STATEMENT OF
The Military Retiree Grass Roots Group
Health Care White Paper Group
Before the
Committee on Armed Services
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Presented By
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Perspectives on
Military Health Care Program

David Vann, Lieutenant Colonel, U.S. Army (Retired) has been a member of the Military Retiree Grass Roots Group since it began in 1996. He became a military health care advocate after his wife was diagnosed with a very rare brain tumor. Raised as a military dependent, he has been a user of military health care for more than 60 years. In 1960 he enlisted in the Army at age 17 and graduated from the United States Military Academy in 1965. As a Vietnam combat veteran he served in command and staff positions with the 1ST ARVN Division. He has extensive leadership and management experience at all levels of Defense Logistics, including requirements analysis, systems design, and program management. He received an MS in Logistics Management from Florida Institute of Technology. His last assignment prior to his retirement was logistics officer for the Corps of Cadets at West Point. Among his military awards are the Bronze Star and the Combat Infantry Badge, which he prizes most. He is married with three daughters, two of whom have also graduated from the United States Military Academy.

Disclosure

The Military Retiree Grass Roots Group (MRGRG) is an unfunded informal organization of military retirees from across the nation founded for the purpose of restoring promised and earned health care. It has never received a grant from (and/or subgrant) or a contract (and/or subcontract) with the federal government.
Introduction

Mr. Chairman, and distinguished members of the House Armed Services Committee's Subcommittee on Total Force, I would like to thank you for this invitation to appear before you and present a summary of our concerns and recommendations. I am speaking as a member of the health care White Paper Group, on behalf of many members of the MRGRG. The MRGRG represents thousands of retirees, active duty families, reservists, and others who are connected to our network. We were formed for the purpose of improving military health care. Congressional interest based on MRGRG efforts, together with the stellar work by the Associations represented here resulted in TRICARE for Life (TFL). We hope that together our efforts will continue to result in the additional permanent and fundamental changes to military health care that are desperately needed.

Our testimony is based on personal experience and research. Our collective knowledge is documented in what we call the "White Paper", produced as both a written study and CD-ROM. We received no “official” assistance in creating either that document or this testimony, and all the data provided was obtained from public domain sources. Here is a copy, and I have additional copies for members who were not here last year when we visited all 535 congressional offices with both our letter requesting support and a CD like this one prepared by a disabled Sgt. Major in Missouri. We also provided a printed copy of our study to all members. May I ask that a copy be provided for the record?

It is the only comprehensive analysis of military health care from the user perspective we have been able to find. Our written framework with supporting documentation for action would guarantee military families the affordable health care that was earned and expected, but is not being provided by the TRICARE system. We have focused primarily on TRICARE Standard, the most neglected of the TRICARE program features. Problems with that system are described extensively, as well as the recommended solutions, which include TRICARE improvements, FEHBP as an option, and funding.

We deeply appreciate the past work of Congress to help MEDICARE beneficiaries with TRICARE FOR LIFE (TFL) and improvements for those currently on active duty and their families. Further, we thank you for requiring the use of standardized MEDICARE procedure codes in the future for all of us. This will help clarify claim submissions. I hope my testimony will encourage your attention to the one group that has not seen any measurable improvement in their health care benefits since the implementation of TRICARE in 1995, the retirees and families under age 65--most of whom do not have access to TRICARE Prime or FEHBP.
Overview

When the Department of Defense developed and implemented a new health care program, the most fundamental change was replacing the reasonably successful non-profit system called CHAMPUS with the for-profit system called TRICARE. The rationale was based solely on reducing costs to the government. The results of that change can be seen today with significant restrictions on choice, access, and cost. Other problems remain which can no longer be dismissed as growing pains from the TRICARE experiment. We have seen no evidence to demonstrate that TRICARE was successful in its primary goal of cost reduction, although we know service has declined significantly. While the contractors continue to show profitability, we also know that, regardless of any government cost reduction, costs have risen, often significantly, for the beneficiary. Contracting out of health care was significant since it removed from the uniformed leaders of the Armed Forces their ability to carry out one of their most important responsibilities – the ability to provide for the health care of active, retiree, and reserve service members and their families.

