NATIONAL MILITARY FAMILY ASSOCIATION

Together we're stronger

Statement

by the

**NATIONAL MILITARY FAMILY ASSOCIATION**

for

**Subcommittee on Personnel**

of the

**UNITED STATES SENATE**
**ARMED SERVICES COMMITTEE**

February 14, 2018

Not for Publication Until Released by
The Committee

The National Military Family Association (NMFA) is the leading nonprofit dedicated to serving the families who stand behind the uniform. Since 1969, NMFA has worked to strengthen and protect millions of families through its advocacy and programs. We provide spouse scholarships, camps for military kids, and retreats for families reconnecting after deployment and for the families of the wounded, ill, or injured. NMFA serves the families of the currently serving, retired, wounded or fallen members of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA.

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

The Association does not have or receive federal grants or contracts.

Our website is: *www.MilitaryFamily.org*.

**Kelly B. Hruska, Government Relations Director**
Kelly became the Government Relations Director of the National Military Family Association in 2015. In this role, she leads the Association's advocacy for the families of the seven Uniformed Services and monitors the range of issues relevant to their quality of life. She began her work with the Association in 2007 as a Government Relations Deputy Director and served as Outreach Coordinator in 2014.

Kelly has represented military families on several committees and task forces for offices and agencies of the Department of Defense (DoD) and military services. She serves on several committees of The Military Coalition, an organization of 33 military-related associations. She is co-chair of the Coalition's Survivor Committee. In 2008-2011, she served on the first DoD Military Family Readiness Council.

A Navy spouse for 25 years, Kelly has served in various volunteer leadership positions in civilian and military community organizations including COMPASS, Navy-Marine Corps Relief Society, The Girl Scouts, and Navy Spouses Clubs. She was also appointed to the City Commission on Children and Youth by the Corpus Christi City Council.

Kelly is a recipient of the Navy's Meritorious Civilian Service Medal in recognition of her work on behalf of service members and their families at Navy Region Center Singapore.

A Pennsylvania native, Kelly earned her B.A. in Political Science from La Salle University and a Masters of Public Administration from Shippensburg University. Kelly and her husband, Captain Jim Hruska, USN (Ret) reside in Annandale, Virginia with their daughter, Emily.

## EXECUTIVE SUMMARY

The United States military is the most capable fighting force in the world. For almost two decades of war, service members and their families never failed to answer the call, steadfastly sacrificing in order to protect our nation. They make these sacrifices trusting that our government will provide them with the tools to keep them ready. Continued national fiscal challenges have left military families confused and concerned about whether the programs and benefits contributing to their strength, resilience, and readiness will remain available to support them and be flexible enough to address emerging needs. The Department of Defense (DoD) must provide the level of programs and resources necessary to meet this standard. Service members and their families have kept trust with America through 16 years of war with multiple deployments and separations. Unfortunately, that trust continues to be tested.

**We ask Congress:**

As you evaluate spending proposals, consider the cumulative impact on military families' purchasing power and financial well-being, as well as the effects on the morale and readiness of the all-volunteer force now and in the future.

Please:

- Reject budget proposals that threaten military family financial well-being as a way to save money for the government.
- Keep military pay commensurate with service and aligned with private sector wages.
- Provide oversight to ensure recently-enacted military health reform efforts enhance military families' access to quality health care and that readiness costs are not passed along to families as cost shares or premiums.

We ask Congress to make improving and sustaining the programs and resources necessary to keep military families ready a national priority.

We also ask Congress to:

- Provide oversight to ensure DoD and the individual Services are supporting families of all components by meeting the standards for deployment support, reintegration, financial readiness, and family health. Fund appropriately at all levels.
- Ensure adequate funding for military child care programs, including child care fee assistance programs. Improve access to installation-based child care and increase availability of part-time and hourly care.
- Facilitate easier paths to both licensure and employment for military spouses and veterans who are in the mental health field when they work with our service members and their families. Include military spouses who enter the mental health profession in federal loan-forgiveness programs.
- Preserve the savings military families receive by shopping at the commissary and oppose any reform measures that would reduce the value of the benefit.
- Require DoD to study where military families with severe special needs are concentrated and whether DoD Impact Aid for schools serving military children with special needs is appropriately allocated.
- Expand service member and family access to Military OneSource counseling and other assistance to one year post-separation.
- Ensure appropriate and timely funding of Impact Aid through the Department of Education (DoEd).

- Continue to authorize DoD Impact Aid for schools educating large numbers of military children and military children with severe special needs.
- Bring the Extended Care Health Option (ECHO) benefits on par with State Medicaid waiver programs and extend ECHO eligibility for one year following separation.
- Correct inequities in Survivor benefits by eliminating the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP).
- Ease the financial burden and coverage confusion faced by Medicare-eligible, medically-retired wounded, ill, and injured service members.

After over 16 years of war, we continue to see the impact of repeated deployments and separations on our service members and their families. We appreciate Congress' recognition of the service and sacrifice of these families. Your response through legislation to the ever-changing need for support has resulted in programs and policies that have helped sustain our families through these difficult times.

**PAY AND COMPENSATION**

We appreciate Congress making the pay raise at Employment Cost Index (ECI) a priority in the Fiscal Year 2018 National Defense Authorization Act (FY18 NDAA). Congress chose the Employment Cost Index (ECI) as the standard for active duty pay raises in order to recruit and retain the quality of service members needed to sustain the all-volunteer force and we thank you for meeting that standard this year.

Although the last two years have seen military pay raises at the ECI, reductions to service member housing allowances, increased health care costs, and the new requirement under the Blended Retirement System for new service members to contribute to their retirement savings lower service member take-home pay. We ask you to consider the cumulative effects of these policies on military families' financial well-being and reject any proposals that ask families to shoulder a greater financial burden.

***We believe that Basic Allowance for Housing (BAH) is an essential component of military compensation. We oppose any changes that threaten to reduce military families' pay.***

***We ask Congress to keep military pay commensurate with service and aligned with private sector wage increases.***

***We ask Congress to reject budget proposals that threaten military family financial well-being as a way to achieve savings for DoD.***

**MILITARY HEALTH SYSTEM**

We greatly appreciate efforts by Congress on Military Health System (MHS) reform and were gratified the process included listening to beneficiary concerns over costs, quality of care, and the patient experience in both direct and purchased care. However, as we reviewed the National Defense Authorization Act for Fiscal Year 2017 (FY17 NDAA), we were struck by how few MHS reform provisions represent immediate tangible wins for military families. Ready access to high quality health care is imperative for families managing the stress and unpredictability of military life. There are areas of the system that deliver, but we still consistently hear from families who face barriers in accessing quality medical care – barriers that range from punishing levels of inconvenience and inconsistent military hospital policies to complete lack of access to basic standards of care. These are urgent problems that must be fixed. For instance:

*Facebook Post from July 28, 2017:*

**Anne H**: Okay so I have never been seen by base doctors until we moved here. Of course we moved here and are now pregnant with baby number 5. So excited until we had to be seen on base. The ob coordinator is such a sweetheart! However, it just seems like they have no time for appointments. **I called women's health and they were an even bigger mess telling me to call back in September and they would set up my first intake appointment for then. Which I'm 12 weeks tomorrow so that seemed kinda crazy.** So my question is how do I get a doctor off base. I have a history of high risk pregnancy. I have low iron, high blood pressure, and a guarantee c section as this will be my 4th one. Any help is very much appreciated.

**Sarah N**: You will have to switch to TRICARE standard to be seen off post

**Anne H**: I'm just used to doctors that have more flexibility. We have never had to be on base. If a normal doctor told me a month to see my doctor I would find a new doctor but maybe it's just me.

**Sarah N**: That's not so bad. Usually you are only seen every 4 weeks when not high risk. I was considered complicated and was seen every 3 weeks.

**Anne H**: I haven't been seen since becoming pregnant. **I had an appointment this past week, got there to be told they gave my appointment to someone else. I have yet to do an intake appointment.** So it's actually pretty horrible. I know you are seen once a month normally. But I haven't been seen at all.

**Sarah N:** oh, geesh! I figured you had already had your intake. Around here, with pretty much everything, due to the sheer amount of people, you have to be pretty persistent.

(Per later Facebook posts, Anne's baby was born 5 weeks and 1 day early and spent time in the NICU.)

While the FY17 NDAA includes many well-intentioned provisions for MHS improvement, nearly all are contingent on successful implementation, including an emphasis on getting the patient experience right. We fear the required focus on the patient experience will be a heavy lift for the MHS, an organization that routinely reminds families their primary mission is not beneficiary care, but military medical readiness. It seems like a great distance – with much room for error – between the law's good intentions and actual improvements that military families will experience. Which provision in the FY17 NDAA will address a problem such as this? How long will families have to wait to see that fix?

*Facebook Post from July 10, 2017:*

**Chris M**: Hi guys! I have a quick question about Tricare. I'm 20 and just had my son 5 months ago. When I got pregnant, I immediately went to family medicine and started being seen there. I had my 6 week postpartum check up there and decided against getting birth control at that moment. I'm ready to start on birth control now and I called to get an appointment with my dr and they got me an appointment with the pediatrician. Then the pediatrician's office called me and told me they don't do birth control there. So I called family medicine back and they said I'm too young to be seen there now because pediatrics treats all the way until 22…that doesn't sound correct to me. I'm at a loss of what to do. Please help haha

**Kate W**: Contact women's health to see if they can help you.

**Chris M**: I actually did call women's health and they said I need a referral. The dr I saw at family medicine is my PCM but they won't let me make an appt with him. I'm so new to Tricare. lol I've only been married a year so I'm confused by this. lol

This spouse made what seems to be a reasonable effort to make an appointment to obtain birth control. She spoke to three different clinics at her military hospital, but none helped her or pointed her to a resource to resolve her issue. Within the scope of MHS reform, what's the plan to fix problems like this?

On January 1, MHS reform launched with changes to the TRICARE plans. As implementation has begun, our wary optimism has morphed into grave concerns about what seems to be a focus on cost savings and not improvements to address beneficiary health care needs. TRICARE reform thus far does not fix coverage gaps such as TRICARE's failure to adapt coverage to emerging technologies or treatment protocols or pediatric coverage issues due to TRICARE policies based on Medicare, a plan for seniors. TRICARE reform does not address locations with TRICARE provider network inadequacy or the concerns that "race to the bottom" contracts will eventually result in lower provider reimbursements and narrowed networks. TRICARE reform does not fix bureaucratic and customer service problems such as those families are currently experiencing with the T17 contract transition. We understood part of TRICARE reform was to reset a balance between beneficiaries' out of pocket costs and DoD costs. Yet, we did not expect new TRICARE policies and copay constructs that are so clearly detrimental to military families. We are concerned that while the Department of Defense (DoD) will achieve cost savings, beneficiaries will face higher costs while still waiting for improvements in the care they receive.

