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STATEMENT OF

THE MILITARY COALITION (TMC)

before the

HOUSE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

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MADAM CHAIR AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning issues affecting the uniformed services community. This testimony provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

Air Force Association
Air Force Sergeants Association
Air Force Women Officers Associated
American Logistics Association
AMVETS (American Veterans)
Army Aviation Association of America
Association of Military Surgeons of the United States
Association of the United States Army
Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
Commissioned Officers Association of the U.S. Public Health Service, Inc.
Enlisted Association of the National Guard of the United States
Fleet Reserve Association
Gold Star Wives of America, Inc.
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the United States of America
Marine Corps League
Marine Corps Reserve Association
Military Chaplains Association of the United States of America
Military Officers Association of America
Military Order of the Purple Heart
National Association for Uniformed Services
National Military Family Association
National Order of Battlefield Commissions
Naval Enlisted Reserve Association
Naval Reserve Association
Non Commissioned Officers Association
Reserve Enlisted Association
Reserve Officers Association*
Society of Medical Consultants to the Armed Forces
The Retired Enlisted Association
United States Army Warrant Officers Association
United States Coast Guard Chief Petty Officers Association
Veterans of Foreign Wars of the United States

*The Reserve Officers Association supports the non-health care portion of the testimony.

The Military Coalition, Inc., does not receive any grants or contracts from the federal government.

EXECUTIVE SUMMARY

Wounded Warrior Care

DoD-VA Seamless Transition Oversight – It is of overriding importance to establish a permanent Joint Seamless Transition Office, responsible for managing, implementing, monitoring, and reporting to senior DoD, VA and congressional leaders on all aspects of the seamless transition process including, but not limited to:

- Joint, single separation physical for active, Guard and Reserve forces;
- Consistent DoD/VA disability evaluation system;
- Bi-directional electronic medical and personnel records data transfer;
- Medical centers of excellence and operations/research projects; and
- Coordination of care, treatment, and information, including DoD-VA federal/recovery coordinator clinical and non-clinical services and case management programs

Disability Evaluation System (DES) –

- Bar "pre-existing condition" determinations for any member who has been deployed to a combat zone;
- Retain the 30% disability threshold for award of disability retired pay and lifetime family TRICARE coverage
- Ensure that any adjustment to the disability retirement system does not result in a member receiving less disability retired pay than he or she would receive under the current system; and
- Ensure that members electing accelerated disability retirement/separation are fully counseled on all possible negative changes in compensation, health care and other benefits, and give consideration to allowing a limited time to reverse a regrettable decision.

Continuity of Health Care Coverage –

- Authorize all medically retired members with a severe service-caused disability to retain active-duty-level TRICARE eligibility for themselves and their eligible family members for at least three years to protect against "falling through the cracks" of unforeseen coverage changes upon conversion to retired/veteran status;
- Establish common DoD and VA protocols for diagnosis, treatment, and rehabilitation for TBI conditions;
- Either exempt severely wounded, ill, or injured members who must be medically retired from paying Medicare Part B premiums until age 65 or authorize a special DoD allowance to reimburse them for the cost of such premiums; and
- Waive DoD preauthorization/referral requirements for active duty/Guard/Reserve members referred to VA polytrauma facilities for care.

Psychological Health and Traumatic Brain Injury (TBI) – TMC recommends:

- Priority efforts to deliver information on-line and by other means to servicemembers and family members concerning availability of providers, confidential options for counseling, and virtual counseling/advice;
- Special outreach efforts to provide such services and resources, including through VA facilities, to Guard and Reserve members and families who don't live near military facilities;
- Priority efforts to educate private sector providers on the unique needs of military and veteran patients and family members, and deliver needed information to them on-line, including contact points for discussion/consultation with military/VA providers;

- Consistent implementation of pre- and post-deployment screenings, particularly for Guard and Reserve members who may be leaving active duty;
- Increased research on the impact of combat stress and TBI on family members, particularly children;
- Increasing destigmatization efforts, with emphasis at unit levels to actively encourage affected service members, veterans, and family members to seek help, and thus increase effectiveness and military readiness;
- Increasing availability and outreach on substance abuse counseling options;
- Pursuing aggressive medication reconciliation and management programs to protect against inadvertent overmedication and adverse reactions;
- Requiring TBI and psychological health assessments for members who have been deployed to a combat zone as part of any disciplinary process prior to a decision concerning non-medical separation; and
- Developing a partnership between DoD, VA, and other governmental and non-governmental agencies and civilian health care systems to improve access to treatment for PTSD, TBI, depression and other combat-related stress conditions for servicemembers and their families.

Caregiver and Family Support Services for Active, Guard and Reserve –
- Authorize compensation, training and certification, and respite care for family members required to serve as full-time caregivers, whether the member is in active duty or retired status;
- Authorize health care coverage for full-time caregivers and their families; and
- Extend on-base housing eligibility for up to one year to medically retired, severely injured service members and their families.

Active Forces

End Strength –
- Sustain planned Army and Marine Corps end strength growth as a top priority;
- Resist budget-driven (rather than requirements-driven) manpower reductions for the Air Force and Navy and Guard/Reserve components; and
- Seek a 2010 defense budget of at least 5% of Gross Domestic Product.

Military Pay Comparability – Sustain military raises of at least .5% above the Employment Cost Index (ECI) until the current 2.9% shortfall is eliminated.

Military vs. Civilian Total Compensation Comparisons – Reject proposals to "civilianize" military comparisons that, by their nature, cannot similarly calculate the dramatic differentials in military vs. civilian working conditions.

REDUX and the 15-Year Career Status Bonus – The Coalition believes the REDUX/Career Bonus authority should be repealed. For the shorter term, recognizing the significant budget hurdles to that objective, the Coalition urges the Subcommittee to require the services to exert more effort to educate members on size of the future retired pay loss incurred in choosing that option.

Family Readiness and Support –
- Accelerate increases in availability of child care to meet active and Reserve component requirements;

- Direct DoD to report on the extent of reallocation of approved funding for support programs and the attendant impact on military families; and
- Continue pressing the Defense Department to implement flexible spending accounts to enable active duty and Selected Reserve families to pay out-of-pocket dependent care and health care expenses with pre-tax dollars.
- Correct the new paternity leave authority to cover all seven "uniformed services"

Access to Quality Housing – Continue efforts to extend the single-family detached house standard to members in grade E-8 and subsequently to grade E-7 and below over several years as resources allow.

Post-9/11 GI Bill – Support a technical correction to ensure uniform applicability to all seven uniformed services.

Permanent Change of Station (PCS) Allowances – Continue efforts to upgrade permanent change-of-station allowances to better reflect expenses imposed on servicemembers, with priority on shipping a second vehicle on overseas accompanied assignments and authorizing at least some reimbursement for house-hunting trip expenses.

Morale, Welfare, and Recreation Programs –
- Oppose any initiative to withhold or reduce MWR appropriated support for Category A and B programs or reduce the exchange dividend derived; and
- Ensure needed access to exchange, commissary, family support, and other quality of life programs at gaining and losing installations involved in BRAC/rebasing.

National Guard & Reserve Forces

Retirement Age Credit –
- For the near term, the Coalition places particular priority on authorizing early retirement credit for all qualifying post-9/11 active duty service performed by Guard/Reserve servicemembers and eliminating the fiscal-year-specific accumulator that bars equal credit for members deploying for equal periods during different months of the year;
- Ultimately, there should be a reduced age entitlement for retired pay and health coverage for all Reserve Component members – that is, an age/service formula or outright eligibility at age 55; and
- Repeal the annual cap of 130 days of inactive duty training points that may be credited towards a reserve retirement.

Seamless Transition for Activated Guard and Reserve and Their Families -
- Fully fund and field "yellow ribbon reintegration" programs by modeling best practices
- Implement GAO recommendations (GAO Rpt. 08-901) for the Benefits Delivery at Discharge (BDD) program

Guard/Reserve GI Bill –
- Restore basic reserve MGIB benefits for initially joining the Selected Reserve to the historic benchmark of 47-50% of active duty benefits;
- Integrate reserve and active duty MGIB laws in Title 38 to ensure proportionality is maintained in any future benefit changes; and

- Providing full academic protection, including guaranteed enrollment, for mobilized Guard and Reserve students.

Special and Incentive Pays – Ensure equitable treatment of Guard and Reserve vs. active duty members for the full range of special and incentive pays.

Retiree Issues

Concurrent Receipt – The Coalition's continuing goal is to eliminate the deduction of VA disability compensation from earned military retired pay for all disabled retirees. In pursuit of that goal, the Coalition's immediate priorities include:

- Correcting the statutory Combat-Related Special Compensation (CRSC) formula to ensure the intended compensation is delivered; and
- Expanding current authority for Concurrent Retired Disability Pay to members forced into medical retirement before attaining 20 years of service.

Proposed Military Retirement Changes – Reject retirement plan changes such as those proposed by the 10th Quadrennial Review of Military Compensation that would "civilianize" the military system without adequate consideration of the extraordinary demands and sacrifices inherent in a military vs. a civilian career.

Disability Severance Pay – Amend the eligibility rules to include all combat- or operations-related injuries, using same definition as CRSC. For the longer term, the Coalition believes the offset should be ended for all members separated for service-caused disabilities.

Survivor Issues

SBP-DIC Offset – Repeal the SBP-DIC offset and:

- Authorize payment of SBP annuities for disabled survivors into a Special Needs Trust;
- Allow SBP eligibility to switch to children if a surviving spouse is convicted of complicity in the member's death;
- Reinstate SBP for survivors who previously transferred payments to their children at such time as the children attain majority, or upon termination of a second or subsequent marriage.

Final Retired Pay Check – Authorize survivors of retired members to retain the final month's retired pay for the month in which the retiree dies.

Health Care Issues

Full Funding for the Defense Health Program – Restore any reduction in TRICARE-related budget authority that may be included in the FY2010 budget, and continued full funding for Defense Health Program needs.

Protecting Beneficiaries Against Cost-Shifting – Require DoD to pursue greater efforts to improve TRICARE and find more effective and appropriate ways to make TRICARE more cost-efficient without seeking to "tax" beneficiaries and make unrealistic budget assumptions.

TMC Healthcare Cost Principles – The Coalition most strongly recommends Rep. Chet Edwards' and Rep. Walter Jones' H.R. 816 as a model to establish statutory findings, a sense of

Congress on the purpose and principles of military health care benefits, and guidelines on the benefit levels earned by a career of uniformed service.

- Active duty members and families should be charged no fees except retail pharmacy co-payments, except to the extent they make the choice to participate in TRICARE Standard or use out-of-network providers under TRICARE Prime.
- The TRICARE Standard inpatient copay should not be increased further for the foreseeable future. At $535 per day, it already far exceeds inpatient copays for virtually any private sector health plan.
- There should be no enrollment fee for TRICARE Standard or TRICARE For Life (TFL), since neither offers assured access to TRICARE-participating providers. An enrollment fee implies enrollees will receive additional services, as Prime enrollees are guaranteed access to participating providers in return for their fee. Congress already has required TFL beneficiaries to pay substantial Medicare Part B fees to gain TFL coverage.
- There should be one TRICARE fee schedule for all retired beneficiaries, just as all legislators, Defense leaders and other federal civilian grades have the same health fee schedule. The current TRICARE schedule is significantly lower than the lowest tier recommended by the Defense Department, recognizing that all retired service members paid large up-front premiums for their coverage through decades of arduous service and sacrifice.

TRICARE Prime – Require a DoD report, including reports from managed care support contractors, on actions being taken to improve Prime patient satisfaction, provide appointments within Prime access standards, reduce delays in obtaining pre-authorizations and referrals, and provide quality information to assist beneficiaries in making informed decisions.

TRICARE Standard Enrollment – Oppose establishment of any TRICARE Standard enrollment system; to the extent enrollment may be required, any beneficiary filing a claim should be enrolled automatically, without denying the claim. No enrollment fee should be charged for TRICARE Standard until and unless the program offers guaranteed access to a participating provider.

TRICARE Standard Provider Participation Adequacy – Continue monitoring DoD and GAO reporting on provider participation to ensure proper follow-on action.

Administrative Deterrents to Provider Participation – Continue efforts to reduce administrative impediments that deter health care providers from accepting TRICARE patients.

TRICARE Reimbursement Rates – To the extent the Medicare rate freeze continues, encourage DoD to use rate adjustment authority as needed to sustain provider acceptance. Require a Comptroller General report on the relative propensity of physicians to participate in Medicare vs. TRICARE.

