But, if you wanted the BlueCross, oh, my

gosh, the numbers -- oh, I'm sorry, it's 43 for orthopaedic surgeons.

Senator Graham: Gotcha.

Mr. Buyer: So, TRICARE would be 15 --

Senator Gillibrand: Reimbursement rates or that's --

Mr. Buyer: -- GEHA median plan is 43; with BlueCross/BlueShield, 163.

Senator Graham: Gotcha.

Mr. Buyer: So, look at the avenue of choice and access and quality of healthcare. Pretty extraordinary.

Senator Graham: And your --

General Chiarelli: And I would also point out, besides being it -- the cost, and paying below Medicare rates, there's another bureaucratic requirement, and that's to get certified by TRICARE to be in the network. And many people -- many doctors back away from joining the network when they realize that there's the additional bureaucratic requirement to get certified and made part of the network, even though they're certified in their State to provide that care.

Admiral Giambastiani: Finally, if I could say, when you look at this chart, this is just a static chart that exists today. As we go on in the history of TRICARE, these numbers keep getting wider and wider and wider, which is why we think TRICARE, long term, is in a death spiral.

Senator Graham: Well, that was very impressive for a

House member. So --

[Laughter.]

Senator Graham: Senator Cotton.

Mr. Buyer: You have a feigned memory, Mr. Chairman.

[Laughter.]

Senator Graham: Senator Cotton. Nope, you're next.

Senator Cotton: So, your comment about vision makes me think of a -- an element of the essay "What Does ISIS Really Want from the Atlantic," last week, where the reporter had gotten -- had talked about the roots of ISIS, and he went to interview a jihadi in London, said that no one really understood how great Sharia was, because all they saw was the beheadings and the cutting off of hands. They didn't understand all the social-justice elements of it: free public education, free housing, free healthcare. And the reporter asked the jihadi, "But, doesn't Great Britain already have free healthcare?" And the jihadi said, "No, a lot of stuff like vision isn't covered."

[Laughter.]

Senator Cotton: So, maybe that's the legitimate grievances that they have.

Mr. Chairman, I'll start with you. So, I mean, as I've gone through some of the recommendations -- and I've heard, last week, from a lot of folks at home -- one points that, you know, you commonly hear is, "Well, we're going to have

to pay for more." I mean, it is a -- is it a fair characterization to say maybe you're paying a little bit more, but you're also getting a lot more? And, furthermore, you would be getting less for what you're already paying for if we proceed with the current sequestration policies?

Mr. Maldon: I think that is absolutely correct, Senator Cotton.

Senator Cotton: Okay. I mean, other -- feedback from other folks on the panel?

But, how -- when you -- we were talking to the beneficiaries here, and they, in the end, just see that they have a higher bottom line. Like, what are the key benefits that you think we can tell them, like, "No, this is what you're getting if you pay a little bit more, you know, on a periodic basis"?

General Chiarelli: Well, I would argue the mere fact that you take it out of the government contracting business and -- DOD contracting -- and you don't wait 5 -- you have a 5-year contract that's very, very difficult when a new medical procedure comes out, of some kind, to go ahead and modify that contract. That 5-year contract turns into an 8-year contract after the protest takes place. So, in the eighth year, all those things that were brought to medicine in that 7-year period aren't available to the TRICARE recipient. That's why we've literally got people that we're

putting together treatment plans for traumatic brain injury and post-traumatic stress at the NICO at Walter Reed. They go under the TRICARE system, and TRICARE, their insurance, refuses to pay for 50 percent of the things that are on the plan that we said that this particular servicemember needed, to get better. That, to me, validates Admiral Giambastiani's statement that this system is broken.

Senator Cotton: Other feedback?

Admiral?

Admiral Giambastiani: I would just tell you that you just look at the way the numbers keep going. Unfortunately, what's happened over the years is, because we haven't changed the copays, because we haven't changed any of the fees, because they've remained virtually static, you've got to get money out of it somewhere out of the system. So, we keep changing the size of the sectors or the areas of responsibility. We try to collapse contracts that -- the DOD is working as hard as they can to make it as efficient, but, ultimately, what happens to this is, you reduce the amount of available care to beneficiaries, you reduce the quality, because the groups that are available to do this have shrunk considerably. And so, therefore, the system keeps eating itself from within, is what I would tell you. That's why I think it's in a death spiral.

Mr. Buyer: I would just like to add this. In the

1990s, after the first BRAC, and it was exposed that the military retiree really wasn't enjoying the freedom and liberties that they had fought for, because they felt that they had to live in close proximity to a military base to access healthcare. Then the BRAC exposed them, that, wait a minute, that the government was about to throw them onto Medicare. Congress responded with TRICARE for Life. And when we did that, we essentially said to the military retiree, "You're free. You can live anywhere you want in the country that you fought to defend." And it really changed the interdynamic of the military retiree, because now they can go live with their children and know their grandchildren. Better yet, when they go do that -- and I'm a military retiree of which I'm a military retiree -- I look at this and say, "I can actually access better choice, a greater number of highly qualified doctors." There is -- it's not written about in the press.

This debacle that occurred in the VA, on waiting times -- the reason America got so upset about it was because of the integrity question. It really was. We still -- we -- if you go in and you look at the inside of the MTFs today, talk to those soldiers and the families, talk to the wives. The waiting times for primary care and specialty care -- shameless.

So, accessing this under TRICARE Choice, not only for

the families, but also for the military retirees, that gray-area retiree, we get them better access to care, increase their choice, and increase their quality.

So, that's what they get for a little more money.

Senator Cotton: I mean -- go ahead, Chairman.