Given the magnitude of MHS reform, it would be difficult for any organization to get every piece of the implementation 100% right from the start. We trust there will be an opportunity to make adjustments as second and third order effects become apparent and we pledge to assist DoD in understanding where improvement is needed. To that end, we ask Congress and DoD to:

- Modify the TRICARE Annual Open Enrollment policy to prevent military families from becoming trapped in underperforming military treatment facilities (MTFs)
- Adjust TRICARE Prime and Select copay constructs
- Monitor and provide oversight on T17 contract implementation
- Align TRICARE Extended Care Health Option (ECHO) respite coverage with Medicaid waiver programs
- Implement the Defense Health Board's recommendation to broaden TRICARE's definition of pediatric medical necessity
- Expand Federal Employee Dental and Vision Program eligibility to active duty family member dental coverage while maintaining DoD's premium contribution levels
- Ensure military family perspectives are considered as MTF management is transitioned to the Defense Health Agency (DHA) and reforms related to direct care system right sizing are implemented

## TRICARE REFORM IMPLEMENTATION

### TRICARE Prime

We are grateful TRICARE Prime remains a low/no out-of-pocket cost option for all active duty families. It is important that those managing the stress, sacrifices, and unpredictability of military life are spared concerns about health care costs.

#### *Referral Free Urgent Care Policy*

We greatly appreciate that TRICARE Prime beneficiaries can now access civilian urgent care without a referral. For years, we have highlighted this problem – families had no option but the emergency room for acute medical issues when their MTFs were closed or fully booked. While the direct care system has made strides on meeting access standards, problems persist at the local level and during Permanent Change of Station (PCS) season. Many thanks to Congress for authorizing

TRICARE Prime referral free urgent care in the FY17 NDAA. We are grateful DHA implemented this policy with no restrictions on the number of visits and urge them to maintain referral-free urgent care moving forward. Changing the number of referral-free urgent care visits annually, as suggested in DoD's September 2017 IFR *Establishment of TRICARE Select and Other TRICARE Reforms*, would create confusion among beneficiaries and providers as well as communication and implementation challenges for DHA and the managed care support contractors.

***Annual Open Enrollment Period***

Our biggest concern about TRICARE Prime is related to the **annual open enrollment period's potential to trap TRICARE Prime families in underperforming MTFs**. Prior to 2018, beneficiaries could switch from TRICARE Prime to TRICARE Standard at any time. This flexibility provided a critical escape hatch for families who believed they were not receiving adequate access and/or medical care at their MTF.

> *My son had a collapsing trachea. It had been discovered before he was a year old. At age 3 the strider returned. The MTF DX it as "hiccups." I left the appointment, in disbelief, and walked straight to the enrollment office. I moved him from prime to standard and within 24 hours had a civilian children's specialist "waiting for me in the lobby" to do a scope on my son. Where the MTF dismissed a possible life threatening condition, the civilians treated it like it was their priority and moved mountains to get immediate answers. From that moment on, all three of my kids were standard.*
>
> *I had a history of ectopic pregnancy and a damaged fallopian tube as a result. I had been told I was at greater risk in the future and it was critical to have an ultrasound at 8 weeks to rule out another ectopic pregnancy, a condition that could threaten my future fertility or even my life if it went undetected. Soon after my husband deployed, I got a positive home pregnancy test. I immediately called the appointment line and tried to schedule an appointment but was told they would not see me until I was 14 weeks along. I explained my history and what I had been told about getting an ultrasound at 8 weeks, but the appointment line clerk would not budge. I called back several times, trying to convince them I needed an earlier appointment. Finally, they told me if I started having tubal pregnancy symptoms I should just go to the ER. When I finally reached my husband on the ship, I was frantic. I was caring for a toddler at a new base on my own. I didn't yet have a support network to lean on. I knew what my last ectopic pregnancy emergency was like – how was I going to handle a toddler on top of that and being alone to boot? My husband was upset but knew there was nothing he could do from the ship, so he told me to switch to Standard. I did and immediately got an appointment at a civilian office where they ordered an 8 week ultrasound. (BTW, although this pregnancy was fine I did eventually have another ectopic pregnancy with the next one.)*

We realize the annual open enrollment period is a feature of civilian plans and generally have no issues with this new requirement. However, TRICARE Prime's reliance on military hospitals and clinics creates a situation unique to the military and demands a policy tailored to military family needs for the following reasons:

- Given the variability in access, quality of care, and the patient experience across the direct system, military families may not be able to make informed choices during the Open Enrollment Period or following a Qualifying Life Event, such as a PCS move. TRICARE Prime, and specifically getting care at the MTF, may work for a family at one duty station but not at another. MTF access to care can also vary over time as providers come and go, making an informed decision nearly impossible.

  *We are currently contemplating making the switch to Standard. We had no issues on Prime at our last duty station, and a great experience with the clinics and hospital there, but since PCSing it's been a nightmare. It's absolutely impossible to get an acute care appointment here. Last time I tried I was told my two year old wouldn't be able to be seen for two weeks for a double ear infection, and he's a patient being considered for tubes!*

  *I switched my kids from Prime to Standard several years ago. We were at a large navy hospital and got great care from a phenomenal civilian pediatrician. I switched when she shared that she was leaving practice, and that the hospital hadn't added personnel to cope with two carriers newly moved to the area. That explained why it was so much more difficult to get urgent appointments. I didn't want to continue the hassle of going through them without the benefit of our awesome doctor.*

- Although the Patient Advocate and PCM change request should help families resolve MTF problems, these may be ineffective in addressing systemic access or quality concerns particularly in time sensitive situations. Additionally, appointment line clerks and MTF staff do not typically direct families to resources such as the Patient Advocate who can help resolve access and quality of care issues.

- The unique aspects of the Military Health System demand solutions tailored to military beneficiaries. For commercial health plans, the annual enrollment period locks in beneficiaries to coverage levels, not specific providers or a single medical facility. While an annual enrollment period for military families is not unreasonable, preventing them from seeking care outside the MTF will severely limit patient autonomy in a way that is inconsistent with commercial plans. Even those commercial plans with extremely narrow networks do not limit beneficiaries/members to a single medical facility. Please see Appendix A for a comparison of medical facilities available to Kaiser Foundation Health Plan members versus beneficiaries stationed in the National Capitol Region.

- Allowing families to switch enrollment from Prime to Select provides an important aspect of MTF accountability. Analyzing enrollment changes from Prime to Select will afford the MHS an opportunity to understand why families leave. It should also allow the MHS to identify problematic MTFs and target solutions to local access and quality of care problems.

Our Association has suggested two possible solutions. The FY17 NDAA gives DoD discretion in defining Qualifying Life Events. We believe one potential solution is to include "dissatisfaction with MTF access or quality of care" as a qualifying life event. Another option is to extend the enrollment "grace period" to maintain the TRICARE Select escape hatch while allowing DHA more time to develop and publicize an effective MTF problem resolution process. We are open to other ideas and

stand by to assist in developing a solution that prevents military families from becoming trapped in underperforming MTFs.

***TRICARE Prime Copays***

While we are not opposed to modest and predictable copay increases, the increased copays outlined for Group A/Grandfathered Retiree Families are unacceptable and have stunned military families and retirees seeking care this year. Although we did not support grandfathering, we are disturbed by DHA's complete disregard for the Congressional intent behind the decision to create the grandfathering. Furthermore, the increases outlined in the IFR are far from modest, ranging from 67-173% higher than 2017 TRICARE Prime Retiree copays:

**TRICARE Prime Cost Sharing:** 2017 vs. 2018 – Group A/Grandfathered

| | **2017** | **2018 Group A/ Grandfathered** | **% Increase** |
|---|---|---|---|
| Preventative Care Visit | $0 | $0 | No change |
| Primary Care Outpatient Visit | $12 | $20 | +67% |
| Specialty Care Outpatient Visit | $12 | $30 | +150% |
| ER Visit | $30 | $60 | +100% |
| Urgent Care Center | $12 | $30 | +150% |
| Ambulatory Surgery | $25 | $60 | +140% |
| Ambulance Service | $20 | $40 | +100% |
| Durable Medical Equipment | 20% | 20% | No change |
| Inpatient Admission | $11/day | $150/admission | N/A |
| Inpatient Skilled Nursing/Rehab | $11/day | $30/day | +173% |

While we follow the rationale outlined in the September 2017 IFR for DHA's authority to increase copays, dating back to the FY1994 NDAA, it feels like a "gotcha" for military retirees – as if they should have read the fine print regarding their military retirement health benefit. Is this really the way we want to treat men and women who served a full military career, particularly at a time when those approaching retirement have served nearly their entire careers during a period of sustained conflict and high OPTEMPO?

Furthermore, DHA's rationale for increasing copays rests on achieving "cost neutrality" – that is, keeping per beneficiary costs for TRICARE Prime in line with TRICARE Standard/Select. The IFR cites a Congressional Budget Office (CBO) cost estimate: "CBO estimates that under current law, a

typical retiree household enrolled in TRICARE Prime as a 'family' in 2018, and for whom TRICARE is the primary payer of health benefits, will cost DoD about $17,400, and a typical family that uses Standard/Extra will cost DoD about $12,700."[1] What DHA fails to add is that the same CBO report acknowledges that MTFs, where most Prime beneficiaries receive their care, are run less efficiently than private facilities and hence have higher costs per service. Our Association also contends the Department of Defense has historically done a poor job of differentiating readiness costs from costs to provide beneficiary care. We believe TRICARE Prime cost estimates are inflated due to MTF inefficiencies and erroneously include costs that should be attributed to readiness. DHA should not put the burden on TRICARE Prime beneficiaries to achieve "cost neutrality" through copay increases.

Finally, these TRICARE Prime fee increases aren't even being put toward MHS improvements that will benefit military families and retirees. According to senior DoD officials, they are being used to fund readiness – we are tapping military retirees to pay for equipping and training the current force. This is unacceptable.