Active Duty Dependent Dental Plan – Increase the DoD subsidy for the Active Duty Dependent Dental Plan to 72% and increase the cap on orthodontia payments to $2,000.

TRICARE Dependent Dental Coverage for Surviving Children – Authorize children of members who die on active duty to retain coverage under the Active Duty Dependent Dental Plan until they reach 21 or 23 if enrolled in college.

TRICARE Reserve Select (TRS) Access – Require a DoD report on options to assure TRS enrollees' access to TRICARE-participating providers.

TRS Alternative Option – Authorize an option to have DoD subsidize premiums for continuation of a member's civilian family health insurance during activation periods.

Reserve Separatee TRS/CHCBP Coverage – Authorize one year of post- Transitional Assistance Management Program (TAMP) TRS coverage for every 90 days deployed for returning IRR or involuntary separatees from the Selected Reserve. Authorize Continued Health Care Benefits Program (CHCBP) coverage for voluntarily separating Reservists subject to TRS disenrollment.

Gray Area Reserve Coverage – Authorize an additional premium-based TRS option for Guard/Reserve members to avoid losing health coverage upon entering "gray area".

Guard/Reserve Dental Coverage – Provide coverage for Reservists once an alert order is issued and for 180 days post-mobilization (during TAMP), unless dental readiness is restored to T-2 condition before demobilization.

Guard/Reserve Mental Health – Guard and Reserve members and their families should have equal access to evidence-based treatment for post traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, and other combat-related stress conditions. Post-deployment health examinations should be offered at the member's home station.

Guard/Reserve Health Information – Improve electronic capture of non-military health information in the service member's medical record.

TRICARE For Life – Oppose any TFL enrollment fee and seek equal coverage of TFL beneficiaries under TRICARE and Medicare preventive care initiatives.

Restoration of Survivor Coverage – Restore TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

BRAC and Re-Basing – Require an annual DoD report on the adequacy of health resources, services, quality and access to care for beneficiaries affected by BRAC/rebasing.

OVERVIEW

Madam Chair, The Military Coalition extends our thanks to you and the entire Subcommittee for your steadfast support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors.

Over the past two years, the Subcommittee provided major increases in military end strength for the Army and Marine Corps; improved pay raises; precedent-setting advancements in survivor benefits and disabled retiree programs; significant improvements in wounded warrior benefits, care, and treatment; and upgrades to Guard/Reserve health care. The Subcommittee also worked hard to resist initiatives that would have imposed disproportional increases in TRICARE fees.

Your efforts made a huge, positive difference in the lives of the entire uniformed services community – active, Guard and Reserve personnel, veterans, retirees, survivors, and families.

Despite these many advancements, the Services continue to report that they are wearing out both equipment and personnel. As our men and women in uniform prosecute wars on two fronts, the Coalition believes it is critical that the Nation continue to support military people programs with the appropriate resources.

The Army attempted last fall to ease the strain of operations tempo by reducing deployment time from 15 to 12 months, yet prolonged, repeated separations and the attendant stress on our troops and their families continue to put longer-term readiness at risk.

Men and women in uniform are still answering the call – but only at the cost of ever-greater sacrifices. They, with the support of their families, continue to endure the mounting stresses brought about by repeated deployments, ever-increasing workloads, and the strain of knowing (as documented by Rand Corp.'s study) that with each successive deployment, the likelihood increases that they won't return home as the same person.

We have been encouraged that the Nation seems to recognize that the only way to ease these burdens is through significant increases to end strength that will allow more dwell time between deployments in today's high-threat environment that will continue for the foreseeable future.

The Coalition hopes that, in these times of growing political and economic pressures, Congress won't lose sight of that fundamental priority, or be persuaded to make a false choice between end strength increases and weapons needs, when both are vital to the nation's strength.

In this testimony, The Coalition offers its collective recommendations on what needs to be done to address important personnel-related issues in order to sustain long-term personnel readiness.

Wounded Warrior Care

In 2007, *The Washington Post* reported deplorable conditions and poor oversight at Walter Reed Medical Center for wounded service members transitioning from in-patient to out-patient status.

Congress, DoD and VA acted quickly to improve wounded care based on the findings and recommendations of several commissions and task forces. Some of the recommendations were

addressed in the FY 2008 and 2009 National Defense Authorization Acts (NDAAs), but these were just initial steps, and much more remains to be done if we are to do the right thing by those who have suffered physical and psychological harm in the Nation's defense.

TMC offers recommendations in five major areas of concern: DoD-VA seamless transition oversight; the disability evaluation system; continuity of health care coverage; mental health/traumatic brain injury (TBI) needs; and support services for families and caregivers.

DoD-VA Seamless Transition Oversight – The Coalition believes strongly that seamless transition goals will never be realized without the vigilant oversight of a permanent, jointly-staffed DoD-VA oversight agency. Part-time oversight by joint committees that meet periodically have never been and never will be adequate to meet that need.

Success will require aggressive personal involvement and accountability from the most senior leaders of both Departments. But nothing can replace the leadership accountability of a single-mission, joint office in which representatives of the two agencies are assigned full-time responsibility, authority, and resources to provide meaningful oversight, with regular reporting responsibilities to the Secretary of Defense, the Secretary of Veterans Affairs and the Committees on Armed Services and Veterans Affairs.

We note, for example, a January 2009 GAO report which found that DoD and VA lack results-oriented performance goals and measures for establishing a joint electronic health record, and that they have not fully executed the statutorily required Joint Interagency Office, which at that time of GAO's evaluation had no director, deputy, or staff.

We're grateful that Congress extended the statutory authority for the DoD/VA Senior Oversight Committee through the end of 2009 rather than allowing it to expire, but the very transience of this authority significantly undermines the Committee's effectiveness. SOC incumbents are understandably distracted by the uncertainty of their own futures and dealing with other governmental priorities, and program administrators being overseen are more than aware that their overseers may not be around very long.

The Coalition believes it is of overriding importance to establish a permanent Joint Seamless Transition Office, responsible for managing, implementing, monitoring and reporting to senior DoD, VA and congressional leaders on all aspects of the seamless transition process including, but not limited to:

- ***Joint, single separation physical;***
- ***Consistent DoD/VA disability evaluation system;***
- ***Bi-directional electronic medical and personnel records data transfer;***
- ***Medical centers of excellence and operations/research projects; and***
- ***Coordination of care, treatment, and information, including DoD-VA federal/recovery coordinator clinical and non-clinical services and case management programs.***

Disability Evaluation System (DES) – The DES pilot has shown that DoD and VA have the capability to standardize, rationalize, and streamline the complex disability rating process as a service member transitions from active duty into the VA system. But several challenges remain.

Pre-existing conditions. We fully agree with the Subcommittee's efforts to limit past practices under which some services have characterized returning warriors' disabilities as existing prior to service entry. The Coalition believes strongly that such characterization should not be an option if a member has been deployed to a combat zone, regardless of his/her length of service.

Disability retirement threshold. The Coalition believes strongly that members determined by the parent service to be 30 percent or more disabled should continue to be eligible for a military disability retirement with all attendant benefits, including lifetime TRICARE eligibility for the member and his/her family. We do not support efforts to disconnect health care eligibility from disability retired pay eligibility. The Coalition also agrees with the opinion expressed by Secretary Gates that a member forced from service for wartime injuries should not be separated, but awarded a high enough rating to be retired for disability.

Disability retired pay calculation. We also do not support simply turning all responsibility for disability payments to the VA, as some have proposed, with DoD only responsible for "vesting" service-based retired pay at 2.5% of pay times years of service. This would significantly disadvantage many severely wounded, ill or injured members from a compensation standpoint. The Coalition does not believe that reforms intended to help wounded warriors should cause them to receive less compensation than is provided by the current system. Under any reform methodology, the member should receive the higher of the two compensation amounts, just as disability retirees with more than 20 years of service currently are awarded the higher amount of either 2.5% of pay times years of service or their disability percentage times their pay.

Accelerated disability-retirement determinations. The Coalition does not object to current efforts to allow disabled members to accept accelerated processing of their disability retirements. However, we are concerned whether members facing such decisions are receiving complete counseling on the potential impacts of their decision on their compensation, rehabilitation program availability, health coverage and other benefits. All of these things can change dramatically once a person leaves active duty – and in most cases not for the better. For example, per diem for family member caregivers will terminate and members with TBI can lose eligibility for cognitive therapy. The Coalition believes the government has an obligation to ensure that members making such decisions are fully aware of all implications that could affect them, and that consideration should be given to allowing them at least some period of time in which they are able to reverse a decision that proves to have unexpected adverse consequences.

The Coalition recommends:

- ***Barring "pre-existing condition" determinations for any member who has been deployed to a combat zone;***
- ***Retaining the 30% disability threshold for award of disability retired pay and lifetime family TRICARE coverage;***
- ***Ensuring that any adjustment to the disability retirement system does not result in a member receiving less disability retired pay than he or she would receive under the current system; and***
- ***Ensuring that members electing accelerated disability retirement/separation are fully counseled on all possible negative changes in compensation, health care and other benefits, with consideration to allowing a limited time to reverse a regrettable decision.***

Continuity of Health Care Coverage – Transitioning out of the military is always a difficult time for service members and their families, and it can even be more frightening and uncertain for those who are disabled because of their service.

A major consideration is that there are significant differences between active-duty and retired military health care coverage, and even greater differences between active duty TRICARE and VA health coverage.

When a member is killed in the line of duty, the member's spouse is authorized three years of continued active-duty-level coverage, and the children are authorized continued active-duty-level coverage until they attain majority.

The Coalition believes that, when a member suffers injuries or illness on active duty, especially in combat, that are severe enough to force him or her into disability retirement, the member and the family deserve similar treatment. Three years of continued active-duty-level coverage would provide the necessary transitional protection to ensure they are not faced with abrupt and unforeseen changes in their eligibility or expense for any type of care solely because of the service-caused injury.

Cognitive therapy. This poses potentially serious implications for members who may need years of continuing rehabilitation/therapy after leaving active duty.

A particularly important example concerns cognitive rehabilitation therapy for members with TBI. Active duty members must be approved under a special TRICARE Supplemental Health Care Program for cognitive rehabilitation therapy. Since the therapy is not a covered benefit under TRICARE, members may not automatically receive the treatment and services, and eligibility for the Supplemental Health Care Program terminates once the member is retired. While DoD does provide some rehabilitation services accepted and covered under TRICARE for TBI, cognitive rehabilitation therapy is not covered as a distinct and separate service because DoD believes there is no evidence on the efficacy of cognitive rehabilitation as a therapy. The VA, on the other hand, offers cognitive therapy coverage, but like TRICARE, treatment and services are limited to specific locations where capacity and demand exist.

Congress made some effort to mitigate such potential transition problems with a provision in the FY2008 Defense Authorization Act that authorized continuity of active duty-level TRICARE benefits for a disabled retiree to the extent that VA care is not available.

But this is of limited value when the services and VA each think the other should be making the availability determination, when the availability of VA care is in the eye of the beholder, and when that care is substantively different than the therapy the member was receiving while on active duty. And even this modest protection only applies to the member, not to family members.

Medicare Part B requirement. A major issue faced by many members forced from active duty by severe service-caused disabilities is that the severity of their disability qualifies them for Medicare. In such cases, TRICARE is second-payer to Medicare.

But under laws that were designed for elderly retirees but apply equally to all Medicare-eligible military beneficiaries, these younger disabled warriors must pay Medicare Part B premiums

($96.40 per month in 2009) to retain any coverage under TRICARE. Unfortunately, many weren't well-informed on the requirement to enroll in Medicare and subsequently were denied TRICARE eligibility.

The Coalition believes it's wrong that members whose service caused them to become severely wounded, ill or injured should have to pay extra for their care, and believes they should either be exempt from paying the Part B premium until age 65 or DoD should reimburse them for such payments.

DoD/VA Waiver of Pre-authorizations/Referrals. Doctors at VA polytrauma centers indicate that one of their biggest problems is the requirement to get multiple authorizations from DoD to provide a variety of specialty care for active duty members with multiple medical problems.

It is grossly inappropriate that bureaucratic requirements are impeding the delivery of urgent and essential care for members who have suffered most severely for their country.

When an active duty member is referred to VA facility for care, DoD should grant an automatic waiver of preauthorization/referral requirements to allow the VA providers to deliver needed care without bureaucratic delays.