Mr. Maldon: And, Senator, I'd just also add to this -- and, I think, in terms of just summarizing it, here, into three different areas. For the Active Duty family members, they get those -- for their money, there's no additional costs, here, but they get a lot more, in terms of choice, access, and so forth, as my colleagues have already said. And then, for the Reserve components, you -- it's -- they get a lot more, because, one, the cost has been reduced from 28 percent of their premium to 25 percent, so they -- that's a -- there's a cost savings there to them. It's a lower cost there. And, in addition to that, there are -- there's no break in coverage when the Reserve-component member is mobilizing, deploying, and back and forth, and so forth. They don't have that break in coverage that they would have under the current system. And so, they're going to have consistent coverage during that period of time, which would be a much better value under the new -- under our proposed --

Mr. Buyer: Could I --

Mr. Maldon: -- recommendations.

Mr. Buyer: Could I add one more? The big winners, that isn't really talked about in this, are those that live in the rural areas. They're the ones who are the really big winners under this type of a health system. Because when -- if you're subject to the TRICARE today, and you're in a limited network, it's so limited, whereby sometimes you go against your migratory pattern. We don't talk about that very often. But, someone from a small town thinks that they need to go to a bigger town for better healthcare. Of if I'm in a bigger town, I need to go to the bigger city for better healthcare.

In the TRICARE network, sometimes when they sign up a particular doctor, they may say, someone in a town of 10,000, you've got to go over to the town of 3,000 people to go get your healthcare. And it just drives them crazy. It really does.

And this type of plan, we can access a greater -- I'm sorry, I didn't mean to point in front of your face -- but you great -- you access a greater number of healthcare providers in rural areas, Senator Cotton, and that is a huge benefit in this plan.

Senator Cotton: I'll yield back.

Senator Graham: Excellent question.

Anything else, Senator Gillibrand?

Senator Gillibrand: No.

Senator Graham: Thank you all. We will --

Absolutely.

Senator Cotton: Since there's no more questions --

Is it your best estimate that beneficiaries in the system, even if they pay -- in certain cases, pay a little bit more than they do now -- still, on average, will be paying less than similarly situated beneficiaries who did not serve in our military?

Mr. Maldon: Yes. In fact, they'd be paying less than what someone that was a part of a healthcare plan similar to FEHBP. They'd be paying, you know, less than those civilian employees that would be enrolled in that plan.

Senator Cotton: And that's at -- everyone's in agreement on that point? So --

Admiral Giambastiani: Yes.

Senator Cotton: Admiral? Yes.

So, one might say that to -- in response to the point that we promised our veterans that they would receive a certain level of healthcare, and that would be a better or lower priced care than civilians who didn't serve receive, yes, this proposal is going to keep that promise.

Mr. Buyer: Absolutely.

Senator Cotton: Yes.

Mr. Buyer: Because today someone of whom worked at a depot as a Federal civilian employee is getting access to

better healthcare than the servicemember in uniform or his -- in particular -- not necessarily him, it's his family, in the TRICARE network. Because the TRICARE network is so limited so that Federal civilian employee is getting access to better healthcare for his children than the servicemember for theirs. That's not right.

Senator Cotton: When you take into account the entire package of healthcare benefit, you know, price, access, quality, so forth.

Mr. Buyer: Yes.

Senator Cotton: And that the promise we made to our servicemembers is that they would receive that package, relative to civilians, not necessarily that that package would never change in any way for the rest of time.

Mr. Buyer: For the rest of time? Well, I don't --

Senator Cotton: For the --

Mr. Buyer: -- I don't know what that means. But, for -- for the rest of time.

Senator Cotton: For -- you know, --

Mr. Buyer: I do know, for the military retiree, for example, they're very artful, okay, in their words that they will select, because they're, "Oh, I've been promised healthcare for life." I mean, you --

Senator Cotton: That's because soldiers are very artful --

Mr. Buyer: Well, you'll --

Senator Cotton: -- and always have been.

Mr. Buyer: -- you'll hear artful things. But, they have --

Mr. Maldon: No, but --

Mr. Buyer: -- they have had a tremendous benefit. They really have.

General Chiarelli: But --

Mr. Buyer: But it's --

General Chiarelli: But, it --

Mr. Buyer: Go ahead.

General Chiarelli: No, I'm just saying, if you look at the details of our legislation, one of the things we did was, we saw that TRICARE used to be good, not so good today, because of actions taken by DOD. Okay? Because they need to save money. We turned to Commissioner Zakheim and said, "Bulletproof this. Set this legislation in a way that, if we can get this through and get this benefit in the hands of these folks, that nobody will be able to do that." And he did. I won't give you the specifics of that, but he did in our legislation.

Mr. Buyer: So, my conclusion is, for that military retiree, when they've been at 5 percent -- they were at 27 percent, right, and they're at 5 percent today, and we walk them up to 20 over 15 years. They are getting so much more

value in a health -- in a quality health system that their complaint does -- is not legitimate.

Senator Cotton: Yeah, I mean, I think it's important that we all be prepared -- Republican, Democrat alike, and the commissioners -- to answer these questions, because we will get those questions, and I think we're all in agreement that we all want the same thing for the retirees. We just have to be able to explain to them exactly how the new system will work and how much better the package could be for them, despite the discrete changes they see in their lives.

Mr. Maldon: Senator, I think that it is fair to say, though, that the retirees -- in all of the travel that we did across the country in townhall meetings, into sessions, and public hearings, and so forth -- retirees basically -- they told us that they didn't mind seeing an increase, frankly, in that cost sharing, as long as they got value for it. They wanted to make sure there was improved value for it. And I think that's what we have provided in those recommendations that we've --

Senator Cotton: Yes.

Mr. Maldon: -- made.

Senator Cotton: Thank you.

Senator Graham: Thank you all very much.

And so, let's hear some -- from retirees. Y'all are

next.

Thank you very much.

Next panel, please.

[Pause.]

Senator Graham: Thank you all very much. Could you introduce yourselves, starting from the -- my left to the right?

Ms. Raezer: Hi, Mr. Chairman. I'm Joyce Raezer, with the National Military Family Association.