***TRICARE Prime Eligibility***

Although TRICARE Prime eligibility wasn't addressed with the FY17 NDAA health care reforms, DoD's September 2017 IFR *Establishment of TRICARE Select and Other TRICARE Reforms* appears to assert DoD's authority to put greater limits on TRICARE Prime availability. The IFR states that the DHA Director has authority to determine locations where TRICARE Prime will be offered using the guiding principle that the purpose of TRICARE Prime is to support the medical readiness of the armed forces and the readiness of medical personnel. The IFR also says TRICARE Prime can be limited to active duty family members if the DHA Director determines it is not practicable to offer Prime to retired beneficiaries as well. From the IFR[2]:

> One other matter on which the interim final rule preserves DoD discretion, similar to that in the current regulation, is with respect to the locations where TRICARE Prime is offered. This is noted in the current regulation at 32 CFR 199.17(a)(5). Under the interim final rule, the locations where TRICARE Prime will be offered will be determined by the Director, Defense Health Agency (DHA) and announced prior to the annual open season enrollment period. The guiding principle for this decision is that the purpose of TRICARE Prime is to support the medical readiness of the armed forces and the readiness of medical personnel…
>
> TRICARE Prime, especially for working age retirees and family members, provides MTFs clinical workload, including for a range of medical specialty areas that permit military health care providers to maintain currency and proficiency in their respective clinical fields. This important support of a ready medical force is what justifies the higher government cost of Prime (which CBO estimates at $17,400 per retiree family), notwithstanding the original statutory requirement of cost neutrality between TRICARE Prime and TRICARE Standard. This cost-benefit assessment supports the conclusion that it is practicable to offer TRICARE Prime

[1] Congressional Budget Office Cost Estimate, S. 2943, National Defense Authorization Act for Fiscal Year 2017, June 10, 2016, page 17

[2] https://www.federalregister.gov/documents/2017/09/29/2017-20392/establishment-of-tricare-select-and-other-tricare-reforms

> in areas where it supports the medical readiness of one or more MTFs. Additionally, where TRICARE Prime is offered, it may be limited to active duty family members if the Director, DHA determines it is not practicable to offer TRICARE Prime to retired beneficiaries as well—a determination that again would take into account the nature of the supported MTF and the range of services it offers.

Please note, the IFR does not just assert DoD's authority to limit access to MTF care but, rather, to limit the availability of the TRICARE Prime plan only to those beneficiaries who provide clinical workload to MTFs. This change would then limit beneficiary opportunities for plan and out-of-pocket cost choices to a greater extent than under current policy.

The IFR language raises additional questions, including: How would this impact Base Realignment and Closure (BRAC) Prime Service Areas? What would happen to retirees currently on Prime but not seen at MTFs? How would this affect active duty family members?

It is our interpretation of the IFR that DoD will continue to offer TRICARE Prime to active duty military families regardless of their geographic location or MTF capacity. NMFA asserts that all active duty families must have the option of a minimal out-of-pocket cost health plan. Additionally, DoD must not create a two-tier health benefit system based on assignment location or MTF capacity, factors that are outside the control of military families.

**TRICARE Select**

***TRICARE Select Copays***

**We are alarmed by DHA's careless approach to establishing copays for TRICARE Select**, a plan that was billed as an improvement for beneficiaries formerly in TRICARE Standard. As currently defined, we believe TRICARE Select out-of-pocket costs are highly inconsistent with private sector PPOs and will be detrimental to most military families and retirees who rely on it for health coverage.

Even though our Association participated in FY17 NDAA working group meetings with DHA since the legislation was passed, we were stunned by the Group A/Grandfathered TRICARE Select copays outlined in the TRICARE Changes Fact Sheet that accompanied the September 2017 IFR *Establishment of TRICARE Select and Other TRICARE Reforms*. The FY17 NDAA directed DoD to calculate TRICARE Select cost-sharing requirements "as if the beneficiary were enrolled in TRICARE Extra or TRICARE Standard as if TRICARE Extra or TRICARE Standard, as the case may be, were still being carried out by the Secretary." However, TRICARE Select network copays for primary and specialty care outpatient visits, emergency room visits, and urgent care centers are much higher than expected given the percent cost shares beneficiaries paid for network encounters under TRICARE Extra.

Further details from DHA (not included in the IFR and not publicly available to date) revealed specifics on their approach. Instead of taking an average of the cost share for the TRICARE allowed amount for each of those encounter types, DHA also included all associated ancillary, laboratory and radiology costs, driving up the average per encounter charge. Since ancillary services are covered by the new fixed dollar copays, TRICARE Select beneficiaries will have no separate copay or cost shares for these services. Although DHA claims this approach is revenue neutral, we remain skeptical. Even with limited methodology details, military Association representatives uncovered a

flaw in the approach that led DHA to revise their calculations and lower TRICARE Select copays from 6 to 22% for outpatient visits, urgent care and ER encounters. While we appreciate DHA listened to our feedback and made a correction to their copay calculations, we still have numerous concerns that have not been addressed:

- The approach of folding labs, radiology and ancillary services into each outpatient encounter drives up the average copay for many, if not most, encounters by shifting costs from those receiving more complex medical care to those receiving less complex care. While this "risk pool" approach may make sense for setting commercial plan *premiums*, it not a sound strategy for establishing TRICARE copays given the role copays play in encouraging sound patient decisions.

- Under the TRICARE Select plan, physical therapy, occupational therapy, and speech therapy are considered specialty care. Active duty families will pay $31 per visit while retiree families will pay $41 per visit, significantly higher than previous TRICARE Extra cost shares.

- **We are concerned about how the dramatically higher copays will impact patient adherence with treatment plans**. When a retiree family member is directed to get physical therapy twice a week for six weeks, will $492 in copays dissuade them from seeking necessary care? What happens to DoD's overall costs for that patient when they fail to follow doctor's orders and the problem progresses? When asked, DHA said no research or analysis was done on the potential impact on treatment plan compliance.

- Mental health visits are also considered specialty care under the TRICARE Select copay plan. The $31 ADFM/$41 retiree copays are significantly higher than the percent cost shares families paid for network mental health visits under TRICARE Extra. The new copays are also higher than out-of-pocket costs for mental health care under FEHBP national PPO plans (see Appendix B.) For many years, DoD has acknowledged the importance of seeking mental health care for families struggling with the impact of 16+ years of war. **We are appalled by TRICARE Select copays that create a cost barrier to accessing mental health care.**

- The IFR says that converting current TRICARE Standard/Extra cost shares into TRICARE Select fixed dollar copays is consistent with prevailing private sector health program practices. However, **we believe DHA's TRICARE Select copay structure (combining outpatient visit costs together with labs, radiology and ancillary services) is *inconsistent* with most private sector preferred provider option (PPO) practices**. An examination of FEHBP national PPO plans (see Appendix B) shows significantly lower copays for office visits with separate percentage cost shares for labs, radiology and ancillary services. FEHBP plans also had significantly lower copays for physical, occupational, and speech therapies as well as mental health office visits.

- When asked, DHA was unaware of any commercial PPO plan that uses their proposed approach of higher copays for office visits with no cost sharing for ancillary services. As follow up to our question, DHA later provided a single example from Fairfax County Public Schools (FCPS) – the CareFirst Blue Choice Advantage plan. This plan does have zero out-of-pocket costs for ancillary services and copays in line with those for TRICARE Select retirees. However, it also appears to be the lower end PPO plan for FCPS employees. The higher end FCPS PPO, Aetna/Innovation Health, also has no cost sharing for ancillary services but much

lower copays across the board compared to TRICARE Select. This reinforces our perspective that, when compared to the appropriate benchmark, TRICARE Select copays are clearly too high.

- **TRICARE Select defies the entire PPO concept with network copays so high beneficiaries could actually pay *less* by seeing non-network providers**. The IFR states TRICARE Select beneficiaries "will enjoy lower out-of-pocket costs if they choose preferred providers within the TRICARE civilian network" but TRICARE Select's high network copays will exceed the 20/25% out-of-network cost share for many therapies and office visits. It won't take long for families to determine they can save money by using non-network providers. How does this make sense for DoD or military families?

- For both active duty families and retirees, TRICARE Select Group A/Grandfathered beneficiaries will pay more out-of-pocket for their care than Group B/New beneficiaries, creating exactly the type of situation we opposed when the grandfathering concept was raised during the FY17 NDAA process.

TRICARE Standard/Extra covers a significant portion of the beneficiary population. In FY16, over 2 million beneficiaries used Standard/Extra including about 1/3 of ADFMs and 1/2 of retirees and their families[3]. Given the IFR comments on Prime eligibility, it seems clear DHA wants to affirm TRICARE Select as the earned health care benefit, potentially shifting many retirees who aren't treated at MTFs from Prime to Select in the future. It is critical the TRICARE Select copay construct reflect best practices and out-of-pocket costs on par or lower than high quality commercial plans.

**A Note About Grandfathering**

Some have suggested many of our issues surrounding TRICARE Select copays can be addressed by eliminating grandfathering. While our Association appreciated Congress' intent to fulfill promises to those currently serving and retired, we opposed "grandfathering" current beneficiaries throughout the FY17 NDAA process for two main reasons: 1) It creates a situation where two service members serving side-by-side earn different health care benefits for their families and future retirement; and 2) It results in a level of operational complexity, which will divert scarce resources away from health care delivery and be difficult for the DHA to manage.

Simply eliminating grandfathering is not the solution. We are not opposed to modest and predictable growth of out-of-pocket costs linked to retiree COLA to ensure they do not outpace military income increases – in fact, we believe it is essential to clearly define the health care benefit including expectations around future out-of-pocket costs. However, that does not mean we support the excessive fee increases imposed on new entrants. The cumulative impact of increased encounter copays, enrollment fees, catastrophic caps and pharmacy copays included in the FY17 NDAA was too much. We also opposed any out-of-pocket cost increases used to fund readiness or other military family programs. Senior DoD leaders have been very clear that savings from increasing beneficiary costs will be "ploughed into readiness." While we would be happy to see grandfathering eliminated, it would have to be part of a larger discussion around appropriate out-of-pocket costs to gain our support.

[3] Evaluation of the TRICARE Program: Fiscal Year 2017 Report to Congress - Plan Choice by Beneficiary Category; please note the ADFM group includes inactive Guard/Reserve and their family members eligible for TRICARE

[**DHA Beneficiary Communication**

Given the magnitude of TRICARE plan changes, communication to beneficiaries has been abysmal. DHA has provided detailed information solely via "pull" channels (communication channels that require the beneficiary to seek them out) such as the tricare.mil website and Facebook page. However, there was very little in the way of "push" communication – such as direct mail – to alert families to impending changes and drive them to digital media outlets for more details. Association representatives were told in December a letter would be sent soon from the new contractors regarding the changes in TRICARE regions and the switch from TRICARE Extra/Standard to TRICARE Select. While those changes occurred January 1, beneficiaries did not receive these letters until a month later.