CHAMPUS was generally regarded as successful by the user. The same is not true of TRICARE. TRICARE introduced stringent managed care features, new rules and guidelines and Fee-For-Service (FFS) constraints. Contracts for TRICARE administration were very different in each region of the country and abroad. CHAMPUS had been universally accepted and understood; TRICARE was rejected by many of the same health care providers who previously accepted CHAMPUS. This degradation of access began as early as 1995, when during the Christmas holidays some of our grassroots associates who were receiving services under CHAMPUS, received notice from their family physicians that they would not be seen under TRICARE. In general, we have found that more doctors reject TRICARE than MEDICARE, and that TRICARE reimbursement rates are lower than MEDICARE. That is true in some cases in Fairfax, Virginia.

DOD's focus on improvements has been directed primarily at the HMO, TRICARE Prime, to the near exclusion of TRICARE Standard. TRICARE Standard is the plan used by nearly half of all beneficiaries and is the only plan available for many of them, mostly retired members. Yet it is the most in need of government attention. For many who relied on military facilities closed by the Base Realignment and Closure Commission, their only health care choice is TRICARE Standard, which clearly increases individual cost, limits access, and reduces health care options.

The "reduction" in government costs, intended for TRICARE, was accomplished by "shifting" the expenses to beneficiaries, for example increased copayments and decreasing services previously covered. Consequently, the amount of health care that could be purchased was decreased in order to pay for contract costs and profits and the new management bureaucracy. Contractors now determine almost every aspect of military family health care. Because of increases in both beneficiary cost and the number of TRICARE Standard users, a cottage industry of TRICARE health care supplements was born, further driving up beneficiary out-of-pocket costs. Many lower grade retirees could not afford these new supplements for themselves and their families, and often were driven into great financial difficulty. TRICARE's answer to these families was the creation of Debt Collection Assistance Officers (DCAO) to help them deal
with mounting financial debt. One widow of a Vietnam veteran and military retiree was completely wiped out by medical debt when her 52 year old husband passed away from Agent Orange-related illnesses. Five-figure and six-figure debt for both active duty servicemembers and military retirees exists.

TRICARE and its options are not available to everyone. And most of us cannot even get TRICARE Prime as a "choice" as we live too far away from military hospitals. When TRICARE Standard is the only option, providers are often not available in the specialties needed, and sometimes no providers are available. In those cases we pay the entire bill at time of service, not a co-payment which is typical of other federal health plans. Our people have had some major financial surprises at times, solved only temporarily by going into debt. Although TRICARE providers may be in the area, they often may not be taking new patients.

As both taxpayers and beneficiaries, we have serious concerns about the high costs of TRICARE. As taxpayers, we are concerned that the General Accounting Office found that the per capita cost of the military health care system is 23% higher than that of the FEHB program. As beneficiaries we are concerned that the expenditures of the military health BENEFIT we earned are not identified and kept separate from the cost of the military health care SYSTEM (the readiness mission, research and development). As both beneficiaries and taxpayers we are also concerned that the money Congress appropriates for retiree health care is being used for contractor profit rather than being applied for our health care. Many people believe that the DOD's military health care cost problems should have been solved by adopting the already existing FEHBP program, used for all other federal employees. Use of the existing OPM FEHBP could offer tremendous savings in DOD overhead and multiple layers of management associated with administration of TRICARE at all levels.

Congress expressed its "intent" as early as 1966 that military retirees and their families should be provided health care coverage equivalent to Blue Cross/Blue Shield High Option program at less cost than for federal civilians, in recognition of the lower basic compensation and career sacrifices of military personnel. However, DOD overlooked that intent in the design of TRICARE Standard. That intent forms the basis of our recommendations for TRICARE improvements and FEHBP as an option.

Recent official surveys indicate 46% of active duty military family members are dissatisfied with military health care. Although there is no survey on the retired population, our extensive contact with the retired community of ALL Grades has led us to believe for many years that the numbers are much higher for retirees and their families under age 65. We need BOTH fixes to TRICARE Standard and the OPTION to participate in the Federal Employees Health Benefit Program at an affordable rate.
RECOMMENDATIONS

The TRICARE system is not consistent with the principles of the President's Health Care initiative. It excludes choice of health care plans, denies access to doctors, and is expensive for users and the government. In addressing these and other problems of ACCESS, CHOICE, and COST, we developed three centerpiece areas where we need legislative action. First, we believe immediate improvements are needed to TRICARE, primarily TRICARE Standard. Second, we proposed that an affordable option to participate in FEHBP is needed for military retirees. Third, we believe funding for military health care for retirees should be moved from the DOD readiness accounts into a trust fund, as was done for TFL, similar to what is done for federal civilian retirees. Our following recommendations represent a comprehensive health program for military retirees at an affordable cost.