Admiral Ryan: Norbert Ryan, with the Military Officers Association of America.

Mr. Snee: Retired Master Chief Tom Snee, Fleet Reserve Association, sir.

General Hargett: Gus Hargett, National Guard Association.

Senator Graham: Thank you all.

I will defer my opening statement and allow Senator Gillibrand to say anything she would like.

Senator Gillibrand: Thank you for your service. Thank you for being here. We look forward to your testimony.

Senator Graham: And speaking of military retirees -- Senator McCain, would you like to say anything?

Chairman McCain: I'm retired.

[Laughter.]

Senator Graham: Okay. With that insight, we'll let

the panel move forward.

So, just --

STATEMENT OF JOYCE W. RAEZER, EXECUTIVE DIRECTOR, NATIONAL MILITARY FAMILY ASSOCIATION

Ms. Raezer: Okay, thank you very much, Mr. Chairman and Senator Gillibrand, Senator McCain. We appreciate the opportunity to speak on behalf of National Military Family Association and the families we serve about the healthcare proposals of the Military Compensation and Retirement Modernization Commission.

We thank the commissioners for their thoughtful approach, outreach, and dedication to obtaining input from troops and their families.

Military families deserve nothing less than the best possible health coverage and care. They also expect the readiness of their servicemember to perform the mission as well as the readiness of their medical providers to meet the challenges of the battlefield in its aftermath to be a priority.

We agree with -- our association agrees with the commissioners who have testified that the current TRICARE benefit and system to deliver that benefit is unsustainable. Budget pressures continue to diminish the benefit, delay access, and threaten military medical readiness in what has been DOD's most frequently proposed reform: raise the fees charged to beneficiaries. When we asked for their input last year for the Defense Department's military health

system review, families cited bureaucratic hassles to obtain referrals, lack of continuity of care, inability to obtain timely care, and a lack of coverage for certain services.

We do know that many families remain satisfied with TRICARE, the care they receive and the low cost of that care. But, what could happen to that care when financial pressures take a greater toll on the military hospitals or the TRICARE benefit over time? Our association is open to other healthcare options for military families because DOD has been well aware of many TRICARE problems -- in some cases, for years -- but has failed to take corrective action. We support, in principle, the concept of moving military families to high quality commercial health plans as a way to improve access to providers and offer more coverage options that match families' needs, but we need more information.

Military families are concerned, as you are, Mr. Chairman, about what would happen to out-of-pocket costs. Even when assured that the proposed basic allowance for healthcare would be set to ensure most Active Duty families have no additional cost, families are unconvinced. They cite recent changes to the basic allowance of health -- housing formula as evidence the healthcare allowance could become a target for cost-cutting. They worry how a formula based on averages will support larger-than-average families

or those with a family member with a chronic or a catastrophic health condition, as you mentioned, Senator Gillibrand. They also -- the families of the wounded also cited the same kind of questions that you are asking, so appreciate you asking those. Many families tell us the cost proposed for retirees and their families are too high, despite the gradual ramp-up.

In our written statement, which we've submitted for the record, we've outlined many logistical challenges involved in implementing TRICARE Choice and the need for families to have the tools they need to make informed decisions. We do believe the Commission's proposal does contain important protections for families, protections they don't have now, but which must be in -- written into any statute implementing the changes.

Implementation plan must also address unique circumstances of military life. For example, FEHBP plans only cover ABA therapy for autistic children if a State requires that coverage. A unique circumstance of military families would be, we would need to see that coverage in any plan offered to military families. Change also demands an analysis of the potential impact on military hospitals to avoid unintended consequences for beneficiaries and military medical readiness.

I would like to touch briefly on one additional

recommendation from the Commission, because of its relation to healthcare, which is recommendation 7, to align the services offered under the Extended Care Health Option, ECHO, to those of State Medicaid waiver programs. The ECHO benefit is currently underutilized because of bureaucratic requirements involved in obtaining some services, such as respite care, and a mismatch between the benefit and what families experience that they need. This match -- mismatch forces families to apply for State Medicaid waiver programs and get stuck on waiting lists whenever they move to a new State. Adopting the Commission's recommendation would provide for better continuity and coverage of services.

In an era of budget constraints, when military families see any proposed change in their benefits as just another attempt to cut costs, it's important to rebuild their trust and show them their service is valued. We hope the Commission's proposals prompt a thorough discussion of how to deliver the best health benefit possible for military families.

Questions you ask about -- and others ask about the Commission's proposals should also be asked about the current system. How does the structure promote medical readiness? How does it ensure timely access and quality care at the best possible price for both beneficiaries and the government? And now is the time to have that

conversation. So, thank you for beginning it.

[The prepared statement of Ms. Raezer follows:]

STATEMENT OF VICE ADMIRAL NORBERT R. RYAN, JR., USN (RET.), PRESIDENT AND CHIEF EXECUTIVE OFFICER, MILITARY OFFICERS ASSOCIATION OF AMERICA

Admiral Ryan: Chairman Graham, Senator Gillibrand, Senator Tillis, and Senator McCain, thank you for this opportunity on behalf of our 390,000 members.

This afternoon, I'd like to make just five brief points:

First, MOAA sincerely appreciates the work that the Commission did. These are very professional, dedicated Americans that have done quality work. The proposed change to the healthcare system is welcome. It's a welcome shot across the bow and should serve as a forcing function, I believe, for Congress to work with DOD and Secretary Carter to push through with the essential and much needed reforms necessary to optimize the system. I believe the one thing we all agree on is that the status quo is not acceptable.

Second, it's obvious that the Commission, Congress, MOAA, and my colleagues here at the table all seek the same objective: a healthcare delivery system that is far more integrated, efficient, effective, and sustainable than the current system.