The numbers speak for themselves. There are 9.4 million TRICARE beneficiaries. About 2.2 million are TRICARE for Life (TFL) and not impacted by the changes. That leaves more than 7 million beneficiaries affected by TRICARE Prime and Select changes. As of mid-January 2018, the TRICARE Facebook page has about 163,000 likes/follows. According to DHA's data, the tricare.mil\changes website section has had only 427,631 users. Even if you assume no viewer overlap across these two channels and no TFL beneficiary visits (unlikely), DHA is reaching only a small percentage of affected families with plan details. Military associations such as ours have worked with DHA to increase awareness of the changes, but many families are only learning about the changes as they receive claims from 2018 encounters and face significantly higher copays.

> *Facebook Post from February 1, 2018:*
>
> **Jennifer P**: It seems like it has all changed. In my opinion, they did not do a very good job in informing those of the (TRICARE) changes coming. I do not remember seeing anything in the mail about the changes. I had an up-front copay for my daughter at the dermatology office. I was told they are specialty so it was $31.
>
> **Michele M:** THIS! To my knowledge changes were only communicated via websites and emails. The biggest change is going from cost shares to copays.
>
> **Jennifer P**: The poor registration lady at the office said that the tricare switch has been awful. She brought out her flow chart to explain my copay. She did tell me to make sure I kept my receipt because I will be needing it! 😅😂

When TRICARE changes occur, a greater effort across multiple communication platforms must be made to raise awareness of the changes and drive beneficiaries to digital media for more details.

## TRICARE 2017 CONTRACT TRANSITION

We are now one month into the T17 contract transition including the consolidation of the North and South Regions to create the East Region. Early January was marked by call center and website customer service problems across both the East and West regions as call volume exceeded expectations and winter weather problems created customer service staffing issues. Humana quickly resolved website problems and long call center hold times in the East Region. According to DHA, Humana is currently at a 3 second hold time for callers. Unfortunately, HealthNet is still struggling to make improvements with phone call hold times clocking in at 30 minutes on average as of late January.

*Facebook post from January 30, 2018*

**Lisa W** ***to*** **From Boots to Wingtips**: We got a letter in December stating that we could pay our Tricare enrollment fee online. Over Christmas, Jeff attempted do that, but couldn't. He called Healthnet and was told "Sorry. You can't make an online payment." Okay. He attempted to set up a monthly payment plan, but they were not set up for that yet. So they took a one time payment and told him to call back this month.
Yesterday, he called back only to listen to a message saying that they are not accepting phone calls. He tried the online thing again, but that was a bust.
We just want to pay our stupid fee. My daughter is having the same issue as she needs to pay her young adult Tricare Prime premium. Grrr...

*Facebook post from February 2, 2018*

**Heather H S** ***to*** **TRICARE:** TRICARE I am extremely disappointed in the service I've received trying to get into a specialist. Tricare neglected to call me after my PCM put in the initial referral to tell me that I had a doctor assigned to me. I eventually called Tricare (with a 58 minute wait time); they gave me incorrect information for a doctor. I had to call back (45 minute wait time) for a different referral. And I had to call back again (45 minute wait time) for an authorization letter for my doctor to even be able to make an appointment. Your recording blames long wait times on inclement weather, which sounds like a poor excuse since there isn't any inclement weather in our country at the moment. Call it what it is, and hire more employees to service the demand you're seeing. (Tricare-west)

> **Heather H S** ***to*** **TRICARE:** Worse, when I try to send a message through the website, I get this message: Unexpected Error While Communicating with Service. Please try again after some time.
>
> > **Heather H S** ***to*** **TRICARE:** Online messaging doesn't work today either.

There are also concerns in the West Region regarding provider networks. We have heard numerous complaints about providers leaving the TRICARE network and overall fewer providers in many geographic areas. We understand Prime Service Areas cover about 80% of the beneficiaries in the West Region, so increasing network coverage to 85% of beneficiaries is not much of a jump and still leaves significant white space in the West Region. While we appreciate HealthNet allowing beneficiaries to nominate their providers for network inclusion, it is unclear if this approach will work. Will these providers be willing to join the network? How long will this process take?

In the East Region, network concerns seem limited to Applied Behavior Analysis (ABA) providers. ABA offices have reported delays in credentialing, treatment authorizations and claims processing. Some providers have already notified TRICARE patients that they will need to suspend services if the issues are not resolved (please see Appendix C.) Although Humana has shared their corrective action plan, we believe this situation warrants further monitoring until problems are resolved.

In both the East and West Regions, provider directory inaccuracies are also contributing to military family frustration about the transition.

Contract transitions are by nature disruptive, particularly for families in the middle of on-going medical treatment. We appreciate the steps the contractors have taken to address problems as they

arise, but continuing complaints from both regions suggest continued oversight is warranted. We hope Congress will continue to demonstrate interest in ensuring a smooth transition for military families.

## SPECIAL NEEDS MILITARY FAMILIES

Thank you to Congress and the Committee Staff for your diligent work in crafting a FY18 NDAA provision to allow TRICARE to cover pediatric hospice services concurrently with curative care and quality of life therapies. The pediatric concurrent hospice legislation not only fixes an urgent problem for impacted families, but it also sends a signal to all military families that egregious TRICARE coverage issues will be addressed.

### TRICARE Extended Care Health Option (ECHO)

Medicaid Waiver programs provide long term care services in home and community-based settings to people who would otherwise require care in an institutional environment. Most states have lengthy waitlists for their Medicaid Waiver programs and, as a result, many military families are unable to access Medicaid Waiver services because they PCS before reaching the top of the waitlist.

> *I have two special needs children and have never been able to access Medicaid services till our recent assignment. When we move out of state this summer, we will again lose services. In 9 years, we have received only 9 months of Medicaid waiver services due to frequent military moves. The process takes so long each time we PCS. It is really discouraging.*

Congress established TRICARE's Extended Care Health Option (ECHO) to substitute for state Medicaid waiver services that are often unavailable to mobile military families. Services provided by Medicaid Waiver programs should serve as the benchmark for ECHO covered services. However, ECHO currently falls short relative to Medicaid waiver services, particularly in the area of respite care.

The 2015 Military Compensation and Retirement Modernization Commission Report validated this issue and recommended **ECHO covered services should be increased to more closely align with state Medicaid waiver programs**. Expanded services should be subject to the ECHO benefit cap of $36,000 per fiscal year, per dependent. Specific examples include, but are not limited to, expanding respite care hours to align more closely with state offerings and allowing families to access respite care without receiving another ECHO benefit.

- Respite care is covered by almost all State Medicaid Waivers: 92% of Waivers cover in-home respite while 86% cover out-of-home respite
- ECHO respite coverage falls far short of Medicaid Waivers. **ECHO currently provides a maximum of 192 respite hours per year while the average State Medicaid Waiver provides 695 respite hours per year.**[4]

### Pediatric Definition of Medical Necessity

TRICARE's adult-based definition of medical necessity prevents some military kids from getting the care they need – care that is widely accepted and practiced in the civilian health care system and

[4] MCRMC state-by-state Medicaid waiver analysis

MTFs. TRICARE is authorized to approve purchased care only when it is "medically or psychologically necessary and appropriate care based on reliable evidence." DoD's hierarchy of reliable evidence includes only "published research based on well controlled clinical studies, formal technology assessments, and/or published national medical organization policies/positions/ reports." While beneficiaries certainly want safe and effective treatment, such tightly prescribed data for children are not always available. TRICARE's strict adherence to this adult-based standard of reliable evidence results in coverage denials for widely accepted pediatric treatments.

After our Association, together with the TRICARE for Kids Coalition, repeatedly raised this issue at Military Family Readiness Council meetings, senior DoD leadership requested the Defense Health Board (DHB) examine opportunities to improve the overall provision of health care and related services for children of members of the Armed Forces. The July 2016 report request specifically directed the DHB to:

> Address any issues associated with the TRICARE definition of "medical necessity" as it might specifically pertain to children and determine if the requirement for TRICARE to comply with Medicare standards disadvantages children from receiving needed health care.

The DHB *Pediatric Health Care Services Report*[5] was released December 18, 2017. The report documented TRICARE is out of step with commercial plans and Medicaid and concluded TRICARE's current definition of medical necessity disadvantages children from receiving some needed services. The DHB recommended the MHS:

> Modify the administrative interpretation of the regulatory language in 32 Code of Federal Regulations 199.2 to broaden the use of the "hierarchy of reliable evidence" for the benefit of pediatric beneficiaries. Exclusions to the hierarchy described under "reliable evidence" in 32 Code of Federal Regulations 199.2 should not preclude pediatric services (a) meeting definitions of medical necessity used broadly in civilian practice or (b) recommended by recognized medical organizations.

Although the DHB's pediatric medical necessity recommendation was released with the pre-decisional report draft last summer, we are not aware of any movement at DHA to update the interpretation of the regulatory language. Although this issue doesn't require legislation, we believe demonstrated Congressional interest will help speed resolution of this documented coverage gap affecting military kids. Fixing TRICARE's definition of pediatric medical necessity is an essential part of the TRICARE reform effort.

## TRICARE DENTAL PROGRAM FOR ACTIVE DUTY FAMILY MEMBERS

The TRICARE Dental Program (TDP) contract change to United Concordia (UCCI) took place May 1, 2017 and has led to a significant reduction in the value of the TDP benefit for many military families. Our Association has heard from dozens of angry families who have lost their dentist and/or can't find a dentist within a reasonable distance of their home/duty station. Not only have

[5] Defense Health Board *Pediatric Health Care Services Report* – December 18, 2017 https://health.mil/About-MHS/Defense-Health-Agency/Special-Staff/Defense-Health-Board/Reports

families reached out to us to provide feedback, they have leveraged multiple forums to raise the issue directly to DHA and the Services including VADM Bono's presentation at AUSA's Military Family Forum, TRICARE webinars, and TRICARE Town Hall events at individual installations.

We are very concerned that, although the contractor is meeting the contractual access standard (a general dentist within 35 miles of 95% of beneficiaries), the value of the military family dental benefit has become significantly diminished by narrowed provider networks. In some areas (Fort Campbell, the Tidewater region of Virginia), we question whether even contractual access standards are being met based on family member feedback as well as UCCI's acknowledgement of network deficiencies in those areas.

Families are also concerned about the quality of dental care they might receive from providers who remain in the network at reduced reimbursement rates, particularly because many dentists have issued letters saying they are unwilling to accept outdated restrictions set forth by UCCI and/or use overseas labs or inferior materials, etc.