The Coalition strongly recommends:

- ***Authorizing medically retired members with a severe service-caused disability to retain active-duty-level TRICARE eligibility for themselves and their eligible family members for at least three years to protect against "falling through the cracks" of unforeseen coverage changes upon conversion to retired/veteran status;***
- ***Establishing common DoD and VA protocols for diagnosis, treatment, and rehabilitation for TBI conditions;***
- ***Either exempting severely disabled military retirees from paying Medicare Part B premiums until age 65 or authorizing a special DoD allowance to reimburse them for the cost of such premiums; and***
- ***Waiving TRICARE Prime preauthorization/referral requirements for active duty/Guard/Reserve members referred to VA polytrauma facilities for care.***

Psychological Health and Traumatic Brain Injury (TBI) – Last year's RAND study documented that about one in five OEF/OIF veterans suffer from Posttraumatic Stress Disorder (PTSD) or major depression and another 10 percent experience some level of TBI.

The report stressed that if the government fails to invest in needed immediate treatment, it will face very large alternative costs in the years ahead as a result of homelessness, unemployment/underemployment and lost tax revenue.

Congress has done the right thing by establishing the Center of Excellence for Psychological Health and Traumatic Brain Injury, and the Coalition is encouraged by service leaders' cooperation in working with the Center. Further, DoD and the VA are pursuing serious efforts to add qualified mental health providers to meet the explosive growth in requirements..

But the Coalition is concerned that it will take years to change thinking, add resources, and implement processes necessary to achieve the kind of results that all interested parties hope for.

In the meantime, thousands of affected members and their family members have gone unidentified, continue to feel deterred from seeking needed care, or are having difficulty accessing needed care.

In many cases, they may be resistant to acknowledging their condition because of fear for the possible impact on their careers or the perceptions of their leaders and peers (in many cases, with good cause), or may seek independent counseling/care from outside providers in efforts to protect their anonymity.

TMC recommends:

- ***Priority efforts to deliver information on-line and by other means to servicemembers and family members concerning availability of providers, confidential options for counseling, and virtual counseling/advice;***
- ***Special outreach efforts to provide such services and resources to Guard and Reserve members and families who don't live near military facilities;***
- ***Priority efforts to educate private sector providers on the unique needs of military and veteran patients and family members, and deliver needed information to them on-line, including contact points for discussion/consultation with military/VA providers;***
- ***Consistent implementation of pre- and post-deployment evaluations, particularly for Guard and Reserve members who may be leaving active duty;***
- ***Increased research on the impact of combat stress and TBI on family members, particularly children;***
- ***Continuing destigmatization efforts with emphasis at unit levels to actively encourage affected service members, veterans, and family members to seek help, and thus increase effectiveness and military readiness;***
- ***Increasing availability and outreach on substance abuse counseling options;***
- ***Pursuing aggressive medication reconciliation and management programs to protect against inadvertent overmedication and adverse reactions;***
- ***Requiring TBI and psychological health assessments for members who have been deployed to a combat zone as part of any disciplinary process prior to a decision concerning non-medical separation; and***
- ***Developing a partnership between DoD, VA, and other governmental and non-governmental agencies and civilian health care systems to improve access to treatment for PTSD, TBI, depression and other combat-related stress conditions for servicemembers and their families.***

Caregiver and Family Support Services – Recent statutory changes authorized a number of support services, but more needs to be done to assist full-time caregivers and family members who also have significant additional needs.

The sad reality is that, for the most severely injured servicemembers, family members or other loved ones are often required to become full-time caregivers. Many have lost their jobs, homes, and savings.

Under current law, TSGLI can provide some offset for immediate expenses for some wounded warriors with qualifying TSGLI wounds/injuries, and authorized caregivers are provided per diem payments while the member remains on active duty. But those payments stop when the

member leaves active duty status. While the VA provides severely disabled veterans a modest allowance for aid and attendance, it is payable to the veteran, not to the caregiver. Further, it is authorized only for spouses, but caregivers are often parents, siblings or other loved ones.

The Coalition believes the government has an obligation to provide reasonable compensation and training for such caregivers, who never dreamed that their own well-being, careers, and futures would be devastated by military-caused injuries to their servicemembers.

In addition, Congress should authorize health coverage and reasonable respite care for full-time caregivers and their family members, recognizing that they often have no other options for care and need periodic relief from their arduous and stressful duties.

In the same vein as the continuity of health care addressed above, many members have difficulty transitioning to medical retirement status. To assist in this process, consideration should be given to authorizing medically retired members and their families to remain in on-base housing for up to one year after retirement, in the same way that families are allowed to do so when a member dies on active duty.

The Coalition recommends:

- ***Authorizing compensation, training and certification, and respite care for family members required to serve as full-time caregivers, whether the member is in active duty or retired status;***
- ***Authorizing health care eligibility for full-time caregivers and their families; and***
- ***Extending on-base housing eligibility for up to one year to medically retired, severely injured service members and their families.***

Active Forces and Their Families

The Coalition is concerned over the rhetoric that military personnel costs are skyrocketing and hopes the Subcommittee will be able to fend off those who wish to reduce costs by cutting back on needed personnel growth and quality of life programs.

Backtracking on planned – and badly needed – end strength increases will only aggravate the unfair abuses already imposed on military people and families with the imposition of repeated, long-term deployments on a too-small force.

BRAC actions pose an additional concern, as DoD is struggling to meet the 2011 deadline at many BRAC locations. The Coalition is very concerned whether needed infrastructure and support programs will be in place in time to meet families' needs.

Military End Strength – Inadequate end strengths and greater-than-anticipated requirements and resources to support the war effort and other operational requirements have taken a terrible toll on the quality of life of military families. This has been reflected in recruiting in recent years and poses a serious and too-often underestimated threat to retention and readiness.

While the Subcommittee succeeded in increasing Army and Marine Corps end strengths last year, those must continue to have any significant prospect of easing rotation burdens.

The Coalition is greatly disturbed at calls by some influential legislators to reduce planned force growth as a means of funding weapons requirements. In some cases, this is justified by rhetoric about leveraging technology to replace people. The past seven years of war have shown that there is no substitute for boots on the ground in the current conflict. And it has been widely acknowledged that any drawdown in Iraq will be offset by increased deployments to Afghanistan.

The Coalition is very concerned that some national leaders seem to have become desensitized to the truly terrible sacrifices that the current mismatch between missions and force levels has already imposed on those in uniform.

If force planners had been told before 9/11 that our armed forces would face the deployment tempo that they have over the past 8 years, every one of them would have predicted that the services would be in a state of retention disaster by now.

We all stand in awe of the level of sacrifice our troops and families have already borne on the nation's behalf.

But we fear that some seem to have gotten the impression that, because they have endured far more than the Nation has had any right to expect, that we can continue demanding – or increasing – that level of sacrifice. Let us not delude ourselves into thinking such a thing.

There are thousands among this new "Greatest Generation" who are saying "enough is enough" and questioning their families can afford to continue accepting such disproportional burdens with little prospect of real relief in sight.

There is no avoiding the reality that years of war have worn out weapons and equipment that must now be replaced and modernized. These and other military requirements will take a great deal of money.

But pretending that the nation can cut one essential readiness component (personnel) to fund another – especially in wartime – would entail a conscious decision to increase the already intolerable burdens imposed on military families. Such gross insensitivity to their sacrifices can only undermine retention and readiness, when they already are at such grave risk.

The Coalition urges the Subcommittee to:

- ***Sustain planned Army and Marine Corps end strength growth as a top priority;***
- ***Resist budget-driven (rather than requirements-driven) manpower reductions for the Air Force and Navy; and***
- ***Seek a 2010 defense budget of at least 5% of Gross Domestic Product.***

Military Pay Raise Comparability – The Coalition thanks the Subcommittee for its sustained commitment to restoring full military pay comparability – a fundamental underpinning of the All-Volunteer Force.

Throughout the 1980s and '90s, our nation didn't adhere to that principle, regularly capping military pay raises below the average American's to the extent that the "pay comparability gap" reached 13.5% in 1998-99, and contributed significantly to serious retention problems.

Since then, the Subcommittee has acted to pare the gap by approving military raises that have been at least .5% above private sector pay growth each year (as measured by the Bureau of Labor Statistics' Employment Cost Index (ECI).

Now that significant progress has been made and the "erosion of pay and benefits" retention-related problems have abated, some have renewed the call to cut back on military raises, create a new comparability standard, or substitute more bonuses for pay raises in the interests of "efficiency".

The Defense Department, for example, wishes to establish a new comparability standard under which each pay and longevity cell would represent the 70th percentile of compensation for similarly-educated civilians.

The Coalition believes that methodology is appropriate to establish a floor to ensure the pay table properly addresses specific changes in force composition (e.g., more highly-educated and technologically sophisticated NCOs and warrant officers).

But it is a bad standard for the overall pay raise, precisely because it is not transparent to anyone but the Pentagon analyst who does the calculation and is highly susceptible to manipulation – as various Defense leaders have sought to do in the past.

The Coalition agrees with the approach the Subcommittee has taken – that the best comparability measure is a comparison of the overall military pay raise percentage (proportionally adjusted for any grade/longevity tweaks such as those undertaken earlier in this decade) with the percentage growth in the ECI.

The ECI is what the government uses for every other measure of private pay growth, and it's very transparent to government leaders and servicemembers alike.

As of 2009, the comparability gap stands a 2.9%.

The Coalition urges the Subcommittee to continue sustaining military raises of at least .5% above the ECI until the current 2.9% shortfall is eliminated.

Military vs. Civilian Total Compensation Comparisons – The 10th Quadrennial Review of Military Compensation recommended what several studies have recommended in the past – building a "Military Annual Compensation" measure that includes not only pay and housing/food allowances and their associated tax advantages, but also the value of military-unique medical and retirement benefits. This would be used to compare military vs civilian "total compensation".

The Coalition believes such methodologies are grossly inappropriate for comparison purposes, because they fail utterly to acknowledge the unique and arduous conditions of military service that necessitate providing military-unique career benefits.

We acknowledge that it's appropriate to educate servicemembers on the value of their total benefit package (which the services already do by providing each member an annual statement itemizing the value of each military compensation element). But even these often draw negative

member reactions, such as "Where does this statement show the negative value of having spent three of the last six years away from my family?"

In the context of the incalculable differential in working conditions and demands and sacrifices expected of the two groups, any attempt to monetize the total compensation differential is meaningless.

The Coalition urges the Subcommittee to continue to reject proposals to "civilianize" military comparisons that, by their nature, cannot similarly calculate the dramatic differentials in military vs. civilian working conditions.

REDUX and the 15-Year Career Status Bonus – The Coalition is very concerned that the Defense Department and the Services are not doing enough to educate military people on protecting their long-term financial interests concerning the choice each member faces at the 15-year point between retaining the regular military retirement system or accepting a $30,000 "career status bonus" and the far-less-advantageous REDUX retirement system.

The Coalition believes that selecting the $30,000 bonus/REDUX is a demonstrably bad financial choice for nearly all servicemembers.

A typical enlisted member who accepts the REDUX "bonus" and subsequently retires as an E-7 with 20 years of service will have forfeited $300,000 of lifetime retired pay (in 2009 dollars) for the $30,000 bonus.

And yet one-quarter to one-half of enlisted members, depending on service, opt to take the bonus.

Thinking about this another way, accepting the REDUX bonus is equivalent to taking out a 24% APR mortgage on the retired pay differential. For an officer, who receives the same $30,000 bonus but sacrifices far more retired pay, it's equivalent to a 35% APR mortgage.

The Coalition believes strongly, from this context, calling the $30,000 a "bonus" is false advertising.

The Coalition believes that the REDUX/Career Status Bonus option should be repealed. For the shorter term, recognizing the significant budget hurdles to that objective, the Coalition urges the Subcommittee to require the services to exert more effort to educate members on the size of the future retired pay loss incurred in choosing that option.

Family Readiness and Support – A fully funded, robust family readiness program continues to be crucial to overall readiness of our military, especially with the demands of frequent and extended deployments.

Resource issues continue to plague basic installation support programs. At a time when families are dealing with increased deployments, they often are being asked to do without in other important areas.

Availability of child care is a particular problem when so much of the force is deployed.

The Coalition recommends that the Subcommittee:

- ***Provide authorization and funding to accelerate increases in availability of child care to meet both active and Reserve Component requirements;***
- ***Direct DoD to report on the extent of reallocation of approved funding for support programs and the attendant impact on military families; and***
- ***Continue pressing the Defense Department to implement flexible spending accounts to enable active duty and Selected Reserve families to pay out-of-pocket dependent care and health care expenses with pre-tax dollars.***

Access to Quality Housing – Today's housing allowances come much closer to meeting military members' and families' housing needs than in the past, thanks to the conscientious efforts of the Subcommittee in recent years.