Third, where MOAA respectfully differs with the Commission is, we believe the problems that TRICARE has can be addressed in a systematic manner without resorting to its

elimination. MOAA has consistently stated that the largest barrier to a truly efficient and highly reliable healthcare organization is the current three-service system. In the 1980s, Congress demanded, over the strong objection of Pentagon leadership, that the services fight wars jointly. It is now time for Congress to insist that the services do the same thing immediately in the medical-care area. Study after study has concluded that a unified medical command that has a single budget authority over the three military systems will yield significant cost savings and efficiencies that will make the military system one we can be proud of.

Fourth, MOAA's recent electronic survey of 7500 beneficiaries, 1500 of which were enlisted, 400 spouses, indicates that, even with its problems -- even with its problems, 8 out of 10 prefer TRICARE to a health plan similar to what Federal civilians use. If Congress contemplates moving to a healthcare plan similar to the Commission's recommendation, it needs to take the time necessary to ensure all stakeholders understand the second- and third-order effects.

Finally, MOAA believes that, out of the Commission's 15 recommendations, the two that propose dramatic changes to both military retirement compensation and military care programs could have a serious impact on career retention required in the All-Volunteer Force. Both recommendations

produce a negative effect on the pocketbook of patriotic Americans for whom the government needs to serve for -- needs to draw to a 20-year career.

So, it isn't necessarily as much the money, but I would like to put up a chart on this, because, Senator Graham, as you pointed out, people would sign up for this retirement benefit when they came in because, as Senator McCain has said, it would be prospective. But, what we're concerned about is the combination if we implemented a retirement system that was prospective and we also integrated that with the healthcare system that the Commission reports, the question is, Would there still be a sufficient draw for those young men and women who are coming in, in the future, that they would feel it's worth going from 10 years to 20 years? We think there's considerable risk with this. And, you know, all you have to do is multiply that 20 by 20 and you would see, it's about 128,000 less in benefit. So, the question is, Would that be sufficient to get people to stay in for a career, let alone more than one tour?

If Congress -- and because that's basically a 27-percent cut, as you see -- if Congress and the administration decide to adopt these two very financially impactful recommendations from the Commission, MOAA believes the risk to the quality of the All-Volunteer Force would be significant because of -- the incentive to stay for a career

would be in doubt.

Again, thank you for this opportunity, and thank you all for your continued leadership.

[The prepared statement of Admiral Ryan follows:]

STATEMENT OF THOMAS J. SNEE, NATIONAL EXECUTIVE DIRECTOR, FLEET RESERVE ASSOCIATION

Mr. Snee: Senator Graham, Ranking Member Gillibrand, Senator Tillis, Senator McCain -- Senator McCain, it's good to see you. A few years ago, we worked on the reemployment rates of our veterans a few years ago, and I'm glad that we're still producing that and keep going. So, again, I thank you -- and other members of the subcommittee, my name is Tom Snee, and I'm the National Executive Director for the Fleet Reserve Association of 60,000-plus enlisted serving in the United States Navy, Marine Corps, and Coast Guard. I want to thank you today for the opportunity to express the views of our Association on the Commission's recommendations related to healthcare, a valued concern throughout. We also want to thank the Commission for reaching out to the Fleet Reserve Association to seek our input on these complex and challenging issues during their deliberations.

Before commenting on the Commission's healthcare recommendations, Fleet Reserve Association still notes with concern the impact of sequestration that is felt outside, not only towards national security, but to pay and allowances. Please remove DOD from sequestration.

It should be also noted, on aside, that, in the total force manning of over 75 percent enlisted mannings, that there were no representation of enlisted on the Commission

staff.

Recommendation number 6 of the Military Compensation and Retirement Modernization Commission is the most wide-ranging recommendation that calls on the Congress to replace the current healthcare arrangement with a new system that provides beneficiaries with choices offered by commercial insurance companies. The Commission found that TRICARE is no longer fiscally sustainable. FRA believes that such vast and dramatic change to the healthcare benefits should require additional reviews. It is recognized that the beneficiaries would be offered a variety of cost choices in their geographic areas of medical service providers, ranging from the array of copays and premiums. The critical factor is the making of these choices as having a well-informed service and family members in the decisionmaking process of these plans. This is the cause-and-effect attribute to recommendation number 3, the need for a well-structured and reenergized financial literacy program providing an understanding of health insurance and accompanying care.

Again, recommendation number 6 calls for the realignment of costs for beneficiaries, which has a major concern with our members under the age of 65. The Association believes that, over time, this could devalue the current 20-plus-year career of military service that retirees can expect as reduction in healthcare premiums.

The question we need to ask is, Are we advocating a culture of early departure over a viable career with a potential negative impact on manning requirements either through recruiting or retention models? FRA advocates that other options to make TRICARE a more cost-effective measure would be implemented before raising costs -- higher costs to TRICARE beneficiaries.

It has been noted that higher costs will be ensure a better access in care response. We ask, Will this be a measured contractual guarantee of the future? FRA shares the concern about the timely access and waiting time for care. The NMRC has reported TRICARE benefit beneficiaries in some locations are experiencing half of the referrals for purchased care network that waited longer than the 28-day standard. Even in locations with the highest access to care, only 16 percent of referrals maintain the 28-day standard. FRA recommends a measurable pilot program in specific geographic locations currently not served by TRICARE Prime that might be a demonstration if the plan is effective in meeting the needs of the beneficiaries.

FRA supports the recommendation number 8, and strongly encourages, again, a quicker collaborative joint action between DOD and the Department of Veteran Affairs on the joint electronic health record system to provide a seamless transition for our members once they leave Department of

Defense into the VA system.

Limited time does not permit me to go into more detail, but our written testimony does provide further details.

Mr. Chairman and the committee, I thank you very much for our opportunity to express our views. Thank you.