1. IMPROVE TRICARE STANDARD

TRICARE Standard, the source of the major problems and beneficiaries dissatisfaction, is the DOD health care program that affects the vast majority of military retirees under age 65 and many active duty, Reserve, and Guard families, a potential beneficiary population of 4 million people. Those who are satisfied with TRICARE are primarily the 85% of the active duty population in good health and using the TRICARE Prime HMO, where DOD places its funds and emphasis.

Beneficiaries, especially retirees, face significant problems in provider access/choice, communications, and claims and benefit administration, which affects cost, quality, and reliability. GAO reports document many systemic problems and the AMA has expressed concern. Our documented problems complemented their findings. We hope that our recommendations will help the effort to make TRICARE a viable program. The breadth of MRGRG support enriches the understanding of problems as viewed by TRICARE users and medical providers. Our concerns also included readiness and the resultant impact upon recruiting and retention—and therefore the nation's security.

We believe the management focus needs to be on TRICARE Standard since it has been largely neglected, even in such important documents as the Annual Stakeholders Report, which clearly emphasizes TRICARE Prime. For three consecutive years the widely used TRICARE Standard program was not even mentioned. We believe specific disclosure about how much is being spent per beneficiary eligible for TRICARE Standard would be useful for senior management and Congress. Without the benefit of these disclosures it is difficult for anyone to evaluate success of the largest program in TRICARE.

A. TRICARE ACCESS/CHOICE

Access to medical providers who accept TRICARE and the ability to select medical providers of choice continue to be a significant problem. Retired and active duty families in some areas have no viable health care options because doctors refuse to participate in TRICARE. This is a source of embarrassment to the nation, and should be at the very top of the congressional agenda for action.
1) Eliminate the Non Availability Statement (NAS) for TRICARE Standard

TRICARE Standard participants pay for the expressed purpose of having choice of doctors. Elimination of the NAS would make TRICARE Standard a true fee-for-service plan as advertised. Use of the NAS is appropriate as an HMO tool and should be restricted to the HMO pool of TRICARE Prime participants. NAS compels unwilling patients under the age of 65 to use military treatment facilities (MTF) for surgery, when they live within the 40 miles "catchment area" for an MTF, and even greater distances for specialized treatment when the need for choice is greatest.

We note that testimony by the Military Coalition last year presented a clear and compelling case for elimination of the NAS and its associated waivers. We fully support that effort.

Continued use of the NAS in TRICARE Standard cannot stand a test of logic. While TRICARE was patterned after the civilian health care system, the NAS was retained as a feature unique only to the military system. Design of the TRICARE system with its fee-for-service option carries with it an obligation of offering the beneficiary a choice of providers in exchange for higher copayments and deductibles, which results in the need to purchase supplemental insurance. Continued use of the NAS is tantamount to reneging on that obligation to offer choice and presents a dilemma of perennial uncertainty to patients whenever surgery is anticipated, since both TRICARE and expensive supplemental insurance reimbursement will not be authorized without the NAS.

Ironically, the NAS has been eliminated for the HMO, TRICARE Prime, who may use a point of service option outside the MTF. But the TRICARE Standard patients MUST obtain the NAS, which has recently become more restrictive and shows a total disregard of the patient.

As current regulations state, DOD may waive the NAS if:

--The Secretary demonstrates that significant costs would be avoided by performing specific procedures at the MTF
--The Secretary determines that a specific procedure must be provided at the affected MTF to ensure the proficiency levels of the practitioners at the facility
--The lack of an NAS would significantly interfere with TRICARE contract administration

However, the waiver authority is so liberal that the practical effect of the waiver authority is to grant carte blanche authority to MTFs to deny NAS requests routinely and arbitrarily when the MTFs are underutilized. Rather than seeking patients through other means or simply closing the facility if demand for its services do not exist, the NAS remains in full force.