But the Coalition believes it's important to understand that some fundamental flaws in the standards used to set those allowances remain to be corrected, especially for enlisted members.

The Coalition supports revised housing standards that are more realistic and appropriate for each pay grade. For example, only 1.25% of the enlisted force (E-9) is eligible for BAH sufficient to pay for a 3-bedroom single-family detached house, even though thousands of more junior enlisted members do, in fact, reside in detached homes.

We appreciate the Subcommittee's effort to extend the single-family home standard to E-8s in its markup last year, and regret that this measure was not sustained in conference action.

The Coalition urges the Subcommittee to continue its efforts to extend the single-family detached house standard to members in grade E-8 and subsequently to grade E-7 and below over several years as resources allow.

Post 9/11 GI Bill – Congress' action last year in approving the Post-9/11 GI Bill was a truly historic achievement that will provide major long-term benefits for military people and for America.

However, the Coalition is sensitive that, unlike every other GI Bill program since World War II, eligibility was restricted to members of the "armed forces" rather than "uniformed services". This had the very serious effect of excluding eligibility for commissioned officers of the US Public Health Service and NOAA Corps.

The Coalition urges the Subcommittee's support for a technical correction to the Post-9/11 GI Bill statute to ensure uniform applicability to all seven uniformed services.

Paternity Leave – The Coalition is grateful for Congress' action last year to provide 10 days of paternity leave to servicemembers who have or adopt a child. However, eligibility was restricted to members of the "armed forces" rather than "uniformed services". This had the effect of excluding eligibility for commissioned officers of the US Public Health Service and NOAA Corps.

The Coalition urges the Subcommittee's support for a technical correction to the paternity leave statute to ensure uniform applicability to all seven uniformed services.

Permanent Change of Station (PCS) Allowances – The Coalition is grateful for the Subcommittee's successful initiative last year to raise the maximum daily Temporary Lodging Expense (TLE) allowance from $180 to $290 and authorize certain increases in PCS weight allowances.

But it's an unfortunate fact that servicemembers and their families are forced to incur other significant out-of-pocket expenses when complying with government-directed moves.

For example, PCS mileage rates still have not been adjusted since 1985. The current rates range from 15 to 20 cents per mile – an ever-shrinking fraction of the 48.5 cents per mile authorized for temporary duty travel. Also, military members must make any advance house-hunting trips at personal expense, without any government reimbursement such as federal civilians receive.

Additionally, the overwhelming majority of service families consist of two working spouses, making two privately owned vehicles a necessity. Yet the military pays for shipment of only one vehicle on overseas moves, including moves to Hawaii and Alaska. This forces relocating families into large out-of-pocket expenses, either by shipping a second vehicle at their own expense or selling one car before leaving the states and buying another upon arrival.

The Coalition urges the Subcommittee to continue its efforts to upgrade permanent change-of-station allowances to better reflect expenses imposed on servicemembers, with priority on shipping a second vehicle on overseas accompanied assignments and authorizing at least some reimbursement for house-hunting trip expenses.

Morale, Welfare, and Recreation Programs – The availability of appropriated funds to support MWR activities is an area of continuing concern.

Service members and their families are reaching the breaking point as a result of extended deployments and the constant changes going on in the force. It is unacceptable to have troops and families continue to take on more responsibilities and sacrifices and not give them the support and resources to do the job and to take care of the needs of their families. TMC is particularly concerned that additional reductions in funding or support services may occur because of the U.S. economic crisis and budget shortfalls across the Defense Department.

TMC urges the Subcommittee to:

- ***Oppose any initiative to withhold or reduce MWR appropriated support for Category A and B programs or reduce the exchange dividend derived; and***
- ***Ensure needed access to exchange, commissary and TRICARE programs at gaining and losing installations involved in BRAC/rebasing.***

Guard and Reserve Forces and Their Families

Since Sept. 11, 2001, more than 690,000 Guard and Reserve service men and women have been called to active federal service. More than 190,000 have served multiple deployments. In this regard, they are experiencing virtually the same sacrifices as active duty members and families – on a level never envisioned by the architects of Guard and Reserve personnel and compensation systems.

However, readjusting to home life, returning to civilian jobs and the communities and families they left behind pose unique problems and added stress for Reserve Component members.

Unlike active duty personnel, whose combat experience enhances their careers, many Guard and Reserve members return to employers who are unhappy about their active duty service and find that their civilian careers have been inhibited by their prolonged absences.

In many cases, those returning with various degrees of combat-related injuries and stress disorders encounter additional difficulties after they return that also can cost them their jobs and careers.

This is compounded by the reality that, despite the continuing efforts of the Subcommittee, most Guard and Reserve families do not have access to the same level of counseling and support services that the active duty members have.

In short, the Reserve components face increasing challenges virtually across the board, including major equipment shortages, end-strength requirements, wounded-warrior health care, and pre- and post-deployment assistance and counseling.

Reserve Retirement Age Credit – TMC deeply appreciates Congress' authorization of early retirement for certain members of the Guard and Reserve activated since January 28, 2008. However, in recognition of the continuing service and sacrifice of Reserve Components members and as an inducement to longer service and to maintain the Operational Reserve Force, more must be done.

Guard/Reserve mission increases and a smaller active duty force mean Guard/Reserve members must devote far more of their working lives to military service than envisioned when the current retirement system was developed in 1948. Repeated, extended activations make it more difficult to sustain a full civilian career and will impede Reservists' ability to build a full civilian retirement, 401(k), etc.

Regardless of statutory protections, periodic long-term absences from the civilian workplace can only limit Guard/Reserve members' upward mobility, employability and financial security. Further, strengthening the reserve retirement system will serve as an incentive to retaining critical mid-career officers and NCOs for continued service and thereby enhance readiness.

TMC strongly urges further progress in revamping the reserve retirement system in recognition of increased service and sacrifice of Reserve Component members, including at a minimum, extending the new authority for a 90 day - three month reduction to all Guard and Reserve members who have served since 9/11.

TMC also urges amending the statute to eliminate the inequity inherent in the current fiscal year calculation, which only credits 90 days of active service for early retirement purposes if it occurs within the same fiscal year.

This has the effect of significantly penalizing members who deploy in July or August vs. those deploying earlier in the fiscal year.

It is patently unfair, as the current law requires, to give three months' retirement age credit for a 90-day tour served from January through March, but no credit at all for a 120-day tour served from August through November (because the latter covers 60 days in each of two fiscal years).

For the near term, the Coalition places particular priority on authorizing early retirement credit for all qualifying post-9/11 active duty service performed by Guard/Reserve servicemembers and eliminating the fiscal-year-specific accumulator that bars equal credit for members deploying for equal periods during different months of the year.

Ultimately, TMC believes we must move forward to provide a reduced age entitlement for retired pay and health coverage for all Reserve Component members – that is, an age/service formula or outright eligibility at age 55.

Further, TMC urges repeal of the annual cap of 130 days of inactive duty training points that may be credited towards a reserve retirement.

Guard/Reserve Support – Additional initiatives are essential to address unique difficulties encountered by Guard and Reserve members and families in accommodating demands for additional active duty service.

TMC urges the Subcommittee to:

- ***Fully fund and field "yellow ribbon reintegration" programs by modeling best practices***
- ***Implement GAO recommendations (GAO Rpt. 08-901) for the Benefits Delivery at Discharge (BDD) program***
- ***Ensure Federal Reserve veterans have equal access to services and support available to National Guard veterans;***
- ***Secure waivers for scheduled licensing/certification/promotion exams scheduled during a mobilization; and***
- ***Establish reemployment rights for Guard and Reserve spouses who must suspend employment to care for children during mobilization.***

Guard/Reserve GI Bill – TMC is most grateful to Congress for passage of the Post-9/11 GI Bill, which authorizes cumulative credit for Guard/Reserve service on active duty.

However, benefits for joining the Selected Reserve were not upgraded or integrated in the Post-9/11 GI Bill as TMC has long recommended.

Today, Reserve Montgomery GI Bill benefits offer only 25% of active duty benefits, compared to the originally intended 47-50%. That would require raising the current Reserve rate from $329 per month to roughly $650 for full time study.

This is not simply a matter of "proportional equity." Restoring the relative ratio between the two programs' benefits is essential to long-term success of Guard and Reserve recruiting programs.

TMC strongly urges:

- ***Restoring basic reserve MGIB benefits for initially joining the Selected Reserve to the historic benchmark of 47-50% of active duty benefits;***

- ***Integrating reserve and active duty MGIB laws in Title 38 to ensure proportionality is maintained in any future benefit changes; and***
- ***Providing full academic protection, including guaranteed enrollment, for mobilized Guard and Reserve students.***

Special and Incentive Pays – Increased reliance on Guard and Reserve forces to perform active duty missions have highlighted differentials and inconsistencies between treatment of active duty vs. Guard/Reserve members on a range of special and incentive pays.

Congress has acted to address some of these disparities, but more work is needed.

The Coalition urges the Subcommittee to ensure equitable treatment of Guard and Reserve vs. active duty members for the full range of special and incentive pays.

Retiree Issues

The Military Coalition is extremely grateful to the Subcommittee for its support of maintaining a strong military retirement system to help offset the extraordinary demands and sacrifices inherent in a career of uniformed service.

Concurrent Receipt – In the FY2004 NDAA, Congress acknowledged the inequity of the disability offset to earned retired pay and established a process to end or phase out the offset for all members with at least 20 years of service and at least a 50% disability rating.

Congress further directed establishment of a Veterans Disability Benefits Commission (VDBC) to assess whether changes to the disability offset law are warranted for the remaining categories of disabled retirees.

In its final report, the VDBC validated the long-standing Coalition assertion that the deduction of VA disability compensation from earned military retired pay is inappropriate and should be ended for all categories of disabled retirees.

The Coalition is grateful that the Subcommittee has continued its efforts to make progress in easing the adverse effects of the offset – most recently by extending eligibility for Combat-Related Special Compensation (CRSC) to disabled retirees forced into medical retirement by operations-related injuries before attaining 20 years of service.

The Coalition believes strongly that the same logic – that such members should at least be "vested" in their service-earned retired pay at 2.5% of pay times years of service – applies to those forced into early medical retirement for service-caused conditions that aren't related to combat. In this regard, the affect on the member's quality of life and future earning power is the same, regardless of whether the disability was caused by a bullet or some other service-caused circumstance.

It is simply inappropriate that current law forces thousands of severely injured members with as much as 19 years and 11 months of service to forfeit most or all of their earned retired pay.

Similarly, the Coalition believes that, if the offset is inappropriate for a member with a 50% or greater service-connected disability, as Congress already has acknowledged in current statute, it is no less appropriate for a member with a 40% service-caused disability, etc.

The issue is whether a military retiree earned his or her retired pay, independent of incurring a disability. Clearly, that answer is "yes". It follows logically that, if a member also has the misfortune to incur a disability as a direct result of that service, the disability compensation received from the VA should be added to the member's earned retired pay, not subtracted from it.

Finally, the Coalition has learned of an inadvertent problem in the statutory CRSC computation formula that causes many seriously disabled and clearly eligible members to receive little or nothing in the way of CRSC. The Defense Department has acknowledged the problem in discussions with the Subcommittee staff.

The Coalition's continuing goal is to eliminate the deduction of VA disability compensation for from earned military retired pay for all disabled retirees. In pursuit of that goal, the Coalition's immediate priorities include:

- ***Correcting the Combat-Related Special Compensation formula to ensure the intended compensation is delivered; and***
- ***Expanding current authority for Concurrent Retired Disability Pay to members forced into medical retirement before attaining 20 years of service.***

Proposed Military Retirement Changes – The Coalition has reviewed the results of the 10th Quadrennial Review of Military Compensation (QRMC) and does not support its recommendation to modify the military retirement system to more closely reflect civilian practices.

Specifically, the QRMC proposed:

- Converting the military retirement system to a civilian-style plan under which full retired pay wouldn't be paid until age 57-60;
- Vesting retirement benefits after 10 years of service; and
- Authorizing the services to pay flexible "gate pays" and separation pay at certain points of service to encourage continued service in certain age groups or skills and encourage others to leave, depending on the services needs for certain kinds of people at the time.

The Coalition is very concerned that this proposal is so complicated that people evaluating career decisions at the 4-to-10 year point would have no way to project their future military retirement benefits. Gate pays available at the beginning of a career could be cut back radically if the force happened to be undergoing a strength reduction later in a member's career.

