NATIONAL MILITARY FAMILY ASSOCIATION

Together we're stronger

Statement

of the

NATIONAL MILITARY FAMILY ASSOCIATION

Before the

Subcommittee on
Military Personnel

of the

UNITED STATES HOUSE OF REPRESENTATIVES
ARMED SERVICES COMMITTEE

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The National Military Family Association is the leading nonprofit organization committed to strengthening and protecting military families. Our over 40 years of accomplishments have made us a trusted resource for families and the Nation's leaders. We have been at the vanguard of promoting an appropriate quality of life for active duty, National Guard, Reserve, retired service members, their families and survivors from the seven Uniformed Services: Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

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*.

Karen Ruedisueli, Government Relations Deputy Director
Karen Ruedisueli joined the National Military Family Association as a Deputy Director of Government Relations in May, 2013. In her role, she conducts research, monitors issues, and advocates for families of the uniformed services. Karen's focus is on military family health care, including the direct care system, TRICARE, and behavioral health care. In this capacity, she represents the Association on The Military Coalition's (TMC) Health Care Committee. Karen also handles issues related to wounded warriors and caregivers, suicide prevention, child and domestic abuse, and military sexual trauma.

A graduate of the University of Michigan, Karen previously worked as a marketing professional and management consultant. She has extensive experience in market research, brand strategy, and new product/service development. Karen has helped clients such as Sara Lee, Frito-Lay, General Mills and the *Chicago Tribune* assess the effectiveness of their marketing initiatives and develop new product and brand strategies. She has also been a guest lecturer at Northwestern University's Kellogg Graduate School of Management on the topic of brand-based innovation.

As an Army spouse, Karen has had extensive volunteer experience identifying and resolving military family issues. She was an active member of the Family Readiness Group (FRG) and served as a Battery level FRG Leader during the unit's train up and deployment to Afghanistan. She also served as the Co-Director of Research for Blue Star Families and led the development and analysis of their first Military Family Lifestyle Survey. Karen has lived at Fort Sill, MCB Quantico, Fort Drum and Fort Leavenworth. She and her husband, MAJ G. Kurt Ruedisueli, currently reside in the Washington D.C. metro area with their two children.

Executive Summary

The National Military Family Association (NMFA) appreciates the creation by Congress of the Military Compensation and Retirement Modernization Commission (MCRMC or the Commission) and we thank the commissioners and their staff for their work over the past 18 months.

Recommendation 5: Ensure service members receive the best possible combat casualty care by creating a joint readiness command, new standards for essential medical capabilities, and innovative tools to attract readiness-related medical cases to military hospitals.

Recommendation 6: Increase access, choice and value of health care for active duty family members, Reserve Component members, and retirees

Readiness First

The MCRMC recognizes the Military Health System's (MHS) dual mission by making two separate recommendations aimed at modernizing the MHS. The proposed Joint Readiness Command (JRC) is charged with ensuring service members receive the best possible combat casualty care while the TRICARE Choice concept proposes a new way to deliver the health benefit. We agree with the MCRMC assessment that the two proposals are interdependent. While the JRC and TRICARE Choice recommendations must be in sync, the MHS must start with maintaining and improving readiness as the primary objective of any modernization proposal. Military families expect the readiness of their service members to perform the mission, as well as the readiness of their medical providers to meet the medical challenges of the battlefield and its aftermath, to be a priority.

National Military Family Association Position on TRICARE Choice

The Commission's health care proposal merits further study and serious consideration. Offering military families a selection of high quality commercial health plans could provide them with better access to high quality care, a more comprehensive set of benefits, and the ability to tailor coverage options based on individual family needs. Our Association believes military families could benefit from increased choice in health care options.

While our Association supports, in principle, the concept of moving military families to high quality commercial health plans, more information and analysis are needed before we can fully endorse the Commission's health care proposal. The MCRMC report raises several questions and areas of concern. Some segments of the military family community will incur significantly higher out-of-pocket costs versus the current system. Implementation details are sparse for important aspects of the plan. Most importantly, we believe a change of this magnitude demands a more thorough analysis of the potential impact on MTFs to avoid unintended consequences for beneficiaries and military medical readiness.

We agree with Commissioners who have testified before Congress that TRICARE—both the benefit and the system to deliver the benefit—is unsustainable as currently structured. **Specifically, TRICARE's beneficiary satisfaction and fiscal sustainability have both declined.** Given fiscal constraints, future improvements to address beneficiary dissatisfaction are unlikely. In fact, further dilution of the TRICARE benefit seems inevitable. Therefore, we are receptive to alternative ways of delivering the military health care benefit to families.