[The prepared statement of Mr. Snee follows:]

STATEMENT OF MAJOR GENERAL GUS L. HARGETT, JR., ARNG (RET.), PRESIDENT, NATI9ONAL GUARD ASSOCIATION OF THE UNITED STATES

General Hargett: Mr. Chairman, Senator Gillibrand, Senator Tillis, Senator McCain, thank you for the opportunity to testify today on the healthcare recommendation made by the Military Commission in their final report.

National guardsmen nationwide applaud the Commission for providing some innovative ideas and a real starting point to deliver a reform of the military retirement and healthcare systems. Maintaining medical readiness, including dental readiness, allows the National Guard to remain a truly operational force for the Army and Air Force.

The Commission recommends that changes and alternatives to TRICARE are in order, citing problems with access to care, number and location of providers, cumbersome referral and authorization process, limited provider networks, and member preferences for greater choice. All these problems exist today in the National Guard, and I can assure you, because I have been there and done that.

The Commission recommends giving servicemembers the option of selecting from the more than 250 Federal healthcare plans available under the Federal Employee Health Benefit Program. This program would be called TRICARE

Choice. I believe that expanded choices for health insurance will be well-received by all National Guardsmen.

One of our top priorities has always been to see that every member of the National Guard and their families are able to afford healthcare. But, NGAUS remains concerned with the actual cost of these plans. Although the research work of the Commission is broad and important, that we see the actual numbers and the cost of each program and it be given to each servicemember under these 250 plans. NGAUS would recommend the subcommittee bring in actuaries to do cost-benefit analysis of each of the programs. These questions need to be answered before members and retirees of the Guard would feel secure in supporting the change in TRICARE as it now stands.

Another issue of access to healthcare benefits involves the men and women of the Guard who are military technicians. Our technician force is made up of people who run our armies, our wings, on a daily basis. They do not have the same privileges under the current law, nor were changes in access and affordability addressed by the Commission. These men and women who serve under Title 32 or Title 5 should also be able to take advantage of a new modernized healthcare program. And I ask that the subcommittee examine the healthcare benefits now available to our technicians.

One access issue involves the Guard and Reserve

retirees under age 60, gray area of retirees, who would continue to have access to healthcare benefits, but at full premium. This does not compare fairly to the Commission's recommendation that would allow Active Duty retirees to maintain continuity of coverage at only 20-percent premium cost-share. In all fairness, providing a premium cost subsidy to gray-area retirees to assist them in maintaining continuity of health needs to be included in the report and any legislation passed to incorporate the Commission's health access recommendation.

Any recommendation of the Commission, although not directly healthcare related, does not -- although not directly healthcare related, is to the mental health and welfare of the families of the members of the Guard. This recommendation concerns military children. The Commission noted that children experience unique stress associated with parental deployments and that these stresses can adversely affect academic performance, and recommends that children of Active Duty servicemembers be identified in nationwide reporting of student performance. Although not mentioned, children of the National Guard and Reserves should be identified, and their issues addressed, and NGAUS asks the subcommittee to include them.

We support the changes to protect the viability of the total force. That cannot be done under the current system

and under the constraints of sequester.

Mr. Chairman, as always, we thank you for the opportunity to testify before the Commission and stand ready to present -- to assist, as required.

[The prepared statement of General Hargett follows:]

Senator Graham: Thank you all.

Senator McCain, would you like to go first?

Senator McCain: No, thank you, Mr. Chairman.

Senator Graham: Okay. Let's sort of get right into it, here.

Do you all agree that the 5-percent number has to change? Does anybody expect, if you kept the current system and you didn't change it at all, that we'd have to adjust premiums upward over time?

Admiral Ryan: Mr. Chairman, you know, as you know, we work with you all to increase the premiums and then have them at a cost-of-living rate, so they're already planned to continue to go up. What we don't have a lot of visibility on is, frankly, where the 5 percent came from.

Senator Graham: Okay. Well, the bottom line is, I think we need to get over that hurdle that something's got to give, here, on that side. And the question is -- you're going to have to pay more or the system's going to collapse over time, and I want to make sure that you're getting more value for your money.

As to the provider network, it seems to me that they're been hitting -- they've been hit hard, in terms of trying to keep TRICARE afloat. The only explanation I can give for the fact that there's so many less people participating in TRICARE versus these other programs is the reimbursement

rate. Does that make sense?

Admiral Ryan: Mr. Chairman, one thing I would say is that we, at MOAA, certainly agree that we can't continue with the fee for service. We have to do, I think, what the Health and Human Services is doing. I think we have to do what the U.S. Family Health Plan is doing, with capitated financing or paying for the value of healthcare rather than the number or volume of procedures that you take. That has got -- this policy that Admiral Giambastiani talked about, that's got us into this spiral that we're into. And I think if DOD would come under a single unified command and go to what HHS and others are going to, with a different way of financing healthcare, paying for the quality, you would get these networks to start opening back up again.

Senator Graham: Anybody want to take a shot at that?

General Hargett: Mr. Chairman, when I was the adjutant general of Tennessee and we had the rural communities, as they were discussed earlier, that were underserved, I actually had to write letters to healthcare professionals in communities where we were not served at all, and just ask them to sign up for TRICARE. What I constantly heard from everyone is that, "We're -- we just can't take the reduced benefit and see the number of people that are required under the current system."

Ms. Raezer: Yeah, Mr. Chairman, I would agree. And I

think what -- one of our concerns about TRICARE is, TRICARE is not fast enough to look at changes in how healthcare is financed, incentivized, where some commercial plans have had to do that. There have been things happening, as --

Senator Graham: That's what General Chiarelli was saying.

Ms. Raezer: Yes, exactly. And so, you know, some of it comes down to a choice. Do you want DOD to take this task on, or do you want to look for solutions among the private sector in -- that's --

Senator Graham: Okay. That's the ultimate issue. Let's take a poll. Starting with you. What do you think is the best thing for the Congress to do? Try to take the current system and do what the Admiral is talking about, or look at the private sector?