Under today's system, it's very clear from the pay table what level of retired pay would be payable, depending how long one served and how well one progressed in grade.

From a broader force-planning standpoint, one thing history shows is that no one is able to accurately project force requirements 10 years downstream. World events and economic situations have driven dramatic force size changes within relatively short periods. The sustained

drawing power of the 20-year retirement system provides an essential long-term moderating influence that keeps force managers from over-reacting to short-term circumstances. Had force planners had such a system in effect during the drawdown-oriented 1990s, the services would have been far less prepared for the post 9/11 wartime environment.

Of equal or greater concern, this plan would effectively take money from people who serve a career (by deferring receipt of full retired pay until age 57-60) in order to fund vesting of retirement benefits for people who separate early. The Coalition believes pursuing that course would pose a significant threat to long-term retention and readiness.

The Coalition believes that the strong career pull of the 20-year retirement system has been the principal bulwark against a retention disaster in the current overstressed wartime environment.

A civilian-style retirement plan with receipt of retired pay deferred until a later age would be appropriate for the military only if military service conditions were similar to civilian working conditions – which they most decidedly are not – and if historical experience had not shown that the military depends on a maintaining a relatively young and healthy force.

The Coalition believes strongly that, if such a system as recommended by the QRMC existed for today's force under today's service conditions, the military services would already be mired in a deep and traumatic retention crisis.

Many such proposals have been offered in the past, and have been discarded for good reasons. The only initiative to substantially curtail/delay military retired pay that was enacted – the 1986 REDUX plan – had to be scrapped 13 years later after it began inhibiting retention.
The reality is that unique military service conditions demand a unique retirement system. Surveys consistently show that the military retirement system is the single most powerful incentive to serve a full career under conditions few civilians would be willing to endure for even one year, much less 20 or 30.

TMC urges the Subcommittee to reject retirement plan changes such as those proposed by the 10th Quadrennial Review of Military Compensation that would "civilianize" the military system without adequate consideration of the extraordinary demands and sacrifices inherent in a military vs. a civilian career.

Disability Severance Pay – The Coalition is grateful for the Subcommittee's inclusion of a provision in the FY08 NDAA that ended the VA compensation offset of a service member's disability severance for people injured in the combat zone.

However, we are concerned that the language of this provision imposes much stricter eligibility than that used for Combat-Related Special Compensation.

The Coalition urges the Subcommittee to amend the eligibility rules for disability severance pay to include all combat- or operations-related injuries, using same definition as CRSC. For the longer term, the Coalition believes the offset should be ended for all members separated for service-caused disabilities.

Survivors

The Coalition is grateful to the Subcommittee for its significant efforts in recent years to improve the Survivor Benefit Plan (SBP). We particularly note that, as of this past April, thanks to the Subcommittee's efforts, the Social Security offset ended and SBP beneficiaries, regardless of age, receive 55% of covered retired pay.

We also appreciate the Subcommittee's initiative in the FY 2008 defense bill that establishes a special survivor indemnity allowance. This is the first step in a longer-term effort to phase out the Dependency and Indemnity Compensation (DIC) offset to SBP when the member died of a service-caused condition.

Additionally, we are pleased that the Subcommittee and Congress extended the indemnity allowance to survivors of members who died while on active duty in the FY 2009 defense bill.

SBP-DIC Offset – The Coalition believes strongly that current law is unfair in reducing military SBP annuities by the amount of any survivor benefits payable from the DIC program.

If the surviving spouse of a retiree who dies of a service-connected cause is entitled to DIC from the Department of Veterans Affairs and if the retiree was also enrolled in SBP, the surviving spouse's SBP benefits are reduced by the amount of DIC. A pro-rata share of SBP premiums is refunded to the widow upon the member's death in a lump sum, but with no interest. This offset also affects all survivors of members who are killed on active duty.

The Coalition believes SBP and DIC payments are paid for different reasons. SBP is purchased by the retiree and is intended to provide a portion of retired pay to the survivor. DIC is a special indemnity compensation paid to the survivor when a member's service causes his or her premature death. In such cases, the VA indemnity compensation should be added to the SBP the retiree paid for, not substituted for it.

It should be noted as a matter of equity that surviving spouses of federal civilian retirees who are disabled veterans and die of military-service-connected causes can receive DIC without losing any of their federal civilian SBP benefits.

The reality is that, in every SBP-DIC case, active duty or retired, the true premium extracted by the service from both the member and the survivor was the ultimate one – the very life of the member – and that all such deaths are officially acknowledged as having been caused by military service.

The Veterans Disability Benefits Commission (VDBC) was tasked to review the SBP-DIC issue, among other DoD/VA benefit topics. The VDBC's final report to Congress agreed with the Coalition in finding that the offset is inappropriate and should be eliminated.

Speaker Pelosi and all House leaders made repeal of the SBP-DIC offset a centerpiece of their GI Bill of Rights for the 21st Century. Leadership has made great progress in delivering on other elements of that plan, but the only progress to date on the SBP-DIC offset has been the offer of a

scant $50 per month (growing to $100 a month over 5 years) Supplemental Survivor Indemnity Allowance (SSIA).

We appreciate that the Subcommittee understands the military community's (and especially the SBP-DIC widows') view that the new allowance is grossly inadequate. We also appreciate the courage of the Subcommittee in its determination to authorize at least this small amount as a token of good faith, when it could have elected to do nothing.

The Coalition urges repeal of the SBP-DIC offset. The Coalition further recommends:

- ***Authorizing payment of SBP annuities for disabled survivors into a Special Needs Trust.*** Certain permanently disabled survivors can lose eligibility for Supplemental Security Income (SSI) and Medicaid and access to means-tested state programs because of receipt of SBP. This initiative is essential to put disabled SBP annuitants on an equal footing with other SSI/Medicaid-eligibles who have use of special needs trusts.

- ***Allowing SBP eligibility to switch to children if a surviving spouse is convicted of complicity in the member's death; and***

- ***Reinstating SBP for survivors who previously transferred payments to their children at such time as the children majority, or upon termination of a second or subsequent marriage.***

Final Retired Pay Check – Under current law, DFAS recoups from military widows' bank accounts all retired pay for the month in which a retiree dies. Subsequently, DFAS pays the survivor a pro-rated amount for the number of days of that month in which the retiree was alive. This often creates hardships for survivors who have already spent that pay on rent, food, etc., and who routinely are required to wait several months for DFAS to start paying SBP benefits.

The Coalition believes this is an extremely insensitive policy imposed by the government at the most traumatic time for a deceased member's next of kin. Unlike his or her active duty counterpart, a retiree's survivor receives no death gratuity. Many older retirees do not have adequate insurance to provide even a moderate financial cushion for surviving spouses.

Recent media coverage highlighted the VA's failure to implement a decade-old law change that required the VA to make full payment of the final month's VA disability compensation to the survivor of a disabled veteran.

The disparity between DoD and VA policy on this matter is indefensible. Congress should do for retirees' widows the same thing it did ten years ago to protect veterans' widows.

TMC urges the Subcommittee to authorize survivors of retired members to retain the final month's retired pay for the month in which the retiree dies.

HEALTH CARE ISSUES

The Coalition appreciates the Subcommittee's strong and continuing interest in keeping health care commitments to military beneficiaries. We are particularly grateful for your support for the

last few years in refusing to allow the Department of Defense to implement beneficiary health care fee increases.

Prior to the past several years, the Coalition and the Defense Department have had regular and substantive dialogues that proved very productive in facilitating reasonably smooth implementation of such major program changes as TRICARE Prime and TRICARE for Life.

It is a great source of regret to the Coalition that there has been substantively less dialogue on the recent fee increase initiatives. In recent years, DoD's main concern has been to extract a specified amount of budget savings from beneficiaries, primarily by driving beneficiaries away from using their earned TRICARE coverage.

The unique package of military retirement benefits – of which a key component is a top-of-the-line health care benefit – is the primary offset afforded uniformed service members for enduring a career of unique and extraordinary sacrifices that few Americans are willing to accept for one year, let alone 20 or 30. It is an unusual, and essential, compensation package that a grateful Nation provides for the miniscule fraction of the US population who agree to subordinate their personal and family lives to protecting our national interests for so many years. This sacrifice, in a very real sense, constitutes a pre-paid premium for their future healthcare.

Full Funding for the Defense Health Program – The Coalition is grateful for the Subcommittee's support for maintaining – and expanding where needed – the healthcare benefit for all military beneficiaries, consistent with the demands imposed upon them.

To a large extent, military health care cost growth is a reflection of private sector trends. But those who measure cost growth since 1999 or 2000 start from an erroneous benchmark. At that time, military health care delivery was at its bottom point, with most Medicare-eligibles having been driven entirely out of military health care coverage by the closure and downsizing of military health facilities (MTF).

The resultant bad publicity was hurting retention, and that's a major reason why Congress enacted TRICARE For Life to restore lost benefits to military Medicare-eligibles. Congress knew from the start and fully intended that restoring medical and pharmacy coverage for beneficiaries over age 65 would substantially increase military health care outlays.

It's true that many private sector employers are choosing to shift an ever-greater share of health care costs to their employees and retirees, and that's causing many still-working military retirees to fall back on their service-earned TRICARE coverage.

In the bottom-line-oriented corporate world, many firms see their employees as another form of capital, from which maximum utility is to be extracted at minimum cost, and those who quit are replaceable by similarly experienced new hires. But that can't be the culture in the military's closed, all-volunteer personnel system, whose long-term effectiveness is dependent on establishing a sense of mutual, long-term commitment between the service member and his/her country.

The Coalition believes it's essential to bear other considerations in mind when considering the extent to which military beneficiaries should share in military health care costs.

First and foremost, the military health care system is not built for the beneficiary, but to sustain military readiness. Each Service maintains its unique facilities and systems to meet its unique needs, and its primary mission is to sustain readiness by keeping a healthy force and to be able to treat casualties from military actions. To reiterate, that model is not built for cost efficiency or beneficiary welfare. It's built for military readiness requirements.

Similarly, when military forces deploy, the military medical force goes with them, and that forces families, retirees and survivors to use the more expensive civilian health care system in the absence of so many uniformed health care providers.

These are readiness costs incurred for the convenience of the military, not for any beneficiary consideration, and beneficiaries should not be expected to bear any share of that cost -- particularly in wartime.

The Coalition is uncertain whether the new Administration will again propose some reduction to the defense health care budget based on the assumption that Congress will approve beneficiary fee increases for FY2010. But the Coalition would object strongly to any such reduction.

The Coalition urges the Subcommittee to take all possible steps to restore any reduction in TRICARE-related budget authority that may be included in the FY2010 budget, and ensure continued full funding for Defense Health Program needs.

Protecting Beneficiaries Against Cost-Shifting

The Task Force on the Future of Military Health Care had a great opportunity for objective evaluation of the larger health care issues. Unfortunately, the Coalition believes the Task Force missed that mark by a substantial margin.

The bulk of its report cites statistics provided by the Defense Department and focuses discussions of cost-sharing almost solely on government costs, while devoting hardly a sentence to what the Coalition views as an equally fundamental issue – the level of health care coverage that service members earn by their arduous career service, the value of that service as an in-kind, up-front premium pre-payment, and the role of lifetime health care coverage as an important offset to the unique conditions of military service.

The Task Force gave short shrift to what the Coalition sees as a fundamental point – that generations of military people have been told by their leaders that their service earned them their health care benefit, and DoD and Congress reinforced that perception by sustaining flat, modest TRICARE fees over long periods of time. But now the Department and the Task Force imply that the military retirement health care benefit is no longer earned by service. They now say beneficiary costs should be "restored" to some fixed share of Defense Department costs, even though no such relationship was ever stated or intended in the past.

The Task Force report acknowledged that DoD cost increases over the intervening years have been inflated by military/wartime requirements, inefficiency, lack of effective oversight, structural dysfunction, or conscious political decisions by the Administration and Congress. They acknowledged GAO findings that DoD financial statements and cost accounting are not auditable because of system problems, inadequate business processes and internal controls. Yet the Task Force accepted DoD-prepared cost data from 1996 and subsequent years, and said the

government should foist a fixed share of those costs on beneficiaries anyway. The Coalition has requested information concerning the 1996 costing calculation and has never received an adequate accounting as to what was included in the calculation.

The following charts illustrate the annual cost increase the Task Force plan would impose various categories of military families.