Our Association believes growing TRICARE beneficiary dissatisfaction and increased cost pressures warrant a reexamination of how DoD delivers the health benefit to military families.

MCRMC Recommendations We Support

- *Recommendation 7: Improve Support for Service Members Dependents with Special Needs*
- *Recommendation 10: Improve Access to Child Care on Military Installations*
- *Recommendation 13: Ensure Service Members Receive Financial Assistance to Cover Nutritional Needs by Providing Them Cost-Effective Supplemental Benefits*
- *Recommendation 14: Expand Space-Available travel to more families of Service members*
- *Recommendation 15: Measure how the Challenges of Military Life Affect Children's School Work by Implementing a National Military Dependent Student Identifier*

We support the proposal to improve support for dependents with special needs, reducing their reliance on state programs that very few are able to access. We thank the Commission for recognizing the importance of child care for the readiness of service members and their families. Making access to Federal nutrition programs easier will help service members and their families meet their nutritional needs. We have supported the need for a Military Student Identifier for several years as a means of tracking graduation rates and other milestones for military children as they move from one school district to another.

Recommendations We Cannot Support

- *Recommendation 2: Provide more options for service members to protect their pay for survivors*
- *Recommendation 11: Safeguard education benefits for Service members by reducing redundancy and ensuring the fiscal sustainability of education programs.*

We cannot support the Commission's recommendation on the Survivor Benefit Plan (SBP), as it does nothing to eliminate the SBP-DIC offset for today's survivors and imposes additional costs on some of the most vulnerable military families. We believe Congress should preserve the full Post 9-11 GI Bill for military families whose service members have already transferred the benefit.

Recommendations Requiring Further Study

- *Recommendation 1: Help more service members save for retirement earlier in their careers, leverage the retention power of traditional Uniformed Service retirement, and give the Services greater flexibility to retain quality people in demanding career fields.*
- *Recommendation 3: Promote service members' financial literacy by implementing a more robust financial and health benefit training program.*
- *Recommendation 9: Protect both access to and savings at Department of Defense commissaries and exchanges by consolidating these activities into a single defense resale organization.*

The proposals for the new retirement system and the health care proposal call for service members and their families to make responsible choices that will require a robust financial training program. We wonder how DoD and the Services will accomplish this financial training for both the service member and his/her spouse. We also have concerns about the proposal to merge commissary and exchange operations and worry about the effect this change would have on the military resale system. We will seek more information on how these proposals could be implemented and encourage Congress to do the same.

Chairman Heck, Ranking Member Davis, and Distinguished Members of the Subcommittee, the National Military Family Association (NMFA) thanks you for the opportunity to present testimony concerning recommendations of the **Military Compensation and Retirement Modernization Commission's** (MCRMC or the Commission) report. Our primary consideration as we read the report was the impact on the quality of life of military families – the Nation's families. We are concerned about the long-term viability and availability of the benefits, programs, and resources that help service members and their families maintain readiness. We appreciate the Military Personnel Subcommittee's 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 more than a decade of war.

Our Association appreciates the creation of the Commission by Congress and we thank the commissioners and their staff for their work over the past 18 months. Their task, to conduct a holistic evaluation of the entirety of the military compensation system, has been a daunting one. Indeed, in our statement before the Personnel Subcommittee of the Senate Armed Services Committee last year, we requested that Congress delay making any substantial legislative changes to personnel policies until the Commission had finished their study. Now it is our turn to comment on the recommendations the Commission has made in their report.

We thank the Commissioners and their staff for seeking insights from our Association and others during all stages of the Commission's process. We surveyed military families for their input and concerns. We prepared a statement and were invited to testify as part of a panel before the Commission in November 2013 to share what we had heard from military families. We encouraged military families to attend the town hall sessions with the commissioners in their localities. We met with commission staff members on numerous occasions to answer questions and to share information. Since the release of the Commission report, we continued to elicit the thoughts of military families on the recommendations.

The main focus of our statement today will be on the Commission's health care recommendations. Additionally, we appreciate the opportunity to share our thoughts on other pertinent recommendations that we feel impact military families. We hope our analysis will be useful to you as you weigh the merits of the recommendations and think about implementation.

MCRMC Health Care Recommendations

Recommendation 5: Ensure service members receive the best possible combat casualty care by creating a joint readiness command, new standards for essential medical capabilities, and innovative tools to attract readiness-related medical cases to military hospitals.

Recommendation 6: Increase access, choice and value of health care for active duty family members, Reserve Component members, and retirees.