After meeting several times with DHA and UCCI to express our concerns, it seems nothing will be done to improve the TDP under the current contract and we are concerned about the lack of options to address the "race to the bottom" nature of the TDP contract process. **We ask Congress to consider extending Federal Employees Dental/Vision Program (FEDVIP) eligibility to active duty family members while maintaining current DoD contribution levels, adjusted annually for inflation, to dental plan premiums**. FEDVIP participation would provide military families with options for dental coverage that best meets their needs.

## NEXT PHASE OF MHS REFORM: DHA MANAGEMENT OF MTFS/DIRECT CARE SYSTEM RIGHT SIZING

During the MHS reform process, our Association detailed challenges military families face within the Direct Care system, including MTF appointment shortages and scheduling hurdles, variable quality and safety across the Direct Care system, and policies and patient experiences that vary greatly across MTFs. As reform efforts continue, we hope DHA and the Services maintain a focus on addressing these challenges.

**We appreciate and strongly support the FY17 NDAA provision that requires DHA to assume responsibility for the administration of all MTFs**. Currently, DHA sets policy but MTFs have no accountability to the Agency for implementation of that policy. Consolidating MTF administration under DHA should allow the Agency to enforce policy and ensure more consistent communication.

We are also grateful that the FY17 NDAA requires a DHA professional staff including a Deputy Assistant Director for Medical Affairs with responsibility for clinical quality, patient safety and the patient experience. We trust this position will be held accountable for improvements in quality of care and the patient experience.

While we also support MHS reform intended to right-size the Direct Care system, retaining only beneficiary care that directly contributes to the readiness mission, we urge DHA to ensure access for beneficiaries who must transition care to the private sector as a result. If right-sizing includes specialty care consolidation into a handful of military medical centers of excellence, we trust military family preferences will be considered when determining where families will obtain specialty care.

The quality and value of the military health care benefit should reflect the extraordinary demands of military service. MHS care should be on par with that provided by top performing civilian health systems. MTF policies, procedures and customer service should have a beneficiary focus designed to facilitate access to care. In short, military health care should be a robust benefit to families – not another sacrifice to add to the many that military families already make in support of their service members. We truly appreciate your efforts on MHS Reform that will get us closer to that goal.

## COMMISSARY

Military families consistently tell us the commissary is one of their most valued benefits. We have long viewed the commissary - and the savings it provides to military families - as an essential element of military compensation. For that reason, we were concerned when the FY17 NDAA authorized the Defense Commissary Agency (DeCA) to make significant changes to its business operations; specifically, allowing the introduction of private label products and replacing the traditional "cost plus five percent" pricing model with variable pricing. While we understood the changes were introduced to make DeCA more efficient and less reliant on appropriated funds, we worried DeCA lacked the necessary expertise to manage the new system and the changes would ultimately erode the value of the benefit.

A year later, the jury is still out. We have watched closely as DeCA introduced a number of private label products to its stores. Shoppers seem to be accepting the new products and have not complained to us about their quality relative to national brands. However, we often hear from shoppers regarding other elements of the shopping experience: empty shelves, expired dairy products, high-priced produce. We recently received the following report from a family stationed in Germany:

*(Here are) are photos from the commissary the week of Jan 2-Jan 5 where the shelves were bare in the meat section along with eggs, butter, yogurt, cheese and much of the product section. (Though the produce section generally hovered around 60% stocked, so it wasn't startling enough to take a photo. The complete lack of the other categories was surprising...one or two subsection within each category might be low or out of stock, but not everything all at the same time and for a week!)*


Similar issues with keeping shelves stocked have been reported at the commissary at Fort Myer, so the problem is not limited to stores OCONUS. We recognize that some supply chain problems are unavoidable and unrelated to the changes in business operations. However, the problems do speak to DeCA's ability to deliver a high-quality benefit families can rely upon. We are also concerned repeated problems with product quality or availability will lead those families who can do so to shop elsewhere, further contributing to DeCA's decline in sales – and hindering its ability to generate enough revenue to reduce the need for appropriated funds.

It is also important to remember the Exchange retail stores are highly dependent on foot traffic from nearby commissaries. Any threat to the health of the commissary puts the entire military resale system at risk. This is particularly concerning as Services reduce funds for installation Morale, Welfare, and Recreation (MWR) programs and instead increasingly rely on the Exchanges for MWR funding. If Exchange sales revenues decrease, funding for MWR programs will go down as well.

We are gratified both Congress and DoD have recognized the importance of commissary savings to military families and have expressed their commitment to preserving the value of the benefit. We especially appreciate that Congress has demonstrated its commitment by authorizing a full commissary appropriation and by including key oversight provisions in the FY17 NDAA. However, we continue to be concerned about the long-term viability of this essential benefit.

***We ask Congress to continue closely monitoring DeCA as it continues with its business transformation.***

## MILITARY RETIREMENT SYSTEM

Service members with fewer than 12 years of military service are faced this year with an important decision – whether to opt in to the "blended" retirement system created in the FY16 NDAA or remain in the current system. This choice has significant long-term financial ramifications for service members and their families. It is vital to ensure these young service members – and their

spouses – are given the tools and resources they need to make the decision that is in their financial best interest.

In addition to being an extremely important financial decision, the choice to opt in to the BRS is also irreversible. Thus, it is essential that service members and their families know where and how to access information, training, and counseling in order to make the best decision. We are pleased DoD has recognized this responsibility and is taking steps to ensure service members are informed about the new retirement system. Military OneSource and DoD have been proactive in advertising webinars and Facebook live sessions for both service members and families to ask questions. We are especially glad the Department recognizes that the choice of retirement plan must be a family decision and is making its online course available to spouses as well. However, DoD should expand family access to the financial education provided by Military Family Life Counselors and unit Personal Financial Managers.

We appreciate the new military retirement system will allow more service members to accumulate retirement savings while preserving the defined benefit for those who serve a full career. However, we ask Congress to consider amending the plan to increase its value for service members. Specifically, we ask Congress to increase the maximum level of matched contributions to service members' Thrift Savings Plan (TSP) accounts to 5 percent—the level recommended by the Military Compensation and Retirement Modernization Commission (MCRMC). Because the match is based on service members' basic pay, rather than total compensation, service members should have the option of a higher match in order to maximize their retirement savings. We also ask Congress to extend the government match for the full career of the service member, rather than ending it at 26 years of service.

Finally, we note that the adoption of the new retirement plan is likely to affect the Survivor Benefit Plan (SBP). Will future retirees elect to pay into SBP if they have TSP accounts to leave their survivors? What would a lower participation rate mean for the overall health of the SBP? These are important questions that need to be studied. We ask Congress to direct DoD to study the potential impact the blended retirement system will have on the Survivor Benefit Plan.

***We ask Congress to increase the maximum level of matched contributions to service members' TSP accounts to 5 percent—the level recommended by the Military Compensation and Retirement Modernization Commission (MCRMC).***

***We ask Congress to extend the government match for the full career of the service member, rather than ending it at 26 years of service.***

***We ask Congress to direct DoD to study the prospective impact the blended retirement system will have on the Survivor Benefit Plan (SBP).***

## WHAT DO TODAY'S MILITARY FAMILIES NEED TO ENSURE READINESS?

It has often been said while the military recruits a service member, it must retain a family. Our Association has long argued in order to build and maintain the quality force our nation demands, the military must support service members as they balance the competing demands of military service and family life. We urge Congress to strengthen the programs and services available to

support all troops and families in diminishing uncertainty and meeting the daily challenges of military life.

We thank Congress for providing military families with greater flexibility in timing their relocation either before or after a service member's permanent change of station (PCS) report date in the FY18 NDAA. We are anxious to see how the Services implement this new policy and will monitor whether it minimizes the upheaval associated with moving.

Yet, budget issues have increased stress and anxiety for families facing a military-ordered move. The military must evolve to meet the needs of today's military families, but it needs a predictable budget and appropriation to do so.

## CHILD CARE

Military families frequently cite the lack of high quality, affordable child care as among the most significant challenges they face. In part, this reflects a national shortage of affordable child care options. However, the need for child care is especially pressing for the military community, which is disproportionately composed of young families. According to the *2016 Demographics Profile of the Military Community*, more than 40 percent of military personnel have children. Of the nearly 1.8 million military-connected children, the largest cohort – 37.8 percent – is age five or younger.[6]

Like all working parents, service members with young children need access to affordable child care in order to do their jobs. However, the military lifestyle comes with unique challenges and complications for families. Service members rarely live near extended family who might be able to assist with child care. Their jobs frequently demand long hours, including duty overnight. They are often stationed in communities where child care is expensive or unavailable. Service members frequently deploy or travel for training or other assignments, putting strain on at-home parents.

We are grateful to Congress for recognizing the importance of child care to military families and including a number of provisions addressing child care availability in the FY18 NDAA. Thank you for requiring a study of compensation paid to DoD child care providers. Staffing shortages are a frequently-cited reason for lack of availability at installation child development centers (CDCs). Ensuring DoD child care providers are appropriately compensated at a level commensurate with their skills and responsibilities is a critical step in addressing this chronic problem.

DoD is also to be commended for its commitment to providing high-quality, affordable child care to military families. Its facilities are often top-notch and it offers an impressive level of training and professional development opportunities to CDC workers as well as providers in its network of on-installation Family Child Care (FCC) homes. However, there are additional steps that DoD should consider in order to better meet the child care needs of military families.

***Streamline the hiring process for CDC employees and FCC providers:*** The process of hiring CDC personnel is lengthy and arduous. It can be difficult for CDC directors to find, hire, and put into place qualified staff. This limits the number of children a facility can serve. Similarly, military spouses seeking to offer child care in their homes as an FCC provider must endure a hiring process

[6] 2016 Demographics Profile of the Military Community, http://download.militaryonesource.mil/12038/MOS/Reports/2016-Demographics-Report.pdf

that can last up to six months. It's not reasonable to expect a spouse to wait six months before starting her home-based child care business, especially if the spouse's family will only be in a given location for two years or less. While the safety of children is paramount, requiring multiple redundant background checks does nothing to enhance security while significantly impacting the amount of quality care DoD is able to provide. DoD should analyze whether and how the hiring process can be streamlined while still ensuring that necessary background checks and training take place to ensure children's safety.