Current vs. Proposed TRICARE Fees
(Recommended by DoD Task Force on Future of Military Health Care)

Retiree Under Age 65, Family of Three

TRICARE Prime*	Current	Task Force Proposed	QRMC Proposed
Enrollment Fee	$460	$1,090 - $2,090***	$1,165 - $3,728
Doctor Visit Copays	$60	$125	$60
Rx Cost Shares**	$288	$960	$576
Yearly Cost	***$808***	***$2,175 - $3,175***	***$1,801 - $4364***

TRICARE Standard*	Current	Task Force Proposed	QRMC Proposed
Enrollment Fee	$0	$120	$218 - $699
Deductible	$300	$600 - $1,150***	$170****
Rx Cost Shares**	$288	$960	$576
Yearly Cost	***$588***	***$1680 - $2,230***	***$1089 - $1,570***

* Fully phased-in proposal; assumes 5 doctor visits per year.
**Assumes 2 generic and 2 brand name prescriptions per month in retail pharmacy
***Includes annual medical inflation adjustment recommended by the Task Force.
**** Assumes 8% inflation on current Medicare deductible

Retiree Over Age 65 and Spouse

TRICARE For Life*	Current	Task Force Proposed
Medicare Part B	$2,314	$2,314
Enrollment Fee	$0	$240
Rx Cost Shares**	$396	$1,260
Yearly Cost	***$2,710***	***$3,814***

*Assumes lowest tier Medicare Part B premium for 2008.
**2 generic and 3 brand name prescriptions per month in retail pharmacy

Currently Serving Family of Four

TRICARE Standard*	Current	Task Force Proposed
Enrollment Fee	$0	$120
Deductible	$300	$600 - $1,150***
Rx Cost Shares**	$180	$660
Yearly Cost	***$480***	***$1,260 - $1,930***

*Fully phased in proposals. Spouse and 2 children use Standard.
**Assumes 2 generic and 1 brand name prescription per month in retail pharmacy.
*** Includes medical inflation adjustment recommended by the Task Force.

The Tenth Quadrennial Review of Military Compensation (QRMC) offered somewhat different recommendations, but also took a budget-centric approach that failed to explicitly address what level of health care benefit should be considered earned by a career of military service and sacrifice.

The Coalition agrees with QRMC recommendations to:

- Eliminate copays and deductibles for preventive services...immunizations, mammograms, colonoscopies, medications for chronic conditions like diabetes to incentivize people to take medications and get tests that have been proven to reduce longer-term health care costs
- Pursue a wide range of initiatives to improve recruiting and retention of military health care professionals.

But we cannot agree with the QRMC proposals to:

- Establish premiums for retirees under 65 that are 40% of the Medicare Part B premium for those in Prime and 15% of the Medicare Part B premium for those in Standard.
- Means-test retiree premiums based on adjusted gross income.
- Fund care for beneficiaries under 65 on an accrual basis, which would convert it to mandatory spending and make it extremely difficult to execute needed improvements.
- Roughly double retail pharmacy copays.

The Coalition believes it would be wrong to base premiums for beneficiaries in their 40s and 50s on the cost of providing health care to the elderly and disabled, whose health care needs are so much different.

Similarly, means-testing has no place in setting military health fees. Less than 1% of employer-provided plans in the U.S. are income-based. It's one thing to do that for Medicare, which is social insurance provided by the government to every American. It's quite another to apply it to an employer-sponsored program that was earned by decades of service to the government.

The Coalition opposes any enrollment fee for TRICARE Standard, which doesn't guarantee access to a provider.

We continue to believe that the proper course of action is to establish principles and standards in law concerning the specific health benefits military people earn in return for a career in uniform, just as Congress has done for other major compensation elements. Absent such principles and standards, these critically important benefits are left subject to the annual uncertainty of ever-changing Administration budget proposals.

People vs. Weapons – Defense officials have provided briefs to Congress indicating that the rising military health care costs are "impinging on other service programs." Other reports indicate that DoD leaders and others seek to free up funding for weapons programs by reducing spending on military personnel and health care.

The Military Coalition continues to assert that such budget-driven trade-offs are misguided and inappropriate. Cutting people programs to fund weapons ignores the much larger funding problem, and only makes it worse.

The Coalition believes strongly that the proposed defense budget is too small to meet national defense needs. Today's defense budget (in wartime) is only about 4% of GDP, well short of the 6.5% average for the peacetime years since WWII.

The Coalition believes strongly that America can afford to and must pay for both weapons and military health care.

Military vs. Civilian Cost-Sharing Measurement – Defense leaders assert that substantial military fee increases are needed to bring military beneficiary health care costs more in line with civilian practices. But merely contrasting military vs. civilian cash cost-shares is a grossly misleading, "apple-to-orange" comparison.

For all practical purposes, those who wear the uniform of their country are enrolled in a 20- to 30-year pre-payment plan that they must complete to earn lifetime health coverage. In this regard, military retirees and their families paid enormous "up-front" premiums for that coverage through their decades of service and sacrifice. Once that pre-payment is already rendered, the government cannot simply pretend it was never paid, and focus only on post-service cash payments.

The Department of Defense and the Nation – as good-faith employers of the trusting members from whom they demand such extraordinary commitment and sacrifice – have a reciprocal health care obligation to retired service members and their families and survivors that far exceeds any civilian employer's to its workers and retirees.

The Task Force on the Future of Military Health Care acknowledges that its recommendations for beneficiary fee increases, if enacted, would leave military beneficiaries with a lesser benefit than 20-25% of America's corporate employees. The pharmacy copayment schedule they proposed for military beneficiaries is almost the same – and not as robust in some cases – as the better civilian programs they reviewed.

The Coalition believes that military beneficiaries from whom America has demanded decades of extraordinary service and sacrifice have earned coverage that is the best America has to offer – not coverage that's worse than 25% of corporate plans.

Large Retiree Fee Increases Can Only Hurt Retention – The reciprocal obligation of the government to maintain an extraordinary benefit package to offset the extraordinary sacrifices of career military service members is a practical as well as moral obligation. Mid-career military losses can't be replaced like civilians can.

Eroding benefits for career service can only undermine long-term retention/readiness. Today's service members are very conscious of Congress' actions toward those who preceded them in service. One reason Congress enacted TRICARE For Life in 2000 is because the Joint Chiefs of Staff at that time said inadequate retiree health care was affecting attitudes among active duty service members.

This is reinforced by a quote from then Chief of Naval Operations and now Joint Chiefs Chairman Admiral Mike Mullen, in a 2006 Navy Times article:

> "More and more sailors are coming in married. They talk to me more about medical benefits than I ever thought to when I was in my mid-20s. I believe we've got the gold standard...for medical care right now, and that's a recruiting issue, a recruiting strength, and it's a retention strength."

That's more than backed up by two independent Coalition surveys. A 2006 Military Officers Association of America survey drew 40,000 responses, including more than 6,500 from active duty service members. Over 92% in all categories of respondents opposed the DoD-proposed fee hikes. There was virtually no difference between the responses of active duty service members (96% opposed) and retirees under 65 (97% opposed). A Fleet Reserve Association survey showed similar results.

Reducing military retirement benefits would be particularly ill-advised when an overstressed force already is at increasing retention risk.

Pharmacy Copay Proposals Out of Step With Current Trends – Last year's DoD proposal, based on Task Force recommendations, would have increased retail pharmacy copays from $3 (generic), $9 (brand), and $22 (nonformulary) to $15, $25, and $45, respectively. Those represent increases of 400%, 178%, and 100%, respectively.

The QRMC recommended increases to $7, $17, and $29 – increases of 133%, 89%, and 32%.

Despite citing experience in civilian firms that beneficiary use of preferred drugs increased when their copays were reduced or eliminated, DoD and the QRMC proposed the highest percentage copay increases for the medications TRICARE most wants beneficiaries to use.

Further, the large increase for retail generics flies in the face of recent commercial initiatives by Wal-Mart and a number of other civilian pharmacies to offer hundreds of generics to the general public for a $4 copay or less.

If the purpose of these proposals is to push military beneficiaries to use Wal-Mart instead of TRICARE, it might indeed save the government some money on those medications. But it won't make military beneficiaries feel very good about their military pharmacy benefit. And it shouldn't make Congress feel good about it, either.

The Coalition particularly questions the need for pharmacy copay increases now that Congress has approved federal pricing for the TRICARE retail pharmacy system. The Coalition notes that federal pricing still has not been implemented by the Executive Branch, and this failure is costing DoD tens of millions of dollars with every passing month. This is an excellent example of why the Coalition objects to basing beneficiary fees on a percentage of DoD costs – because DoD all-too-frequently does not act, or is not allowed to act, in a prudent way to hold costs down.

Retirees Under 65 "Already Gave" 10% of Retired Pay – Large proposed health care fee increases would impose a financial "double whammy" on retirees and survivors under age 65.

Any assertion that military retirees have been getting some kind of "free ride" because TRICARE fees have not been increased in recent years conveniently overlooks past government actions that have inflicted far larger financial penalties on every retiree and survivor under 65 – penalties that will grow every year for the rest of their lives.

That's because decades of past budget caps already depressed lifetime retired pay by an average of almost 10% for service members who retired between 1984 and 2008. For most of the 1980s and 1990s, military pay raises were capped below private sector pay growth, accumulating a 13.5% "pay gap" by 1998-99 – a gap which has been moderated since then but persists at 2.9% today.

Every service member who has retired since 1984 – exactly the same under-65 retiree population targeted by the proposed TRICARE fee increases – has had his or her retired pay depressed by a percentage equal to the pay gap at the time of retirement. And that depressed pay will persist for the rest of their lives, with a proportional depression of Survivor Benefit Plan annuities for their survivors.

A service member who retired in 1993 – when the pay gap was 11.5% – continues to suffer an 11.5% retired pay loss today. For an E-7 who retired in 1993 with 20 years of service, that means a loss of $2,100 this year and every year because the government capped his military pay below the average American's. An O-5 with 20 years of service loses more than $4,400 a year.

The government has spent almost a decade making incremental reductions in the pay gap for currently serving members, but it still hasn't made up the whole gap – and the government certainly hasn't offered to make up those huge losses suffered by members already retired. Under such circumstances, it strikes the Coalition as ironic when defense officials propose, in effect, billing those same retirees for "back TRICARE fee increases".

Fee-Tiering Scheme Is Inappropriate – The Defense Department, the Task Force and the QRMC all have proposed multi-tiered schemes for proposed beneficiary fee increases, with the Administration's based on retired pay grade, the Task Force's based on retired pay amount, and the QRMC's based on family taxable income. The intent of the plan is to ease opposition to the fee increases by introducing a means-testing initiative that penalizes some groups less than others.

The Coalition rejects such efforts to mask a fundamental inequity by trying to convince some groups that the inequity being imposed on them is somehow more acceptable because even greater penalties would be imposed on other groups.

Any such argument is fundamentally deceptive, especially since the Administration and Task Force plans envisioned adjusting fee levels by medical inflation (7-8% a year), while retired pay thresholds would be adjusted by retiree COLAs (2%-3% a year). That would guarantee "tier creep" – shifting ever greater numbers of beneficiaries into the top tier every year.

Surveys of public and private sector health care coverage indicate that less than 1% of plans differentiate by salary. No other federal plan does so. The Secretary of Defense has the same coverage and pays the same premium as any GS employee, and the Speaker of the House has the same coverage and premium payments as any Representative's lowest-paid staff member.

The Coalition believes strongly that all military retirees earned equal health benefits by virtue of their career service, and that the lowest fee tier proposed so far would be an excessive increase for any military beneficiary.

Alternative Options to Make TRICARE More Cost-Efficient – The Coalition continues to believe strongly that the Defense Department has not sufficiently investigated other options to make TRICARE more cost-efficient without shifting costs to beneficiaries. The Coalition has offered a long list of alternative cost-saving possibilities, including:

- Positive incentives to encourage beneficiaries to seek care in the most appropriate and cost effective venue;
- Encouraging improved collaboration between the direct and purchased care systems and implementing best business practices;
- Focusing the military health system (MHS), health care providers, and beneficiaries on quality measured outcomes;
- Improving MHS financial controls and avoiding overseas fraud by establishing TRICARE networks in areas fraught with fraud;
- Establishing TRICARE networks in areas of high TRICARE Standard utilization to take full advantage of network discounts.
- Promoting retention of other health insurance by making TRICARE a true second-payer to other insurance (far cheaper to pay another insurance's copay than have the beneficiary migrate to TRICARE).
- Changing the electronic claim system to scan for common errors and prompt corrections in real time to help providers submit "clean" claims and reduce delays/multiple submissions.
- Size and staff military treatment facilities to reduce reliance on non-MTF civilian providers.
- Reducing long-term TRICARE Reserve Select costs by allowing service members the option of a government subsidy of civilian employer premiums during periods of mobilization.
- Doing far more to promote use of mail-order pharmacy system via mailings to users of maintenance medications, highlighting the convenience and individual expected cost savings
- Encouraging retirees to use lowest-cost-venue military pharmacies at no charge, rather than discouraging such use by limiting formularies, curtailing courier initiatives, etc.