Ms. Raezer: I think Congress needs more time to do both. And so, what we would recommend is maybe put a hold on the next TRICARE contract procurement until you can ask questions of DOD. How -- what's the best way to address some of these issues? And --

Senator Graham: Here's my bias. If I were trying to run a healthcare company, the last people I'd pick would be the --

Ms. Raezer: Well --

Senator Graham: -- Department of Defense.

Ms. Raezer: -- I --

Senator Graham: They're good at blowing things up.

Ms. Raezer: And so, I think you need -- there have been questions raised about -- that the details in the Commission's report. So, we need more details as --

Senator Graham: All right. Admiral --

Ms. Raezer: But --

Senator Graham: -- what's your bias?

Admiral Ryan: I obviously have biases, but I was surprised by our polling, that, with the challenges that the plan has currently, that eight out of ten, across the spectrum, prefer to TRICARE. So, I would say Plan A ought to be: You ought to do what you did in the 1980s and tell DOD they don't have a choice, they have to go to a unified health plan --

Senator Graham: I gotcha.

Admiral Ryan: -- with one person. And then you could fall back on Plan B if it doesn't work. But, I think --

Senator Graham: Yeah.

Admiral Ryan: -- you could get the financing the way you want it, you could make it a uniform benefit, which is what Senator Gillibrand is concerned about, and we are. Some of the things, like the applied therapy for autistic children, they're not covered in FEHBP, and only about 20 of the programs in all the States --

Senator Graham: Yeah.

Admiral Ryan: -- even cover it. So, a uniform plan is a pretty good benefit.

Senator Graham: Yeah. Okay.

Mr. Snee?

Mr. Snee: Mr. Chairman, you know, the Fleet Reserve, as I mentioned in my statement, of a pilot program, could probably be of the best to reevaluate over a period of time. Of course, I wouldn't come right out and say, but --

Senator Graham: I gotcha.

Mr. Snee: -- maybe I'm just saying -- but, one of -- the other thing is, maybe combine the medical commands.

Senator Graham: Yeah.

Mr. Snee: Another thing is the -- incentivize to encourage retirees to use the MTF, so there's a little bit more of that level from the -- especially of --

Senator Graham: That's not going to work very good under sequestration.

Mr. Snee: Well, I understand, sir.

Senator Graham: Yeah.

General?

Mr. Snee: It's just an idea. And the --

Senator Graham: Yeah, I know. I know.

Mr. Snee: -- other thing is, we can send additional information in writing, sir.

Senator Graham: I gotcha.

General?

General Hargett: Mr. Chairman, I think if we continue to do the same thing with the same systems, we will get the same result. I think we have to look at change. And I think it's up to this subcommittee and the Congress to figure out how to do that change. And we're open to help with the change.

Senator Graham: Senator Gillibrand.

Senator Gillibrand: Thank you, all of you, for the -- your testimony. It's very helpful.

The Commission's report describes significant beneficiary dissatisfaction with the current TRICARE health benefit. So, I -- it's interesting, Admiral, that you said eight out of ten preferred TRICARE, which was pretty alarming -- shocking to me, actually.

So, Ms. Raezer, the National Military Family Association is an important voice for our military families. How would you describe the military family assessment of TRICARE? Did you guys do polling similar to what the Admiral did?

Ms. Raezer: We have not surveyed the way MOAA did, but we did -- have gone out to families, did a lot of gathering of input as we were working through the military health system review and to provide input to DOD for that. We

could get a lot of feedback from families.

There is a -- families are used to TRICARE. They will say, "I'll accept the hassle of TRICARE because of the cost." They're dealing with a lot of things, and accepting of a lot of things that they shouldn't have to accept.

Senator Gillibrand: So, just to follow up on that, one of the concerns we were having is that -- obviously, military families move frequently, and they have limited options under TRICARE. But, at the same time, TRICARE covers a wide range of medical needs, regardless of where they move. Do you think that this new model of care will provide the same level or greater access to quality of care that exists now? Have you assessed that?

Ms. Raezer: I think there are options, but a lot of how families will actually access is -- is going to be dependent on what kind of information they get. It's a lot easier to give information on TRICARE and how it does or doesn't work in certain places. When you have more choices, families are going to need more education, "When do I pick a national plan" --

Senator Gillibrand: Right.

Ms. Raezer: -- "versus a local plan?" for example.

Senator Gillibrand: Are you concerned about how military families will be able to transfer medical records maintained by a private provider when the family is required

to move to a new location? Is that something you've assessed?

Ms. Raezer: That's already a problem. If I go to a civilian -- if my TRICARE prime doc at a military hospital sends me to a civilian specialist, if I don't carry that record back to that civilian's -- to that primary doctor, the -- or vice versa, if I'm going from a military specialist back to a civilian primary care manager, I'm the one carrying the record. So --

Senator Gillibrand: So, we might have to require portable records, which is obviously a huge problem from going to --

Ms. Raezer: Yeah.

Senator Gillibrand: -- Active Duty to veteran service, anyway.

Admiral, in your polling, did you poll both Active Duty military families and retirees?

Admiral Ryan: Yes, Senator, we did.

Senator Gillibrand: Was there a difference in their assessments?

Admiral Ryan: There was a slight difference. We had -- about 10 percent of the folks were Active Duty, because we're -- we have 90,000 Active Duty and we have 300,000 that are in some stage of second careers or third careers.

It was interesting, of the 400 spouses that responded,

they were at 85 percent, they preferred TRICARE to an FEHB program. Overall, it was 80 percent. For the Active Duty, there was a slight split. Below 35, it was about 73 percent. Above 35, it was about 78 percent that preferred TRICARE to the FEHB. So, it was fairly consistent --

Senator Gillibrand: Interesting.

Admiral Ryan: -- across all.

Senator Gillibrand: Mr. Snee and General Hargett, did you have any feedback from your members?