***Increase availability of part-time and hourly care:*** We continue to hear from military families frustrated by the lack of hourly or drop-in care at installation CDCs. Many military families – especially those overseas or in remote locations – do not have easy access to reliable caregivers. For those families, access to drop-in care at an installation child care facility can greatly enhance their quality of life, enabling parents to go to medical appointments, run errands, and volunteer in their communities. This service can be especially vital when a service member is deployed, providing the at-home parent with a much-needed break. Increasing the number of hourly slots would also help address a common conundrum faced by military spouses after a PCS move: they can't look for work without child care, but under DoD priority guidelines, they aren't eligible for child care if they're not working. DoD should evaluate the programs at installation CDCs to ensure the mix of care offered – full time, part-time and hourly – meets the needs of the families they serve.

***Increase participation in the fee assistance program:*** The fee assistance program operated by the services is an innovative, effective approach to the problem of insufficient child care availability on base. The program helps offset the cost of child care in the civilian community, ensuring participating families can access high quality care at an affordable cost. Unfortunately, relatively few families take advantage of this benefit. Expanding participation in the child care fee assistance program would address many families' child care needs.

A major reason why relatively few military families participate in the fee assistance program is a lack of eligible providers. DoD has stringent requirements for child care providers participating in the fee assistance program, to include national certification, regular inspections, and background checks. However, many states have less stringent requirements for providers. In those locations, families often have difficulty locating a provider who meets DoD's eligibility requirements. The Office of Military Community and Family Policy and the Defense State Liaison Office (DSLO) have worked together to encourage states to increase their standards to meet DoD's and have had a great deal of success in this regard. We encourage them to continue with this effort. We also encourage DoD to consider ways that it could broaden the pool of providers eligible to participate in the program while still maintaining its commitment to high quality care.

***Analyze role of FCC Homes:*** For many years, child care providers who offered care in their on-installation homes were an important part of the military child care system. These providers receive training and professional development from DoD much like that given to CDC employees and must comply with stringent DoD inspections and background checks. They provide a flexible care option for parents whose schedules don't work with CDC hours and offer employment opportunities for military spouses. However, the number of FCC Homes has been declining for years. DoD should survey current providers as well as those who leave the program to assess why fewer people are offering this service and what, if anything, could be done to attract and retain in-home care providers.

Part of the problem may be that if an FCC provider moves and no longer lives on an installation, he or she is subject to the licensing requirements of the state. Given DoD's stringent requirements, we expect that FCC providers would meet or exceed most states' requirements for licensing an in-home day care. For that reason, we suggest DoD and the Defense State Liaison Office (DSLO) work with states to expedite licensing for approved FCC providers, so they can quickly reopen their in-home day care in their new location.

In addition, operating an FCC is a difficult, at times isolating job. We have heard that many providers drop out of the system during the deployment of their service member spouse as the burdens of operating an FCC become too much to manage during a time of additional stress. We commend DoD for providing opportunities for training and professional development to its FCC providers but encourage the Department to seek other ways to support these essential care providers in order to make it possible for them to continue offering child care services.

## EFMP Respite Care

Military families with special needs family members are supported through the Services' Exceptional Family Member Programs (EFMP). The primary mission of the EFMP is assignment coordination is to ensure special needs families are sent to locations that can meet their medical and educational requirements. However, the EFMP also includes a family support component. While we appreciate that DoD recognizes the importance of supporting special needs families, we hear often from families who tell us that EFMP family support programs are falling short. This is especially true when it comes to respite care.

Families with special needs children have unique child care needs. For those families, dropping a child off at a day care center or with a sitter may not be an option. Instead, parents of special needs children need respite care provided by trained caregivers. Access to quality respite care allows families to run errands, spend time with other children, and simply recharge.

Recognizing the importance of respite care, especially for military families far from the support of friends or extended family, the Services have provided respite care for military families with eligible special needs family members as part of the EFMP family support function. However, because the respite care programs are operated and funded by each of the individual Services, eligibility requirements and the number of respite care hours available to families vary. This is a significant source of frustration to families assigned to joint bases or installations managed by other Services. We are also concerned the current fiscal environment may lead the Services to reduce the level of respite care they offer.

## MILITARY CHILDREN'S EDUCATION

The vast majority of military-connected students attend local public schools in their civilian communities. Districts serving large numbers of military children rely on funding from the Department of Education and the Department of Defense to help offset the additional expenses they incur. It is incumbent on DoD and the federal government to ensure that schools charged with serving military-connected children have the support they need to provide the best possible education. Military families often have no control over when and where they move. They worry about the effect multiple moves will have on their children's academic achievement. They deserve the assurance that their children will receive a high quality education wherever they happen to be

stationed. ***We urge Congress to continue funding programs designed to support the education of military-connected children.***

We are grateful that Congress chose to permanently authorize the Department of Defense Education Activity (DoDEA) grant program in the FY18 NDAA. This program, which was established by the *John Warner National Defense Authorization Act* for FY 2007, provides tangible, targeted support to public school districts serving large numbers of military-connected children. School districts have used DoDEA grants to fund transition support programs for military children, enhance student proficiency in reading, math, and foreign language, and offer Advanced Placement (AP) classes in locations that would otherwise be unable to offer this level of instruction. We are pleased that military children will continue to benefit from the valuable educational programs made possible through the DoDEA grant program.

**Impact Aid**

Military families care deeply about their children's education. It is essential to them that local public schools – which enroll the vast majority of our nation's military-connected children – receive the resources they need to provide their children with the best possible education. For this reason, we strongly support the Department of Education Impact Aid program and call for its continued funding. Impact Aid is designed to replace some of the property tax revenue lost by school districts with nontaxable federal land such as a military installation within their boundaries. This essential revenue stream goes directly to affected school districts, which use it to meet the needs of the community they serve. Without Impact Aid, the quality of education available to military-connected children AND their civilian classmates would suffer. We thank Congress for recognizing the importance of Impact Aid by reauthorizing it in the *Every Student Succeeds Act of 2015* and continuing to appropriate funds to support the program. We ask you to continue to prioritize Impact Aid funding.

We are also grateful to Congress for authorizing $40 million for DoD Impact Aid and $10 million in Impact Aid for schools serving military children with special needs in the FY18 NDAA. ***We ask Congress to maintain this funding to offset the costs incurred by districts educating large numbers of military children.*** These funds help local school districts meet the education needs of military children in an era of declining state budgets. Both DoD and Department of Education Impact Aid funding are critical in order to ensure school districts can provide quality education for military children.

We strongly oppose proposals that would transition Impact Aid into a voucher program for military-connected kids. Losing Impact Aid would be financially devastating for school districts across the country and critically compromise the education services they are able to provide. Realistically, any voucher program supported by reallocating current levels of Impact Aid funding will only reach a few of the 550,000 school-age children of active duty service members. Who would decide which military children would be eligible for vouchers? Would costs of administering such a program come from the same funding stream as the vouchers? We believe military children should be eligible for local or state funded voucher programs at the same level as their civilian neighbors. But, we question DoD's capacity to administer a voucher program for military-connected children, made more complicated by the transient nature of military life. We urge Congress to reject a federal voucher for military-connected children and preserve Impact Aid.

Under the terms of the Services' Exceptional Family Member Program (EFMP), military family members with special needs should only be sent to locations where their medical and educational needs can be met. In practice, this policy has led to concentrations of special needs military families in locations such as Joint Base Lewis-McCord, where a large MTF and other specialized services are available. While the ready availability of services through the military and local civilian community benefits the special needs military families, we are concerned about the unintended burden on the public school districts serving these installations, which must provide special education services to a larger than normal population. Serving unusually large numbers of children with severe special needs places great strain on the budgets of these public school districts. We fear that in the long term this financial pressure will affect the quality of the education services these districts are able to provide. ***We ask Congress to require DoD to study where military families with severe special needs are concentrated and whether DoD Impact Aid for schools serving military children with special needs is appropriately allocated.***

## SPOUSE EMPLOYMENT AND EDUCATION SUPPORT

Spouse employment and education support is a critical component of military family readiness. Much like their civilian counterparts, many military families rely on two incomes in order to help make ends meet. However, military spouses face barriers hindering their educational pursuits and career progression due in large part to challenges associated with the military lifestyle.

We are gratified in recent years Congress, DoD, the White House, and individual States have all taken steps to lessen the burden of an active duty member's military career on military spouses' educational and career ambitions. We fully support these initiatives, including DoD's portfolio of Spouse Education and Career Opportunities (SECO), which provides educational funding for select military spouses, career counseling, employment support, and the DoD State Liaison Office's (DSLO) state-level initiatives. However, while progress has been made, military spouses continue to face significantly lower earnings and higher levels of unemployment and underemployment than their civilian counterparts, greatly impacting their families' financial stability.[7]

We appreciate that Congress recognized the difficulty military spouses have in moving their careers from state-to-state by providing up to $500 reimbursement for re-licensing and re-certification because of a PCS in the FY18 NDAA. Military spouses are anxiously awaiting the implementation of this new program. We hope DoD and the Services will quickly implement the reimbursement policy so that military spouse can begin to offset the out-of-pocket costs of additional licenses.

### Grow Our Own

One of our top priorities is to ensure adequate access to behavioral health providers who are attuned to the unique stressors of military life for service members and their families who have endured years of repeated deployments, long separations, and possible injuries or illnesses. We support efforts to educate and employ military spouses as mental health professionals.

As military families struggle to cope with the effects of 16 years of war, we are seeing an increasing demand for mental health services within our families and community. Since 2004, NMFA's military

[7] Institute for Veterans and Military Families, *Military Spouse Employment Report*, Syracuse University (IVMF) February 2014: http://vets.syr.edu/wp-content/uploads/2014/02/MilitarySpouseEmploymentReport_2013.pdf

spouse scholarship and professional funds program has had almost 90,000 applicants. Data from this year's approximately 9,000 scholarship applicants, as well as from active duty spouse respondents to the 2015 health care survey done by the Military Officers Association of America (MOAA), indicate increased rates of behavioral health usage among military families. Both surveys show between 40-50 percent of military spouses have sought behavioral health care for someone in their family.

Unfortunately, access to high quality care is limited. The shortage of mental health professionals nationally is mirrored in the military community; it is even greater at military installations in remote areas. We believe our nation has an obligation to prevent, diagnose, and treat the mental health needs of service members and their families. Doing so in the face of a nationwide shortage of mental health professionals will require innovative solutions and strategic public-private partnerships including Congress, DoD, the VA, and other organizations. We believe military spouses may also be a source of help for their community.

Since the launch of our military spouse scholarships, the number of spouses pursuing mental health careers has increased. Our 2017 applicant pool had more than 500 spouses planning to pursue careers in mental health fields. Twenty-two percent of these mental health profession applicants are spouses of wounded or fallen service members.