The Coalition is pleased that DoD has begun to implement at least some of our past suggestions, and stands ready to partner with DoD to investigate and jointly pursue these or other options that offer potential for reducing costs.

TRICARE Still Has Significant Shortcomings – While DoD focuses on the cost of the TRICARE program to the government, surveys show increasing dissatisfaction among active duty, Guard/Reserve and retired beneficiaries who continue to experience significant problems with TRICARE. Beneficiaries at many locations, particularly those lacking large military populations, report difficulty in finding health care providers willing to participate in the program. Doctors complain about the program's low payments and administrative hassles. Withdrawal of providers from TRICARE networks at several locations has generated national publicity.

A 2007 GAO survey of National Guard and Reserve personnel said almost one-third of respondents reported having difficulty obtaining assistance from TRICARE, and more than one-fourth reported difficulty in finding a TRICARE-participating provider.

That problem is getting worse rather than better. The Task Force report said all military beneficiary categories report more difficulty than civilians in accessing health care, and that military beneficiaries' reported satisfaction with access to care declined from 2004 to 2006. A 2008 survey showed a significant further decline.

The Coalition urges the Subcommittee to require DoD to pursue greater efforts to improve TRICARE and find more effective and appropriate ways to make TRICARE more cost-efficient without seeking to "tax" beneficiaries and make unrealistic budget assumptions.

TMC Healthcare Cost Principles – The Military Coalition believes strongly that the current fee controversy is caused in part by the lack of any statutory record of the purpose of military health care benefits and the specific benefit levels earned by a career of service in uniform. Under current law, the Secretary of Defense has broad latitude to make administrative adjustments to fees for TRICARE Prime and the pharmacy systems. Absent congressional intervention, the Secretary can choose not to increase fees for years at a time or can choose to quadruple fees in one year.

Until recently, this was not a particular matter of concern, as no Secretary had previously proposed dramatic fee increases. Given recent years' unsettling experience, the Coalition believes strongly that the Subcommittee needs to establish more specific and permanent principles, guidelines, and prohibitions to protect against dramatic budget-driven fluctuations in this most vital element of service members' career compensation incentive package.

Other major elements of the military compensation package have much more specific standards in permanent law. There is a formula for the initial amount of retired pay and for subsequent annual adjustments. Basic pay raises are tied to the Employment Cost Index, and housing and food allowances are tied to specific standards as well.

The Coalition most strongly recommends that Congress establish statutory findings, a sense of Congress on the purpose and principles of military health care benefits, and the specific benefit levels earned by a career of uniformed service.

- ***Active duty members and families should be charged no fees except retail pharmacy co-payments, except to the extent they make the choice to participate in TRICARE Standard or use out-of-network providers under TRICARE Prime.***
- ***The TRICARE Standard inpatient copay should not be increased further for the foreseeable future. At $535 per day, it already far exceeds inpatient copays for virtually any private sector health plan.***
- ***There should be no enrollment fee for TRICARE Standard or TRICARE For Life (TFL), since neither offers assured access to TRICARE-participating providers. An enrollment fee implies enrollees will receive additional services, as Prime enrollees are guaranteed access to participating providers in return for their fee. Congress already has required TFL beneficiaries to pay substantial Medicare Part B fees to gain TFL coverage.***
- ***There should be one TRICARE fee schedule for all retired beneficiaries, just as all legislators, Defense leaders and other federal civilian grades have the same health fee schedule. The current TRICARE schedule is significantly lower than the lowest tier recommended by the Defense Department, recognizing that all retired service members paid large up-front premiums for their coverage through decades of arduous service and sacrifice.***

TRICARE Prime

TRICARE Prime – The Coalition is very concerned about growing dissatisfaction among TRICARE Prime enrollees – which is actually higher among active duty families than among retired families.

The dissatisfaction arises from increasing difficulties experienced by beneficiaries in getting appointments, referrals to specialists, and sustaining continuity of care from specific providers.

Increasingly, beneficiaries with a primary care manager in a military treatment facility find themselves unable to get appointments because so many providers have deployed, PCSed, or are otherwise understaffed/unavailable.

Instead of offering beneficiaries appointments with civilian network providers, many appointment administrators are simply telling the beneficiary that no appointments are available and to try back later. This is contrary to the best interests of the beneficiary, violates clear TRICARE Prime standards for timely access to care, makes beneficiaries see the military as insensitive to their vital family needs, and undermines long-term retention and readiness.

This problem disproportionally affects active duty families who are given priority over retirees for military PCMs. And because most active duty family members are used to getting care in the military facility, they often don't know to demand an appointment with a civilian provider if a military appointment isn't available.

The problem is compounded by Prime's continuing makeshift system for referrals to specialists and by beneficiary confusion over whom to call to authorize needed care while traveling away from their home station.

The Military Coalition urges the Subcommittee to require a DoD report, including reports from the managed care support contractors, on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.

TRICARE Standard

TRICARE Standard Enrollment – The Department of Defense has proposed various options to require TRICARE Standard beneficiaries to sign an explicit statement of enrollment in Standard and pay either a one-time or an annual enrollment fee. The Task Force and the QRMC also proposed annual enrollment fees for TRICARE Standard.

The proposals are based on three main arguments:

- Enrollment is needed to define the population that will actually use the program.
- Enrollment would allow more accurate budgeting for program needs.
- The fee would help offset DoD's cost of having the enrollment system (DoD rationale) or "impose some personal accountability for health care costs" (Task Force rationale).

The Coalition believes none of these arguments stands up to scrutiny.

Department officials already know exactly which beneficiaries use TRICARE Standard. They have exhaustive records on what doctors they've seen and what medications they've used when and for what. They already assess usage trends and project trends for current and future years – such as the effect of private employer changes on beneficiaries' return to the TRICARE system.

DoD does not have a good record on communicating policy changes to Standard beneficiaries. That means large numbers of beneficiaries won't get the word, or appreciate the impact if they do. They have always been told that their eligibility is based on the DEERS system.

Thousands of beneficiaries would learn of the requirement only when their TRICARE Standard claims are rejected for failure to enroll. Some would involve claims for cancer, auto accidents and other situations in which it would be unacceptable to deny claims because the beneficiary didn't understand an administrative rule change. DoD administrators who dismiss this argument as involving a minority of people would see the situation differently if it were their family being affected – as hundreds or thousands of military families certainly would be.

Inevitably, most beneficiaries who do receive and understand the implications would enroll simply "to be safe", even if they intended to use mainly VA or employer-provided coverage – thus undercutting the argument that enrollment would increase accuracy of usage projections.

Further, it would be inappropriate to make beneficiaries pay a fee to cover the cost of an enrollment system established solely for the government's benefit and convenience, with no benefit for the beneficiary. One who pays an enrollment fee expects something extra in return for the fee. An enrollment fee for TRICARE Prime is reasonable, because it buys the beneficiary guaranteed access to a participating provider. TRICARE Standard provides no such guarantee, and in some locations it's very difficult for beneficiaries to find a TRICARE provider.

To the extent any enrollment requirement may still be considered for TRICARE Standard, such enrollment should be automatic for any beneficiary who files a TRICARE claim. Establishing an enrollment requirement must not be allowed to become an excuse to deny claims for members who are unaware of the enrollment requirement.

The Coalition strongly recommends against establishment of any TRICARE Standard enrollment system; to the extent enrollment may be required, any beneficiary filing a claim should be enrolled automatically, without denying the claim. No enrollment fee should be charged for TRICARE Standard until and unless the program offers guaranteed access to a participating provider.

TRICARE Standard Provider Participation – The Coalition appreciates the Subcommittee's continuing interest in the specific problems unique to TRICARE Standard beneficiaries. TRICARE Standard beneficiaries need assistance in finding participating providers within a reasonable time and distance from their home. This is particularly important with the expansion of TRICARE Reserve Select, as many of those enrollees don't live in Prime Service Areas.

The Coalition is concerned that DoD has not yet established any standard for the adequacy of provider participation. Participation by half of the providers in a locality may suffice if there is

not a large Standard beneficiary population. The Coalition hopes to see an objective participation standard (perhaps number of beneficiaries per provider) that would help shed more light on which locations have participation shortfalls of Primary Care Managers and Specialists that require positive action.

The Coalition is grateful to the Subcommittee for its past efforts that will require DoD to establish benchmarks for participation adequacy and follow-up reports on actions taken.

The Coalition urges the Subcommittee to continue monitoring DoD and GAO reporting on provider participation to ensure proper follow-on action.

Administrative Deterrents to Provider Participation – Feedback from providers indicates TRICARE imposes additional administrative requirements on providers that are not required by Medicare or other insurance plans. On the average, about 50%of a provider's panel is Medicare patients, whereas only two percent are TRICARE beneficiaries. Providers are unwilling to incur additional administrative expenses that affect only a small number of patients. Thus, many providers are prone to non-participation in TRICARE.

TRICARE Standard still requires submission of a paper claim to determine medical necessity on a wide variety of claims. This thwarts efforts to encourage electronic claim submission and increases provider administrative expenses and payment delays. Examples include speech therapy, occupational/physical therapy, land or air ambulance service, use of an assistant surgeon, nutritional therapy, transplants, durable medical equipment, and pastoral counseling.

Another source of claims hassles and payment delays involve cases of third party liability (e.g., auto insurance health coverage for injuries incurred in auto accidents). TRICARE requires claims to be delayed pending receipt of a third-party-liability form from the beneficiary. This often delays payments for weeks and can result in denial and non-payment to the provider if the beneficiary doesn't get the form in on time. Recently, a major TRICARE claims processing contractor recommended that these claims should be processed regardless of diagnosis and that the third-party-liability questionnaire should be sent out after the claim is processed to eliminate protracted inconvenience to the provider of service.

The Coalition urges the Subcommittee to continue its efforts to reduce administrative impediments that deter providers from accepting TRICARE patients.

TRICARE Reimbursement Rates – Physicians consistently report that TRICARE is virtually the lowest-paying insurance plan in America. Other national plans typically pay providers 25-33% more. In some cases the difference is even higher.

While TRICARE rates are tied to Medicare rates, TRICARE Managed Care Support Contractors make concerted efforts to persuade providers to participate in TRICARE Prime networks at a further discounted rate. Since this is the only information providers receive about TRICARE, they see TRICARE as even lower-paying than Medicare.

This is exacerbated by annual threats of further reductions in TRICARE rates due to the statutory Medicare rate-setting formula. Physicians may not be able to afford turning away Medicare patients, but many are willing to turn away a small number of patients who have low-paying, high-administrative-hassle TRICARE coverage.

The TRICARE Management Activity has the authority to increase the reimbursement rates when there is a provider shortage or extremely low reimbursement rate for a specialty in a certain area and providers are not willing to accept the low rates. In some cases, a state Medicaid reimbursement for a similar service is higher than that of TRICARE. But the Department has been reluctant to establish a standard for adequacy of participation to trigger higher payments.

To the extent the Medicare rate freeze continues, we urge the Subcommittee to encourage the Defense Department to use its reimbursement rate adjustment authority as needed to sustain provider acceptance.

The Coalition urges the Subcommittee to require a Comptroller General report on the relative propensity of physicians to participate in Medicare vs. TRICARE, and the likely effect on such relative participation of a further freeze in Medicare/TRICARE physician payments along with the affect of an absence of bonus payments.

Dental Care

Active Duty Dependent Dental Plan – The Coalition is sensitive to beneficiary concerns that Active Duty Dental Plan coverage for orthodontia has been eroded by inflation over a number of years.

The current orthodontia payment cap is $1,500, which has not been changed since 2001. In the intervening years, the cost of orthodontia has risen from an average of $4,000 to more than $5,000.

The Coalition understands that, under current law, increasing this benefit could require a reduction in some other portion of the benefit, which we do not support.

The Coalition notes that current law assumes a 60% DoD subsidy for the active duty dental plan, whereas other federal health programs (e.g., FEHBP and TRS) are subsidized at 72%.