We feel any connection of the NAS to readiness or graduate medical education (GME) requirements in TRICARE Standard is specious and cannot stand the test of careful public scrutiny. While servicemembers are expected to forego medical choices in the
interests of readiness, retirees and dependents should not. GME should not be rooted in reliance on fee-for-service patients and should seek other alternatives. Resource implications are negligible.

DOD has wisely waived the need for Guard and Reserve family members to obtain the NAS, offering the medically sound rationale, "We're not going to get in the way. We will allow you to continue seeing providers you know." That same medical rationale—continuity of care—should be applied to all beneficiaries. It would bring the military in line with two key features of the President's Health Care initiative, choice and continuity of care.

The committee should be aware of the unintended consequences of retaining the NAS. I offer my personal experience of my wife's brain surgery as an example documented in Exhibit 1.

2) Increase provider reimbursement rates
Because TRICARE Standard reimbursement rates are determined by a completely different methodology than the one used for MEDICARE, the rates of reimbursement are different, and in many cases LOWER for TRICARE Standard than for MEDICARE. We have gathered sample evidence that showed even locally in Northern Virginia, 6 of 9 reimbursement rates for the procedure codes by one doctor's offices were LOWER for Standard than for MEDICARE. The same is true in other areas, but comparisons are difficult because of the reluctance of some owners of the data to release those rates. Doctors are well aware of the disparity, and are typically quite willing to state their dissatisfaction with TRICARE Standard reimbursement rate policies. Reimbursement rates have fallen so far below the original Congressional intent, that the program simply does not pay enough to attract doctors. The low rates, combined with provider billing and payment frustrations, makes TRICARE not cost effective. We believe it is important for the Congress to understand our perspective that MEDICARE, fraught with all its problems of concern to this body, is better than TRICARE Standard in many areas. Doctors and hospitals confirm that assessment. We believe any surveys conducted by DOD to determine why TRICARE provider participation rates are so low should include not only beneficiaries, but equally important, the providers who currently do not accept TRICARE.

3) Establish a comprehensive, defined health benefit
TRICARE Standard does not include dental, vision, chiropractic, physical exams, and other services common to other health plans. MEDICARE, for example, now includes chiropractic care, recognizing its value in both a preventive and healing capacity. Retirees are subject to recall, yet they are denied even a basic physical exam needed to maintain the health readiness. Yet, many of these same benefits are provided, to some degree, in every health plan afforded federal civilians.
B. MANAGEMENT AND ADMINISTRATION

Additional areas we found which merit attention are benefits that were reduced significantly when TRICARE was introduced, claims administration, and the lack of any communication/information to TRICARE Standard beneficiaries. While TRICARE marketing information is extensive, routine communication on a periodic basis is non-existent. An assessment needs to be conducted concerning what information beneficiaries need and whether that information is being provided to all. Improved two-way communication between TRICARE and its beneficiaries is an essential part of making the system accessible and responsive to the user.

1) Eliminate enrollment fees for retirees.
   The promise of free lifetime health care continued to be made as recently as the mid-1990's. When TRICARE enrollment fees were instituted that promise was broken for all retirees who use services of a military treatment facility. We believe the enrollment fees for retirees who select or can access TRICARE Prime should be eliminated.

2) Adjust TRICARE Standard in-patient cost sharing between the patient and DoD to more realistic levels.
   Military retirees find it essential to purchase expensive supplemental insurance because of the extremely high TRICARE inpatient cost-sharing arrangements (lesser of $417 per day or 25% of billed charges, plus 25% of allowed professional fees.) The need for such insurance in cases of hospitalization is the primary reason for supplemental insurance policies, yet they are not needed for FEHBP plans because the cost sharing is much less. We believe the costs of that supplemental insurance could be eliminated or mitigated by reducing the cost sharing between the patient and DoD to reflect FEHBP cost-sharing arrangements of unlimited days, $100 maximum co-payment per day per admission, and especially by including a $500 cap per admission.

3) Raise co-pay levels for TRICARE Standard/Eliminate deductibles.
   Retiree co-pay levels for TRICARE Standard should be returned to CHAMPUS levels of 80% without deductibles, which is also in line with FEHBP copayments. Elimination of the deductible would reduce high up-front costs.