Many of our military spouses pursuing careers in mental health fields intend to serve military families. Helping these spouses overcome obstacles and pursue their careers has the dual benefit of assisting the individual spouse and family while addressing the shortage of mental health providers in the military community. However, these spouses face obstacles due to the unique challenges of the military lifestyle. In a February 2016 Facebook post a Marine Corps spouse shared an experience all too common for military spouse mental health professionals:

> *We are currently stationed at Camp Pendleton, CA and I will start my practicum this June.* ***I have excelled in my graduate program and now I am facing major challenges finding a facility that doesn't require a year sign-on and who has openings for new interns starting this summer. One specific problem I'm facing is we aren't sure when new orders will come or where they will be (making it additionally hard to convince licensed supervisors to take a new intern on if I will only be there for a couple months).*** *Is there anyone who can share a professional contact with me?*

We offer the following recommendations for Congress to consider:

- Include military spouses and others who enter the mental health profession in federal loan-forgiveness programs;
- Facilitate easier paths to both licensure and employment for military spouses and veterans in the mental health field when they work with our service members and families;
- Pass legislation to allow military spouses full reciprocity when transferring an active unrestricted mental or behavioral health license from one state to another due to PCS;
- Support partnerships between the Military Health System and the VA to ease spouse difficulties in obtaining clinical supervision hours, reduce licensing barriers, and spur employment of military spouses and veterans in the mental health field.

***We ask Congress to increase access to behavioral health providers by supporting employment efforts of military spouses in the mental health profession.***

## MILITARY FAMILIES IN CRISIS

Our country is still at war and military families continue to live extraordinarily challenging lives. Reintegration continues to pose challenges for some. Others are anxious about their financial futures. Most military families are resilient and will successfully address whatever challenges come their way. However, some will need help. It is critical military families trust DoD services and programs and feel comfortable turning to them in times of need. These programs and services must be staffed and resourced adequately so when families reach out for help, they can trust it is available. Military families must be assured our nation will support them in times of family or personal crisis.

### Suicide

In 2014, the Defense Suicide Prevention Office (DSPO) released a report outlining an approach for tracking military family member suicides. The report, *Suicide and Military Families: A Report on the Feasibility of Tracking Deaths by Suicide among Military Family Members*, was requested by the Senate and House Armed Services Committees.

***We appreciate Congress including a provision directing DoD to track military family suicides as well as Reserve Component suicides in the FY15 NDAA, but are frustrated by DoD's delays in developing a plan to meet this mandate. If we don't have accurate information on the extent of the issue, targeting solutions is impossible.***

### Preventing Child Abuse and Neglect, and Domestic Violence

Research commissioned by our Association[8] and others during the past decade documents the toll of multiple deployments on children and families, the difficulties many families face on the service member's return, and the added strain a service member's physical and invisible wounds can place on a family. These stressors put military families at risk for marital/relationship problems and compromised parenting that must be addressed with preventative programs.

Those looking for budget cuts may find it tempting to slash family support, family advocacy, and reintegration programs. However, bringing the troops home from war zones does not end our military's mission, family separations, or the necessity to support military families. "Rotations" and "training exercises" of units to Europe and elsewhere must be accompanied by the same high levels of family support as if service members were heading on a combat deployment. To family members, especially young children, "gone is gone".

We are concerned the extraordinary stress military families face could lead to increased domestic violence as well. Preventive programs focused on effective parenting and rebuilding adult relationships are essential. The government should ensure military families have the tools to remain ready and to support the readiness of their service members.

[8] Anita Chandra, et al., RAND Center for Military Health Policy Research, Views from the Homefront: The Experiences of Youth and Spouses from Military Families, 2011

We are encouraged the Family Advocacy Program, a Congressionally mandated DoD program designed to prevent and respond to child abuse/neglect and domestic abuse in military families, has redoubled its focus on prevention programs. Their efforts to repair relationships and strengthen family function will be essential. Programs like New Parent Support focus on helping young parents build strong parenting skills early on.

***We encourage Congress and the DoD to ensure Family Advocacy programs are funded and resourced appropriately to help families heal and aid in the prevention of child and domestic abuse.***

## SUPPORT FOR TRANSITIONING FAMILIES

Transitioning out of the military affects the whole family. In addition to the transition assistance program available to service members, resources relevant to family members need to be identified. Issues such as how to find community resources to replace DoD programs and the military spouse's role in the long-term care of the family as a whole aren't addressed in the transition classes.

Military OneSource is an invaluable resource for military families. Services utilized by military families include: non-medical counseling, financial counseling (to include free tax preparation support), spouse education and career opportunities, and wounded warrior and caregiver support. In fiscal year 2016 Military OneSource completed 167,505 non-medical counseling sessions; 22,629 financial counseling sessions; 223,069 federal and state tax returns; and distributed 1,628,322 educational and promotional materials.[9] The Department of Defense Spouse Education and Career Opportunities (SECO) Program is accessed through the Military OneSource website. SECO provides spouses with career exploration, education, training and licensing requirements and options, career connections, and employment readiness. In fiscal year 2016 Military OneSource received 145,067 calls related to spouse education and career opportunities. Military spouses have said:

> *"I'm a military spouse from overseas. When I came to the states I didn't know what to do and who to ask. No family here, no friends. Military OneSource is a great and fast help. It's like Google for military spouses. I love it and greatly appreciate all the employees."*
>
> *"The spouse relocation and transition consultant was amazing. I felt so comfortable talking with her and she gave me a peace of mind with the PCS process! I absolutely loved her, and give my highest level of recommendation!"*
>
> *"I'm a military spouse for 24+ years and oh how I wish I could say deployments get easier. I sure wish I would have known about Military OneSource all those years ago! I plan on utilizing for many, many years to come!"*

Our Association conducted a survey of military spouses facing transition. Over half the spouses indicated they were extremely or very concerned about relocation and finding employment. Over three quarters of the spouses were extremely/very concerned about being financially prepared and

[9] Fiscal Year 2016 Military One Source Year at a Glance

finding employment for their service member. Access to the counseling and other services provided by Military OneSource, beyond the 180 days currently provided, would make available resources and information to ease some of the concerns of our transitioning military families.

Several weeks ago, President Trump signed an Executive Order titled, "Supporting Our Veterans during Their Transition from Uniformed Service to Civilian Life," which extended Military OneSource services to separating service members to one year post-separation. While we are grateful the Executive Order extended access to Military OneSource, we would like to see the extension written into law.

***Expand the opportunity for spouses to access transition information including face-to-face training and on-line training.***

***We ask for legislation ensuring expanded service member and family access to Military OneSource to one year from a service member's separation from the military.***

## TODAY'S SURVIVING SPOUSES NEED THE DIC OFFSET ELIMINATED

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

We appreciate Congress making the Special Survivor Indemnity Allowance (SSIA) permanent with cost-of-living increases in the FY18 NDAA. This is another step towards permanently eliminating the DIC offset to SBP.

***We ask the DIC offset to SBP be eliminated to recognize the length of commitment and service of the career service member and spouse.***

## CAREGIVER AND WOUNDED SERVICE MEMBER SUPPORT

Service members and their families must be assured our nation will provide unwavering support to the wounded, ill, and injured. This support must extend beyond the recovering warrior's medical and vocational rehabilitation. It must also include programs and services that help military caregivers, typically spouses or parents, successfully navigate their new role.

### Medicare Eligible Wounded Warriors & TRICARE Coverage

Medically retired wounded warriors who receive Social Security Disability Insurance (SSDI) benefits become eligible for Medicare Part A after 24 months on SSDI. At that point, the wounded warrior must enroll in Medicare Part B in order to keep TRICARE coverage. After the wounded

veteran enrolls in Medicare Part B, their TRICARE coverage converts to TRICARE for Life (TFL). This poses a variety of problems for the severely wounded population:

- In the worst case scenario, the wounded warrior or his/her caregiver does not realize or is not appropriately informed they must enroll in Medicare Part B (and pay Part B premiums) in order to avoid losing their TRICARE coverage.

- In other instances, the wounded warrior or caregiver understands and enrolls in Medicare Part B and retains TFL. Although medical coverage is retained, the severely wounded veteran is now paying more for medical coverage than most other working-age TRICARE retirees.

- Finally, some severely wounded veterans receive SSDI for over 24 months and are forced onto Medicare/TFL. Eventually, the wounded veteran returns to work, but is required to stay on Medicare Part B for eight years after returning to work. This results in more than $10,000 in Medicare Part B costs to the severely wounded warrior who returns to work.

This is an extremely complex issue facing the most severely wounded service members and their caregivers. These families face emotionally challenging lives and overwhelming responsibilities. Making a mistake about enrollment in Medicare Part B should not result in the life altering consequence of losing health care coverage. Furthermore, our most severely wounded warriors should not be forced to pay more for their health care than others.

This complex problem crosses many jurisdictions including the Centers for Medicare and Medicaid Services, DoD, the Social Security Administration, the Senate Finance Committee, the House Ways and Means Committee, the HASC and the SASC. Given this problem impacts our most severely wounded veterans and their families, we urge the House and Senate Armed Services Committees to take the lead in creating a solution to this complex issue.

## MILITARY FAMILIES –CONTINUING TO SERVE

Recent national fiscal challenges have left military families confused and concerned about whether the programs, resources, and benefits contributing to their strength, resilience, and readiness will remain available to support them and be flexible enough to address emerging needs. The Department of Defense must provide the level of programs and resources to meet these needs.

Service members and their families have kept trust with America, through more than 16 years of war, with multiple deployments and separations. We ask the nation to keep the trust with military families and not try to balance budget shortfalls from the pockets of those who serve.

Evolving world conflicts keep our military service members on call. Our military families continue this call as well, even as they are dealing with the long-term effects of almost two decades at war. The government should ensure military families have the tools to remain ready and to provide for the readiness of their service members. Effective support for military families must involve a broad network of government agencies, community groups, businesses, and concerned citizens.