The Coalition recommends increasing the DoD subsidy for the Active Duty Dependent Dental Plan to 72% and increasing the cap on orthodontia payments to $2,000.

TRICARE Dental Benefit for Surviving Children – In recent years, the subcommittee acted appropriately to continue active-duty-level TRICARE Prime coverage for children of members who die on active duty for as long as they retain dependent status – until age 21 or 23 if enrolled in college. But dental coverage was not adjusted from the previous law, which authorized only three years of continued active-duty-level benefits in such cases.

The Coalition recommends authorizing children of members who die on active duty to retain coverage under the Active Duty Dependent Dental Plan until they reach 21 or 23 if enrolled in college.

National Guard and Reserve Health Care

The Coalition is grateful to the Subcommittee for its leadership in reducing TRICARE Reserve Select Premiums and ensuring DoD does not overcharge service members for coverage.

While the Subcommittee has worked hard to address the primary health care hurdle, there are still some areas that warrant attention.

TRICARE Reserve Select (TRS) Access – The Coalition is concerned that members and families enrolled in TRS are not guaranteed access to TRICARE-participating providers and are finding it difficult to locate providers willing to take TRICARE. As indicated earlier in this testimony, the Coalition believes that members who are charged a fee for their health coverage should be able to expect assured access, and hopes the Subcommittee will explore options for assuring such access for TRS enrollees.

The Coalition recommends that the Subcommittee require a report from the Department of Defense on options to assure TRS enrollees' access to TRICARE-participating providers.

Private Insurance Premium Option – The Coalition believes Congress is missing an opportunity to reduce long-term health care costs by authorizing eligible members the option of electing a DoD subsidy of their civilian insurance premiums during periods of activation.

Current law already authorizes payment of up to 24 months of FEHBP premiums for activated members who are civilian employees of the Defense Department. The Coalition believes all members of the Selected Reserve should have a similar option to have continuity of their civilian family coverage.

Over the long term, when Guard and Reserve activations can be expected at a reduced pace, this option would offer considerable savings opportunity relative to funding permanent, year-round TRICARE coverage.

The Department could calculate a maximum monthly subsidy level that would represent a cost savings to the government, so that each member who elected that option would reduce TRICARE costs.

The Coalition recommends developing a cost-effective option to have DoD subsidize premiums for continuation of a Reserve employer's private family health insurance during periods of deployment as an alternative to ongoing TRICARE Reserve Select coverage.

Involuntary Separatees – The Coalition believes it is unfair to deny TRS coverage for Individual Ready Reserve (IRR) members who have returned from deployment or terminate coverage for returning members who are involuntarily separated from the Selected Reserve (other than for cause).

The Coalition recommends authorizing one year of post- Transitional Assistance Management Program (TAMP) TRS coverage for every 90 days deployed in the case of returning members of the IRR or members who are involuntarily separated from the Selected Reserve. The Coalition further recommends that voluntarily separating Reservists subject to disenrollment from TRS should be eligible for participation in the Continued Health Care Benefits Program (CHCBP).

Gray Area Reservists – The Coalition is sensitive that Selected Reserve members and families have one remaining "hole" in their military health coverage. They are eligible for TRS while

currently serving in the Selected Reserve, then lose coverage while in "Gray area" retiree status, then regain full TRICARE eligibility at age 60.

The Coalition believes some provisions should be made to allow such members to continue their TRICARE coverage in gray area status. Otherwise, we place some members at risk of losing family health coverage entirely when they retire from the Selected Reserve. We understand that such coverage likely would have to come with a higher premium.

The Coalition urges the Subcommittee to authorize an additional premium-based TRS option under which members entering "gray area" retiree status would be able to avoid losing health coverage.

Guard and Reserve Dental Coverage – The Coalition remains concerned about the dental readiness of the Reserve forces. DoD should be fiscally responsible for medical and dental care to Reservists beginning with the issuance of an alert order and 180 days post mobilization to ensure service members meet readiness standards when DoD facilities are not available within a 50 mile radius of the member's home.

The Coalition supports providing dental coverage to Reservists once an alert order is issued and 180 days post-mobilization (during TAMP), unless the individual's dental readiness is restored to T-2 condition before demobilization.

Guard and Reserve Mental Health – Reserve members deserve the highest levels of care once they demobilize. The Coalition is concerned that there is too much variation in the diagnosis and treatment of post traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, and other combat-related stress conditions. The current post deployment health self assessment program at demobilization sites is inadequate. The Coalition believes that post deployment examination of members should occur while still on active duty deployment orders at their home station. This is necessary to expedite diagnosis, reporting and treatment of physical and mental injuries; to help perfect potential service connected disability claims with the VA; and to help correct the non-reporting of injuries at the demobilization site arising from members' concerns of being medically held away from the home state.

The Coalition believes that Guard and Reserve members and their families should have access to an evidence-based treatment for post traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, and other combat-related stress conditions. Further, Post Deployment Health examinations should be offered at the member's home station.

Guard and Reserve Health Information – The Coalition is concerned that the current health records for many Guard and Reserve members do not contain treatment information that could be vital for diagnosis and treatment of a condition while on active duty. The capture of non-military treatment is an integral part of the members overall health status.

The Coalition believes there should be an effort to improve the electronic capture of non military health information into the service member's medical record.

TRICARE For Life

When Congress enacted TRICARE For Life (TFL) in 2000, it explicitly recognized that this coverage was fully earned by career service members' decades of sacrifice, and that the Medicare Part B premium would serve as the cash portion of the beneficiary premium payment.

TFL Enrollment Fee is Inappropriate – The Coalition disagrees strongly with the Task Force and QRMC recommendations to impose an annual enrollment fee for each TFL beneficiary. The reports acknowledged that this would be little more than a "nuisance fee" and would be contrary to Congress' intent in authorizing TFL.

When the previous Administration came to office in 2001, military and civilian Defense leaders praised TRICARE For Life, as enacted, as an appropriate benefit that retirees had earned and deserved for their career service. But in recent years, those same leaders' concerns about rising health costs have focused disproportionally on the (fully predictable) cost growth attributable to TFL.

For those who now advocate charging older beneficiaries a TFL enrollment fee, the Coalition asks, "What has changed in the intervening years of war that has somehow made their service less meritorious?"

Inclusion of TFL-Eligibles in Preventive Care Programs – The Coalition is aware of the challenges imposed by Congress' mandatory spending rules, and appreciates the Subcommittee's efforts to include TFL-eligibles in the preventive care pilot programs included in the FY2009 Defense Authorization Act. We believe their inclusion would, in fact, save the government money and hope the Subcommittee will be able to find a more certain way to include them than the current discretionary authority.

The Coalition also hopes the subcommittee can find a way to resolve the discrepancy between Medicare and TRICARE treatment of medications such as the shingles vaccine, which Medicare covers under pharmacy benefits and TRICARE covers under doctor visits. This mismatch, which requires TFL patients to absorb the cost in a TRICARE deductible or purchase duplicative Part D coverage, deters beneficiaries from seeking this preventive medication.

The Coalition urges the Subcommittee to oppose any TFL enrollment fee and seek equal coverage of TFL beneficiaries under TRICARE and Medicare preventive care initiatives.

Restoration of Survivors' TRICARE Coverage – When a TRICARE-eligible widow/widower remarries, he/she loses TRICARE benefits. When that individual's second marriage ends in death or divorce, the individual has eligibility restored for military ID card benefits, including SBP coverage, commissary/exchange privileges, etc. – with the sole exception that TRICARE eligibility is not restored.

This is out of line with other federal health program practices, such as the restoration of CHAMPVA eligibility for survivors of veterans who died of service-connected causes. In those cases, VA survivor benefits and health care are restored upon termination of the remarriage. Remarried surviving spouses deserve equal treatment.

The Coalition recommends restoration of TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

BRAC and Re-Basing – Relocation from one geographic region to another and base closures brings multiple problems. A smooth health care transition is crucial to the success of DoD and Service plans to transform the force. And that means ensuring a robust provider network and capacity is available to all beneficiary populations, to include active and Reserve Component and retirees and their family members, and survivors at both closing and gaining installations. It is incumbent upon the Department and its Managed Care Support Contractors to ensure smooth beneficiary transition from one geographic area to another. We stress the importance of coordination of construction and funding in order to maintain access and operations while the process takes place.

The Coalition recommends requiring an annual DoD report on the adequacy of health resources, services, quality and access to care for beneficiaries affected by BRAC/re-basing.

Kathleen B. Moakler
Director, Government Relations
National Military Family Association

Mrs. Moakler has been associated with the National Military Family Association since 1995 as a member of the headquarters staff. She has served as Headquarters Office Manager and several positions in the Government Relations Department, including Deputy Director. In February 2007, Ms. Moakler was appointed as interim Director of Government Relations and was permanently appointed as Director in October 2007. In that position, she monitors the range of issues relevant to the quality of life of the families of the seven uniformed services and coordinates a staff of 4 deputy directors. Mrs. Moakler represents the interests of military families on a variety of advisory panels and working groups, including the American Red Cross "Get to Know Us Before You Need Us" working group, the DoD/VA Survivors Forum, and the State Department Interagency Roundtable. Mrs. Moakler is co-chair of the Survivors Committee for the Military Coalition (TMC), a consortium of 34 military and veteran organizations and serves on the Retiree Committee. She is often called to comment on issues pertaining to military families for such media outlets as the NY Times, CNN, NBC news and the Military Times. She writes regularly for "Military Money" and NMFA publications.

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

Mrs. Moakler is also a military mom. Her daughter is an Army nurse with two tours to Iraq and one son is an Army major stationed at Ft. Belvoir, Virginia. Her oldest son is an aspiring actor in Hollywood, California. Mrs. Moakler and her husband, Colonel Martin W. Moakler Jr. USA (retired), reside in Alexandria, Virginia.

Master Sergeant Michael P. Cline (AUS-Ret)
Executive Director
Enlisted Association of the National Guard of the United States and
President, The Military Coalition

Michael Cline has served as Executive Director/CEO of the EANGUS Service Corporation, and the Chief Executive Officer of the "We Care for America" Foundation since 1990. He represents the constituency of the association—more than 414,000 enlisted men and women of the National Guard, all National Guard retirees, and family members of these patriots.

Cline is the President of The Military Coalition, a consortium of 34 military, veterans, and uniformed services organizations representing over 6 million members of the uniformed services--active, reserve, retired, survivors, veterans--and their families. Cline served as Co-Chairman of the TMC for eight years and currently Co-Chairs the Guard and Reserve Subcommittee. He also serves on the Secretary of Veterans' Affairs Advisory Committee on Education for 11 years and is an ex-officio member of the Board of Directors of the National Guard Youth Challenge Foundation. He is a Trustee of the National Guard Association of the United States Insurance Trust. He is listed in Strathmore's Who's Who in Business and Distinguished Member Who's Who Worldwide.

Master Sergeant Cline has over 38 years of military service to his country. He retired from the Ohio Army National Guard in 1992. His assignments included Infantry, Military Police and Investigation, Communication, Mobilization-Readiness, and Training Program Manager.

Cline is a life member of the Enlisted Association of the National Guard of the United States, the American Legion, AMVETS, National Military Family Association, Association of the United States Army, and the National Rifle Association. He was selected an Honorary Chief Master Sergeant for the Air National Guard in June 1999, only the fourth time this honor had been bestowed and the first time to be presented to an Enlisted member.

Academically, he holds an Associates degree in Business Management and a Bachelor's degree in Human Resource Management from Malone College in Canton, Ohio. He also is a licensed Realtor, Notary Public and holds a teaching certificate in vocational education. Cline has been recognized by numerous state and National associations, most recently having been honored by the South Carolina Military Department with the State's highest award - the Meritorious Service Medal. He is a recipient of The Military Coalition, Award of Merit and was recognized by the Reserve Forces Policy Board for his support of the Guard and Reserve. He has received the Distinguished Service Award from the National Guard Association and was also recognized by the Chief of National Guard Bureau with NGB EAGLE award.

He is married to the former Diana Crawford and has seven children and sixteen grandchildren. His wife is retired from the D.C. Air National Guard after more than 25 years of military service. His wife Diana has been the association's editor of the New Patriot Magazine since 1991 and together they work side-by-side to make EANGUS the association of choice for Enlisted National Guard members and retirees. His oldest son, Mike, is an Army veteran, having served in Operation Desert Storm. His son Bill is an Air Force veteran. His youngest son, John, is an Air Force Major and a former enlisted Ohio Air National Guard member. Cline's immediate family has loyally dedicated more than 93 years of military service to the United States.