4) Eliminate pre-authorization for TRICARE Standard.
   Current national private-sector managed care trends eliminate unnecessary administration such as pre-authorization. It would also be consistent with Medicare/Medicaid trends. Timely scheduling of needed appointments would remove the patient from an inappropriate technical role in a doctor's treatment plan. It would also eliminate administrative costs and significant frustration. Currently pre-authorization is a disincentive to participate in TRICARE.

5) Reinstate "coordination of benefits" and eliminate the 115% billing limit.
   TRICARE Standard beneficiaries with other health insurance from private employment may forfeit their TRICARE benefit if the other health insurance pays an amount equal to or higher than 115% of the TRICARE allowable charge. We believe that, since the
medical benefit was deferred compensation earned by military retirees, the earnings should be available as for federal civilians. One of the options for use of the earnings should be, as in the past, "coordination of benefits." The residual share of bills unpaid by other health insurance should be paid by TRICARE, up to the amount of the TRICARE allowable charge less the costshare that would have paid by the first payer.

6) Establish a system that prevents balance billing at time of service.
The problem of "balance billing" is one that affects both active duty families and retired families, and represents a significant financial burden that Congress did not intend. Beneficiaries are often required to pay the total bill at time of service, with no idea of the approved TRICARE rate. These providers in many cases simply do not want to deal with TRICARE. They consider TRICARE slow, unresponsive, and difficult to deal with, and prefer to place the burden for claims processing entirely on the patient. We believe it is essential for Congress to establish legislation that would remove the requirement for users of TRICARE to have to pay up front for care. Servicemembers are simply not paid at such a level as to carry high debts for medical care.

7) Develop an automated system with an audit trail.
This would reduce cost to the beneficiary and the provider and provide a means of accurate claims tracking from date of receipt to final processing. Any reprocessed claims should retain the original claim number. The automated system should include a means for the beneficiary to input information needed for claims processing. Claims processing by fax capability should be an option.

8) Provide DOD claims ombudsman/fair claims appeal mechanism.
There is no independent advocate for the beneficiary during the claims process. Currently the burden is solely on the patient with total control of the appeals process by the TRICARE contractor.

9) Establish a single DOD-administered source responsible for official questions and problems independent of TRICARE contractors.
There is no single, official source of TRICARE information that the beneficiary can use to make informed decisions BEFORE incurring expenses for health care. We believe a single, responsive, authoritative source should be established for answering questions about costs and benefits to military families. The current mytricare.com website provides only unofficial answers to questions that demand official answers because of financial and legal consequences.

Customer satisfaction is currently determined by random sampling questionnaires solicited months after patient visits. Routine timely DOD surveys of both providers and beneficiaries are needed to enable early identification of systemic problems. Rather than from contractors, comments and data directly from TRICARE beneficiaries and healthcare providers should be used to provide a valid assessment of customer satisfaction. A quality feedback mechanism independent of contractors is essential. Results of that feedback and action taken should be made public.
The following quote from page 63 of the TRICARE Handbook sums up retirees' fears, frustrations, and lack of confidence in TRICARE ability to provide users with specific coverage before the claim is submitted: “Remember: Just because your military or civilian provider tells you that you need certain care doesn’t mean that TRICARE can help you pay for it. If you’re not sure whether TRICARE covers a service or supply, contact your Beneficiary Counseling and Assistance Coordinator (BCAC)/Health Benefits Adviser (HBA) your TRICARE Service Center (TSC) or your regional TRICARE Managed Care Support Contractor (MCSC). They can advise you about covered services, but can’t guarantee that TRICARE will share the cost. That determination comes later, after the claim has been submitted.” (Emphasis added)

Nothing is more frustrating to any health care beneficiary and medical provider than poor claims service and inadequate clarity of coverage protection. The TRICARE claims experience could be improved significantly by bringing coverage protection in line with the industry best practices and increasing the level of responsiveness to its members and medical providers. The problem resides primarily with TRICARE Standard claims processing, though the complex nature of the TRICARE contracts makes claims processing a challenge for ALL beneficiaries.