General Hargett: Yes, ma'am. The most people that we heard from -- and bear in mind, our people are in rural communities, they don't have access to the Fort Braggs and the Fort Campbells -- most of them were favorable to change --

Senator Gillibrand: Okay.

General Hargett: -- because of the lack of access and --

Senator Gillibrand: Because of the challenge with access, yeah --

General Hargett: Yes, ma'am.

Senator Gillibrand: -- very much so.

General Hargett: Yes, ma'am.

Senator Gillibrand: I see that in New York State all the time.

General Hargett: Yes, ma'am.

Senator Gillibrand: And Mr. Snee?

Mr. Snee: Yes, ma'am. We surveyed 80 percent of ours -- membership, as well. And, as you said, it is well with -- in the Tennessee area of considering the Active Duty folks is where they're going to be, especially with our recruiters and our reservists in this type of thing. But, with -- they want to keep TRICARE.

Senator Gillibrand: One of the things that I hear a lot from our veterans is that the mental health services that are needed really aren't there, that, in fact, for a female who is suffering from PTSD, she may avoid the VA, because they don't have specialists who understand her concerns or what she's going through, or various stigma associated with going through existing structures. Do -- have you done any assessment if this would perhaps help, the access to mental health services, being able to go general providers, where there are specialists and expertise, and have a wider choice might benefit some of our retirees and veteran population? But -- I don't know, so I'd like to know if you've had any analysis on that.

Admiral Ryan: Senator Gillibrand, that's a great question. I was surprised. We chartered a study on mental health -- civilian mental health workers and -- were they culturally sensitive to the military, where they could be effective? And RAND did the study for us, and we can make

that available to you, but we were very surprised that the majority -- I want to say close to 90 percent -- did not have the cultural sensitivity to be effective in their counseling --

Senator Gillibrand: In the military --

Admiral Ryan: -- of military families and children, as well as the veterans. And that study, we did in 2014. We briefed up there on the Hill, but we haven't gotten it out as much as we want to.

Some States are more effective at helping with that. Joining forces has helped with doctors. But, overall, the RAND study was pretty dramatic in the fact that they didn't have the cultural sensitivity and awareness that they needed to be effective.

Ms. Raezer: But, Senator, there's also an issue with just the -- the network issue. We hear from too many Active Duty families who are trying to get behavioral healthcare for a child, and they've gone through the list in the -- that -- in the network, and continue to hear, "No, we're not taking any new patients. We're not taking TRICARE patients. No, we're long -- no longer in the network." So, there are access issues right now. We think the sensitivity, there are ways to -- that should be done to make that better for all providers. But, for a lot of our families, it starts with access. They can't get the care.

Senator Graham: One quick question and I'll turn it over to Senator Tillis, here.

When people say they prefer TRICARE to a more commercial system, how do they know, if they've never been in it?

Senator Gillibrand: Yeah, that's the unknown, you're right.

Senator Graham: Yeah.

So, Senator Tillis, go ahead.

Senator Tillis: Actually, just -- I was channeling my first question through the Chair.

But, because the question that I had -- and it went back to maybe some of the surveys or polling, just -- I'd be very interested in taking a look at the methodology and how the questions were asked, because the -- you know, the -- it's one thing to say -- you know, first off, I was astonished by the numbers, in the 70s. I thought, generally speaking, people don't like their health plan, for just general reasons. You know, so getting anywhere beyond the 60s would be surprising to me, in terms of the user experience. But, you know, if you look at -- if you couch some of the questions -- and I think -- and is it -- am I pronouncing it right? Ms. "Razor"?

Ms. Raezer: Yes.

Senator Tillis: If you couch the question by saying --

if I'm in Fayetteville, and I go from having 15 providers who are willing to participate in the TRICARE plan, and 138 -- and I will guarantee you, knowing North Carolina relatively well, I know about the quality of the providers at the other end of the spectrum -- would they potentially answer that question differently?

And this is more with an eye towards the value for the money. And you look at behavioral health, the number of people that may opt out of being in a provider network now simply because the reimbursement rates do not make it viable in the face of a number of other people seeking the care that may be able to be with that insurer that has a higher reimbursement rate.

So, how do we get -- I mean, do you all feel like that, in spite of all that I just said there, that, generally speaking, your members are satisfied with TRICARE as it exists today?

Ms. Raezer: I know there are military families who are very satisfied with TRICARE because they're basically healthy and they're willing, in many cases, to wait for a little bit of access in a military hospital because they're not paying anything out of pocket. But, anecdotally -- and I think a good question for the Department of Defense is -- How many families are switching from prime to standard? And why do you think -- because standard, they pay more, but

they have more choice.

Senator Tillis: Right.

Ms. Raezer: And I know a lot of our families who get frustrated in doing some of the bureaucratic goat ropes will say, "I'm going to manage my own care. I'm going to go to standard." And so, I think there's -- families are looking at the cost. They're afraid of change. There's been so much change. There's a lot of anxiety. And so, "Well, we know what to expect with TRICARE right now, so we're not sure we want to take that leap into something different."

Senator Tillis: I always love my insurance when I'm not using it.

But, what about the rest of the people on the panel, on the same question, about your members?

Admiral Ryan: It's a great question. And this was more than just our members. We had over 1500 noncommissioned officers answer, 400 spouses. Some of them didn't say whether they were NCO spouses or officer spouses. But, we got a cross-section. We were really trying to find out just how people felt. Because the way the Commission asked the question, I think, you know, was fair, but it's -- who was -- who doesn't want more access? Who doesn't want it to be more timely? We know there are problems with that, as Ms. Raezer has said. So, we were surprised by the response, that, despite the challenges -- and that's why

we're leaning toward Plan A, demand that they go to a optimized system of one unified person in charge, where you can hold them accountable for getting a uniform plan, with better type of financing, where there's risk between the contractor and the military, and it -- whether it's capitation or value, and go that way, rather than throw the baby out with the bath water.