**Appendix A**: Comparison of Medical Facility Access – Kaiser Foundation Health Plan vs. TRICARE Prime

*Without the option of switching to Select, TRICARE Prime families will be trapped in their assigned MTF regardless of access or quality issues.*

**Kaiser Foundation Health Plan Mid-Atlantic States**: Search radius around zip code 22315 (Alexandria/Kingstowne)

| **Hospitals – 20 mile radius** | **Medical Office Buildings – 10 mile radius** |
|---|---|
| Virginia Hospital Center | Burke Medical Center |
| Children's National Medical Center | Falls Church Medical Center |
| Sibley Memorial Hospital | Springfield Medical Center |
| Washington Hospital Center | |

**National Capital Region Medical Directorate**: Search radius around zip code 22315 (Alexandria/Kingstowne)

| **Military Hospitals – 20 mile radius** | **Military Clinics – 10 mile radius** |
|---|---|
| Fort Belvoir Community Hospital | Rader Clinic – Fort Myer |

## Appendix B: Copay/Cost Share Comparison

**TRICARE Select vs. Federal Employee Health Benefit & Fairfax County Public Schools Plans**

**FEHBP Plan Types: Nationwide Fee for Service/PPO - Open to All**

| | Network Outpatient Visits | | | | Diagnostic Tests | | Network Therapy Visits | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan Name | Primary Care | Specialty Care | Urgent Care | ER | Labs | Radiology | Physical | Occupa-tional | Speech | Mental Health |
| TRICARE Select - ADFMs/Group A - Grandfathered | $21 | $31 | $21 | $81 | $0 | $0 | $31 | $31 | $31 | $31 |
| TRICARE Select - Retirees/Group A - Grandfathered | $28 | $41 | $28 | $109 | $0 | $0 | $41 | $41 | $41 | $41 |
| **FEHBP Plans** | | | | | | | | | | |
| BCBS Service Benefit Plan - Standard[1] | $25 | $35 | $30 | 15% | 15% | 15% | $25 | $25 | $25 | $25 |
| GEHA Benefit Plan - High | $20 | $20 | $35 | 10% | 10% | 10% | 10% | 10% | 10% | $20 |
| GEHA Benefit Plan - Standard | $15 | $30 | $35 | 15% | 15% | 15% | 15% | 15% | 15% | $15 |
| NALC - High Option<br>*Not-for-profit plan sponsored by National Association of Letter Carriers AFL-CIO*<br>Administered by Cigna Healthcare | $20 | $20 | $20 | 15% | 15% | 15% | $20 | $20 | $20 | $20 |
| MHBP - Standard Option[2]<br>*Sponsored by National Postal Mail Handlers Union*<br>Administered by Aetna | $20<br>$10 | $30 | $5<br>$50 | $200 | 10% | 10% | 10% | 10% | 10% | $20<br>$10 |
| MHBP - Value Option[3]<br>*Sponsored by National Postal Mail Handlers Union*<br>Administered by Aetna | $30<br>$10 | $50 | $15 | 20% | 20% | 20% | 20% | 20% | 20% | $30<br>$10 |
| SAMBA - High Option<br>*Sponsored and administered by Special Agents Mutual Benefit Association* | $25 | $25 | $25 | 15% | 15% | 15% | 15% | 15% | 15% | $25 |
| SAMBA - Standard Option<br>*Sponsored and administered by Special Agents Mutual Benefit Association* | $30 | $30 | $30 | 20% | 20% | 20% | 20% | 20% | 20% | $30 |
| APWU Health Plan - High Option<br>*Sponsored and administered by Americal Postal Workers Union AFL-CIO* | $25 | $25 | $40 | 10% | 10% | 10% | 10% | 10% | 10% | $25 |
| **Fairfax County Public Schools** | | | | | | | | | | |
| CareFirst Blue Choice Advantage[4] | $20 | $40 | $20<br>$40 | 10% plus $150 copay | $0 | $0 | $40 | $40 | $40 | $20 |
| Aetna/Innovation Health | $20 | $20 | 10% | 10% plus $150 copay | 0 | 0 | $20 | $20 | $20 | $20 |

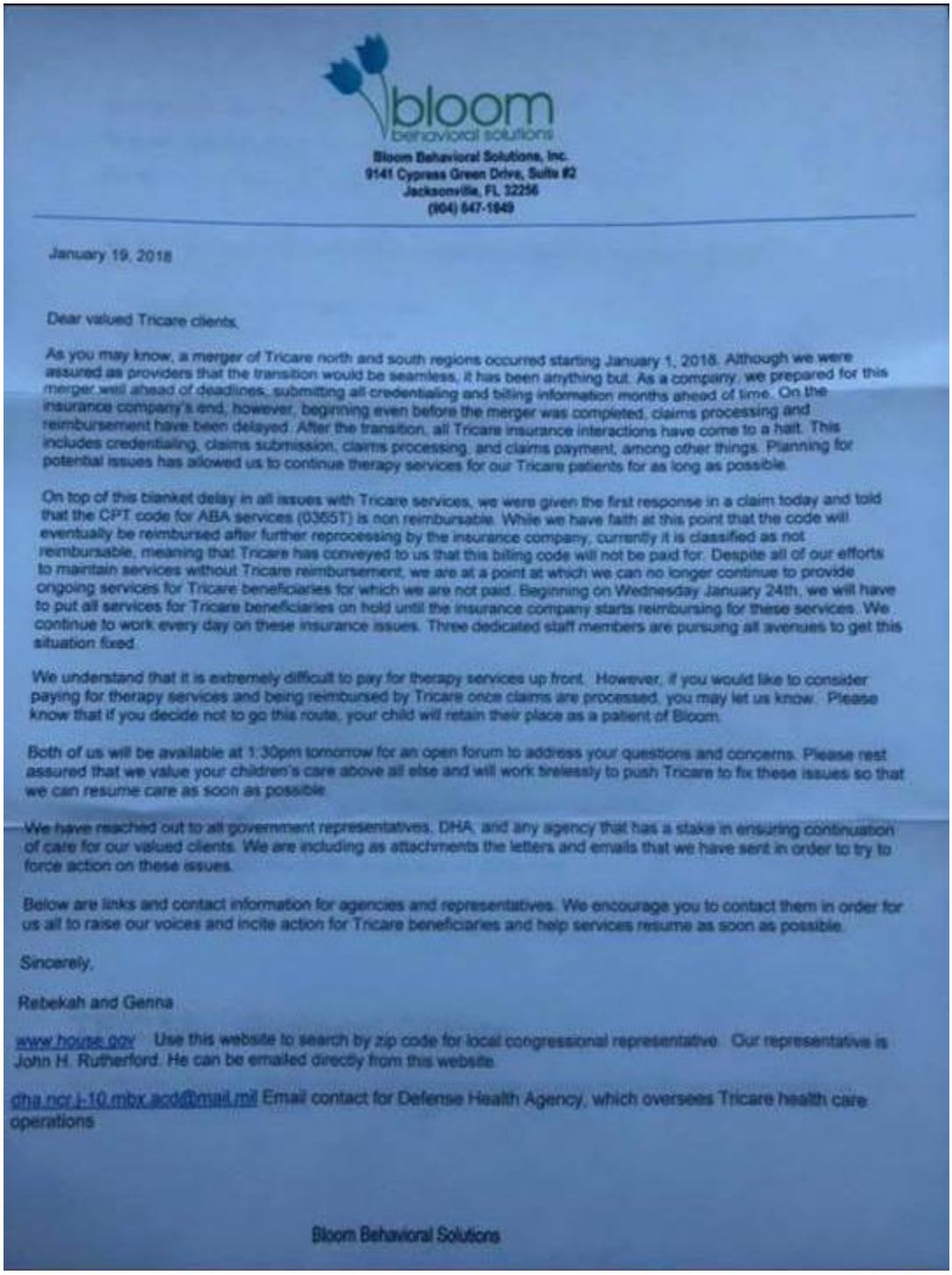
[1]Standard option is closest equivalent to TRICARE Select - FFS with preferred provider network; out of pocket costs lower if you use a preferred provider. Basic option limited to preferred providers only

[2]Standard option has a $20 primary care office visit copay for adults, $10 office visit copay for children < 21; $5 copay for convenience clinics and $50 for urgent care facilities

[3]Value option has a $30 primary care office visit copay for adults, $10 office visit copay for children < 21

[4]FCPS CareFirst Blue Choice Advantage has a $20 copay for a Retail Health Clinic and a $40 copay for Urgent Care

**Appendix C**: Examples of ABA Provider Service Suspension Notices to TRICARE Patients



bloom
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January 19, 2018

Dear valued Tricare clients,

As you may know, a merger of Tricare north and south regions occurred starting January 1, 2018. Although we were assured as providers that the transition would be seamless, it has been anything but. As a company, we prepared for this merger well ahead of deadlines, submitting all credentialing and billing information months ahead of time. On the insurance company's end, however, beginning even before the merger was completed, claims processing and reimbursement have been delayed. After the transition, all Tricare insurance interactions have come to a halt. This includes credentialing, claims submission, claims processing, and claims payment, among other things. Planning for potential issues has allowed us to continue therapy services for our Tricare patients for as long as possible.

On top of this blanket delay in all issues with Tricare services, we were given the first response in a claim today and told that the CPT code for ABA services (0365T) is non reimbursable. While we have faith at this point that the code will eventually be reimbursed after further reprocessing by the insurance company, currently it is classified as not reimbursable, meaning that Tricare has conveyed to us that this billing code will not be paid for. Despite all of our efforts to maintain services without Tricare reimbursement, we are at a point at which we can no longer continue to provide ongoing services for Tricare beneficiaries for which we are not paid. Beginning on Wednesday January 24th, we will have to put all services for Tricare beneficiaries on hold until the insurance company starts reimbursing for these services. We continue to work every day on these insurance issues. Three dedicated staff members are pursuing all avenues to get this situation fixed.

We understand that it is extremely difficult to pay for therapy services up front. However, if you would like to consider paying for therapy services and being reimbursed by Tricare once claims are processed, you may let us know. Please know that if you decide not to go this route, your child will retain their place as a patient of Bloom.

Both of us will be available at 1:30pm tomorrow for an open forum to address your questions and concerns. Please rest assured that we value your children's care above all else and will work tirelessly to push Tricare to fix these issues so that we can resume care as soon as possible.

We have reached out to all government representatives, DHA, and any agency that has a stake in ensuring continuation of care for our valued clients. We are including as attachments the letters and emails that we have sent in order to try to force action on these issues.

Below are links and contact information for agencies and representatives. We encourage you to contact them in order for us all to raise our voices and incite action for Tricare beneficiaries and help services resume as soon as possible.

Sincerely,

Rebekah and Genna

www.house.gov Use this website to search by zip code for local congressional representative. Our representative is John H. Rutherford. He can be emailed directly from this website.

dha.ncr.j-10.mbx.acd@mail.mil Email contact for Defense Health Agency, which oversees Tricare health care operations

Bloom Behavioral Solutions

**Appendix C**: Examples of ABA Provider Service Suspension Notices to TRICARE Patients (cont.)