10) **Standardize essential practices across all TRICARE regions and worldwide for active duty, retiree and eligible Guard and reserve personnel.**

Portability of health care and worldwide reciprocity in the health care system is essential, especially for active duty families required to move frequently. The goal should be a seamless worldwide military health care system for all. Consolidation of TRICARE contracts is a slight improvement for some areas, but there will still be different practices and coverage nationwide and overseas. Most important, the decisions affecting military health care are dependent upon the government contracting process, not an insurance plan. There is no mechanism to inform beneficiaries of daily contract changes that will affect their coverage, to include the effective date of the changes.

11) **Publish an annual Health Benefits Summary and Stakeholders Report for every military family/retiree in TRICARE Standard with the specific information, requirements, and services offered for each Region to include overseas.**

Information is needed which allows users to learn policy and procedures and would reduce frequent user and provider inquiries, reducing the "hassle" factor. There is currently no mechanism to communicate with Standard users about their health care. Recent theft of private medical information in one region pointed to the need for immediate notification to all beneficiaries to preclude possible identity theft. The members of our group have gone nearly five years with no official communication from DOD about their health plans. We believe there should be an annual enrollment period for TRICARE, as in FEHBP, with appropriate current information provided to all beneficiaries about their health care, and the options that exist.
2. FEDERAL EMPLOYEE HEALTH BENEFIT PLAN (FEHBP)

Military retirees and families under 65 have no choice such as that offered to other federal employees under FEHBP. Their only option is an expensive, for-profit, contractor-operated, government managed care PROGRAM, TRICARE. TRICARE does not guarantee either health care or a choice of plans. For example, unlike FEHBP, no fee for service health care plan is offered to military retirees and families under the age of 65. And, there is no civilian HMO option available to many military retirees who might choose that option.

Providing FEHBP as an option to military families is the cornerstone to establishing badly needed competition with TRICARE contractors. It is also crucial to establishing needed access and choice. In areas where TRICARE is unable to provide adequate service to the beneficiary, an FEHBP option would at least permit beneficiaries to have access to doctors who reject all aspects of TRICARE. Although our proposal would for the first time require premiums to be paid by military retiree families, it would at least offer an alternative in areas TRICARE fails to serve. FEHBP has been cited by the President and by the Breaux/Frist task force as a model for the President's Health Care initiative, and his basic principles of providing ACCESS and CHOICE at an affordable COST.

For example, several years ago one of our members in Idaho indicated to his military association a need to cancel his TRICARE supplement since he could find no doctor for his wife's needs who would accept TRICARE. His wife's doctor had decided not to participate in TRICARE any longer for many reasons, including low reimbursement rates. The member's TRICARE supplemental insurance policy was therefore of no value since he could not find another doctor who would accept his wife as a patient, and who was willing to accept the TRICARE rates of reimbursement. As a military retiree his wife was faced with no health care she could use despite his 26 years of service. At the same time, his wife's mother, living with them and a retired federal civilian employee, had absolutely no problem with the same doctor using her FEHBP policy. Clearly, FEHBP is a natural alternative and is a proven success story which would require no additional expensive testing, especially with the valuable experience gained from tests conducted several years ago which should provide the basis for a smooth transition.

During our visits to Capitol Hill offices last year, we asked repeatedly if the hardships of military services justified FEHBP at lower cost for military retirees, since their active duty pay was depressed based on the rationale that health plans were not needed. We found near universal agreement with the intent expressed by Congress in 1966 when CHAMPUS was created to be equivalent to BC/BS HIGH OPTION at a lower rate at a lower cost than for federal civilians. Consequently, any FEHBP program proposed today should also be provided at an affordable rate for military families.

THE BASIC AFFORDABLE PROPOSAL: We believe that any proposal must be affordable to both the Congress and to the individual, and that it can be achieved largely within current resources. Congress has already enacted a prescription drug benefit for all military retirees and that highly successful program should be continued. Our FEHBP proposal would use the existing plans for FEHBP for basic health care, less the drug feature of those FEHBP plans, and combine it with the existing DOD Pharmacy Program. We consider such a proposal particularly
attractive since both FEHBP and the DOD Pharmacy Program are already proven success stories. The drug program is already working for retirees, and Congress is already paying for the costs of drugs as part of the basic TRICARE benefit. That is one of the most successful parts of the DOD Health Care program. By continuing the prescription drug benefit as it is, and adding only the doctor and hospital care portion of the existing FEHBP programs, those programs can be offered at a reduced rate of about 30%, which represents the approximate amount now in FEHBP premiums for prescription drugs.