Senator Tillis: I was glad to hear your points on capitation strategies earlier. I agree with it.

Mr. Snee?

Mr. Snee: Yes, sir. From the culture of change, if you will, from the dependents as to where do we go, we move from one place to another under permanent change-of-station orders. What's going to happen where we get to our next duty station? Is it going to be available? I made mention of recruiters. And, of course, not to take away from my colleague here, the Major General, and the reservists, as to, okay, so where do we go from here, and where can we have the change? Are we going to have something that we know we can use? And if you have that pressure put on the family, especially the spouses, as, "Okay, where do we go?" Nothing the -- from North Carolina, even here in Virginia, but let's go out to Wyoming, let's go out to some of those other areas. As long as you have that MTF umbrella in those referral services outside, that's okay. But, once you get

out of that, you're talking about a culture of change of "What if?"

Thank you.

Senator Tillis: General Hargett?

General Hargett: Yes, sir, Senator.

I -- you know, I'm probably one of those guys that retired from Active Duty and I didn't know what I didn't know. You know, I used TRICARE, and I used the Fort Campbell and Fort Hood and all those places forever. So, I was actually pretty happy with it. But, once you go out and retire, you find that it's far different when you start looking at access.

And -- as a matter of fact, I'll follow onto what she said -- when I retired, and I started figuring out my access, I actually went to MOAA and bought a supplement, where I could switch over to standard and paid, what, I don't know, Norb, $130 every quarter to be able to have access to a larger network. So, you know, I think sometimes that we kind of get caught into what is it we're used to, what we're comfortable with. And when you asked the question about change, people fear change.

Senator Tillis: Mr. Chair, if I may, just one thing.

I would like to underscore what Senator Gillibrand said about medical information, chart data. We did a lot of work in North Carolina trying to make sure comprehensive

information follows the patient. That's one of the dangers. If you have an expanded provider network, and you don't have that transportability of information, you may have a more qualified provider, but they're acting on less information. I think that's a very important part.

And the other thing related to support for spouses. I think one of the panelists mentioned just one of the treatments on autism. And if we're talking about -- this is something that we actually took action on as I was Speaker in North Carolina -- when you're talking about the impact that that has on the family, particularly of deployed personnel, it's not only transformational for the child that may be in the program, but for that parent who's taking care of the family while their loved one's deployed. And I think that's an area that we need to look at, as well.

Ms. Raezer: I would agree, Senator. I think that's where the Commission's recommendation to make sure that the plans are addressing the unique needs of military families, that's so important, and looking at things that TRICARE has -- DOD has already deemed as essential, with your help, like the ABA therapy, they need to be included in these plans as requirements. And we need to look at things like mobility and how to help families as they move. And so -- but, that, we believe, is doable, with a conversation. We all have our lists of what happens. Right now, things are falling

through the cracks, in some cases. So, this is an opportunity to talk about how to make things better.

Senator Graham: Go ahead, Senator Gillibrand.

Senator Gillibrand: Yeah.

You know, following along this concern, I think one thing we can work on, to whatever end we have, a -- minimum requirements. I mean, part of the debate on healthcare reform was the fact that it would be great if you could go to any State at any time and have hundreds of plans at your fingertips, that you could buy whatever you wanted. But, the reason why that was a debatable issue is because some States had minimum standards. So, New York State, for example, said, "You've got to cover mammograms. You cannot not cover mammograms, because we know that if you don't have any money, you're not going to spend that 20 bucks, you're saying to say, 'I'm going to risk it another year. I can wait another year. I don't have that 20 bucks right now.'" Because that was the copay for a mammogram in that fact pattern.

So, maybe one thing we should work on is, What are the minimum standards for the marketplace that we would have? Because obviously you're going to have a lot of new customers. If we do something like this, you have an enormous number of new potential customers, so we say, to be eligible to get these customers, you have to have minimal

standards. Maybe that creates a marketplace. I don't know. But, you know, to the extent you can think through that, or if you have thoughts on that, please advise us. But, I'm going to ask the panel to perhaps brief that issue -- the Commission.

Senator Graham: That's actually a -- here's the big dilemma. One, we've got to do something with the current system, because it's just unsustainable. And, Admiral Ryan, we've been wrestling this alligator 4 or 5 years. I just have lost, sort of, faith that we can take the current construct, the single-payer system that you're envisioning, and make it as efficient as a competitive model. But, having said that, the minimum standards is probably a good idea to look at. You just don't want to have too much so that it loses the whole advantage of being able to get more people to participate.

So -- and here's the honest answer. It seems to me that the person who's going to pay the most is the retiree, no matter what you do. The family members are pretty well held harmless with the new system, maybe a little more out of pocket. The National Guard guys may pay some more, but they're definitely going to get a bigger choice. It's the retiree that we need to really watch, here, and be fair to.

So, you've got reservists who live in rural areas that feel like they would benefit from choice. You've got

families that are accompanying Active Duty members that we want to take care of for recruitment purposes. So, I think probably the more choice, the better, for them. And then you've got the retiree population, who has done their service to the country, and you want to be fair to them. You've got a unsustainable system as it exists today.

So, what I want to do is -- this pilot project? I don't really know what the right answer is, other than: Change is coming. And I just really appreciate the input that you've given us.

And, Admiral, I promise you, whatever we do, we will listen to what you have to say. Probably going to come out differently, at least I will, on the idea of a single-payer system, but I want to make sure that any cost increased borne by the retiree community is something I can look them in the eye and say, "That's justified, and you're getting more for your money." And if I can't do that, I won't do it. Because I am going to ask people to pay a little bit more. There's just no way around that. And if I can't say, "You're getting something better for your money," I'm not going to do it. It's not about just saving money, it's about improving quality of healthcare.

Thank you all. To be continued.

[Whereupon, at 4:28 p.m., the hearing was adjourned.]