Legislation to extend the FEHBP to military retirees was considered in both houses of Congress in 2000, 2001 and 2002. Although 315 House members co-sponsored H.R.179 and 13 senators supported S.278 companion legislation during the 107th Congress, it was not enacted. The reason provided by several military associations was that a small portion of the legislation for WWII retirees was believed to be too expensive. That obstacle no longer exists since Congress granted the TFL benefit, although a very small portion of those over 65 may prefer to choose FEHBP as an option. Unless FEHBP is offered, the only remaining option for hundreds of thousands of military families is the failing TRICARE program, characterized by one member of Congress as the worst HMO in the nation.

Offering the FEHBP option to all retirees would provide significant progress toward a comprehensive military retiree health benefit and eliminating the TRICARE problems of access and choice.

3. Entitlement

Overall funding for TRICARE is uncertain each year because it is provided in the Operations and Maintenance portion of the budget. As a result, the level of care is not only subject to annual appropriations from Congress; it depends upon DOD operational decisions unrelated to earned benefits of retirees. TRICARE funding, especially for TRICARE Standard, is of necessity low priority compared to immediate readiness needs of our deploying forces.

Health care for military families simply does not compete well with the immediate needs of national defense, regardless of past promises made and service of at least twenty years on active duty. It is for this reason that we propose, as was done for TFL, that funding for military retiree health care be placed in a trust fund not subject to readiness considerations, and placed in the entitlement portion of the federal budget. This should not be a budget increase. We believe DOD should welcome the option to place funding for military retirees in that account at the same level as is provided for federal civilian retirees, less the amount set aside for the prescription drug program now offered to all eligible military retirees.

Public Law 106-398 created TFL as a funded MEDICARE supplement for 800,000 of the 1.9 million military retirees. Since that funding is now considered in the "entitlements" section of the federal budget, we believe that is a good precedent to establish a funding model for civilian health care for the remaining military retirees and families under age 65.

The many official promises made to career military personnel concerning their lifelong health care are well documented. The fact that those promises made to nearly all existing retirees have
not been kept is currently a matter of earnest and sobering concern to all, including those considering a lifetime of military service. The value of those promises has been specifically established in annual Personal Statements of Military Compensation at the direction of Congress. This was called indirect compensation, and was part of what was explained as "deferred compensation". In fact, the official Statement of Military Compensation provided in January of 1991 specifically stated that "there is no need for you to carry medical insurance available to civilians ranging from no cost to all cost for the employee." In 1991, it was said the value of that compensation "saved" me $5198.00.

Assuming very conservatively that inflation has caused the value of that compensation to double in the past twelve years, it is reasonable to state the worth of that medical care as at least $10,000.00 a family. Our legislative proposal would transfer that funding to a trust account separate from the TFL costs. The funding would then be made available to those who earned it for use in choosing the health plans that suit them best, as is the case for retired federal civilian employee retirees.

We believe the American public generally has the false impression that military personnel and their families have continuous and adequate free health care through their military careers and retirement. Our members frequently find that friends and neighbors tell them they thought all military people had lifetime free health and dental care. They are genuinely surprised when we tell them we have absolutely no government funded dental care. They are still more surprised when we tell them we are paying as much or more than they are for TRICARE Supplements, deductibles, copayments, and items that are covered in their own and most FEHBP programs for federal civilians.

**Conclusion**

I would be remiss not to take a brief moment to attempt to bring to your attention the depth of feeling we have witnessed surrounding the uncertainty among the retired community who have been left behind as a result of their reliance on TRICARE. That uncertainty largely centers on the meaning to retirees of today of the phrase "keeping the health care promise". We believe that uncertainty would be eliminated if the meaning of that promise were documented by Congress. It is noteworthy to recognize that among military retirees there is no "greatest generation" since we all bleed the same blood, for the same country, for the same freedom--just at a different hour. The same health care promise was made to the Vietnam generation and those who followed as recently as the last Gulf War. We are certain our fellow citizens agree that failure to honor that promise impinges on the honor, dignity, and respect of military retirees who were promised more for noble service and impacts on our nation's ability to attract and retain military manpower in the future. We hope that our recommendations will help avoid that same uncertainty for those soldiers, sailors, airmen, and Marines now in the sands of the Middle East who stand firm ready to keep their promise.

The good news in today's world of constrained resources is that our group believes that much of what we propose in TRICARE improvements, FEHBP, and entitlement is achievable within current resources. We genuinely hope that our efforts will help to achieve better health care for all military and their families.
Outstanding and comprehensive information about problems with TRICARE are at three web sites, which provide extensive facts from TRICARE participants, former surgeons general, GAO reports, governmental sources, and others:

1) Military Health Care Reclamation Group (MHCRG) at: http://rebel.212.net/mhcrg/

2) TRICARE- Now the World Knows at:  
http://www.militarybenefits.org

3) TRICARE Survey at:  
www.moaa.org/Legislative/TricareSurvey2003/survey.asp

Thank you for the privilege of appearing before you today. I would like to acknowledge the members whose collective expertise formed the basis of the White Paper and this testimony.

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CPT Ed Lawton, USAF,Ret
Exhibit 1  Non-availability Statement (NAS)-Personal Story

I can assure you that NOTHING in my entire military career, including combat, was more degrading to my service to my country than the weeks I spent several years ago seeking the NAS immediately after discovery of my wife's very rare brain tumor. Our otolaryngologist stressed the dangerous location of the tumor near the brain stem. He emphasized the importance of immediately seeing the recommended neurosurgeon, the only one in the area with the required extensive experience. Our neurosurgeon urged us to schedule the surgery soon because of the tumor's size and location, symptoms of mild stroke, and to allow enough recovery time before our daughter's wedding. After discussing the surgical options with the neurosurgeon, who gained our complete confidence, the most trying experience of our lives began.

Rather than the freedom to focus on proper treatment for my wife, we spent the ensuing weeks in the military medical bureaucracy quite on our own with what was considered "my" NAS problem, with the tumor becoming secondary. While simultaneously going through the typical emotions of such a crisis (including financial and legal preparations), and the stark reality of facing perhaps the last few weeks on earth with my wife of 36 years, we bore the inconceivable additional burden of worrying about how to prepare a NAS request that would allow us to continue using our chosen doctors. Guidance consisted solely of telling us to "Prepare a letter", which I hand carried to the MTF. Without seeing any medical staff, my letter was returned to me with an explanation that the surgery could be performed at the MTF with no other choice; therefore the NAS request was denied.

We received advice from countless military friends, even senior uniformed folks, to retain a lawyer for the process, "take it to the media", and other such actions which I rejected and elected to appeal the situation in every other way possible. It was in no way reassuring to hear senior medical personnel tell us, "We'll take good care of you, it is just the system we have to live with". At one point, I made it clear to the military medical community that I would rather forego my entire life savings than undergo surgery from an inexperienced doctor for this type of rare tumor. My wife made it clear that she would sooner die than have the surgery in the MTF. Eventually we received the NAS, presumably because it was medically inappropriate. Since that time "medically inappropriate" has been eliminated as a waiver criterion, making it nearly impossible to receive the NAS. Since use of the NAS continues as even more restrictive, I am commenting publicly now on behalf of all servicemembers and beneficiaries.

We do not disparage military doctors, for they are dedicated and in most cases very capable. In fact we have had great respect for them over many years. My wife has had two children and three additional surgeries (two of them with complications) in the military medical system. This was the one time she said NO. Military doctors privately concede their contempt for the NAS, for they do not want unwilling patients. The AMA has seriously questioned its use.

Incredibly, though I had chosen what was called a fee-for-service plan, I found that without the NAS, I would receive NO reimbursement for the entire surgery and associated expenses from either TRICARE or my supplemental insurance.

It is one thing to send me to war and ask me to give my life for my country. You couldn't pay someone enough for that honor. But it is quite another to force my wife to make the same sacrifice for graduate medical education. We had chosen a plan that offered choice and was widely marketed as "giving your family unparalleled protection for inpatient and outpatient care at both military and civilian hospitals with the DOCTOR OF YOUR CHOICE". Servicemembers and retirees view the protection of their family as important as the protection of their country. Retaining the NAS in any form does nothing to advance either.

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