Background: The Dual Missions of the Military Health System

The Military Health System (MHS) is unique in that it has dual readiness and benefit provision missions. The MHS readiness mission must achieve both a medically ready fighting force that is

healthy and capable of deploying as needed and a ready medical provider force capable of delivering health and combat-casualty care for service members in operational environments. The MHS benefit provision mission is responsible for providing the earned health care benefit to family members, retirees, and survivors. The two missions intersect when military medical personnel provide care to family members and retirees in the Military Treatment Facilities (MTFs) honing their medical skills in the process.

The MCRMC recognizes the MHS dual mission by making two separate recommendations aimed at modernizing the MHS. The proposed Joint Readiness Command (JRC) is charged with ensuring service members receive the best possible combat casualty care while the TRICARE Choice concept proposes a new way to deliver the health benefit. In both recommendations, the MCRMC acknowledges that the two proposals are interdependent, but cites few – if any – concerns on how one might negatively impact the other.

With our Association's mission and expertise in advocating for military families, we have clear perspectives on how the MCRMC's proposals might impact beneficiaries. However, we also have concerns about how these recommendations could affect the MTFs' future viability and the ability of the MHS to achieve its military medical readiness goals. We realize that while the JRC and TRICARE Choice recommendations must be in sync, the MHS must start with improving readiness as the primary objective of any modernization proposal.

National Military Family Association Position on TRICARE Choice

The Commission's health care benefit proposal merits further study and serious consideration. Our Association believes military families could benefit from increased choice in health care options. Offering military families a selection of high quality commercial health plans could provide them with better access to high quality care, a more comprehensive set of benefits, and the ability to tailor coverage options based on individual family needs.

While our Association supports, in principle, the concept of moving military families to high quality commercial health plans, more information and analysis are needed before we can fully endorse the Commission's health care proposal. The MCRMC report raises several questions and areas of concern. Some segments of the military family community will incur significantly higher out-of-pocket costs versus the current system. Implementation details are sparse for important aspects of the plan. Most importantly, we believe a change of this magnitude demands a more thorough analysis of the potential impact on MTFs to avoid unintended consequences for beneficiaries and military medical readiness.

Why Is Our Association Open to Changing or Dismantling TRICARE?

We agree with Commissioners who have testified before Congress that the TRICARE status quo is unsustainable. TRICARE—both the benefit and the system in place to deliver that benefit—faces pressure on multiple fronts and beneficiaries will continue to feel that pressure as they access care and in the cost of that care. Specifically, TRICARE's beneficiary satisfaction and fiscal sustainability have both declined. Congress has directed DoD to find efficiencies in the MHS. While it has adopted some better business practices, DoD's most-frequently-proposed "efficiency" seems to be raising

beneficiary cost shares. Given fiscal constraints, future improvements to address beneficiary dissatisfaction are unlikely. In fact, further dilution of the current TRICARE benefit seems inevitable. Therefore, we are receptive to alternate ways of delivering the military health care benefit to families.

Beneficiary Dissatisfaction

The Commission's findings regarding TRICARE beneficiary dissatisfaction are on point. Many military families encounter difficulties in using the TRICARE benefit. Among the most common complaints are:

- **Access Challenges:**
  - **TRICARE's cumbersome referral and authorization process** is not only a hassle, but often leads to treatment delays. These are particularly problematic for a highly mobile population that must endure the referral and authorization process after each PCS simply to continue already established specialty care. Military family members with chronic conditions cite examples that the cumulative effect of repeated treatment interruptions has had a negative impact on their long-term health outcomes.
  - **Limited provider networks** pose challenges to families seeking care. Network provider shortages are more pronounced in certain areas of the country and with certain specialties, particularly behavioral health care.
  - **Inadequate access standards and insufficient measures within many MTFs** mask beneficiaries' (including active duty service members') reported difficulties in obtaining appointments. This disconnect was highlighted in the Military Health System Review ordered by Secretary of Defense Chuck Hagel in 2014.

- **Coverage Issues:**
  - **TRICARE is slow to cover emerging technologies and treatment protocols**. Families frequently complain that TRICARE does not cover services commonly reimbursed by commercial plans such as molecular diagnostic tests and intensive outpatient programs for mental health issues.
  - **TRICARE's pediatric coverage is also problematic**. TRICARE is authorized to approve purchased care only when it is "medically or psychologically necessary and appropriate care based on reliable evidence." The Defense Health Agency's (DHA'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." There is no doubt that evidence of effectiveness is a cornerstone of medical necessity, yet such tightly prescribed data for children is not always readily available. Pediatric providers are adamant advocates of robust research for children's health needs, but the reality is strict adherence to this adult-based standard of reliable evidence results in military children being denied care and treatment that is widely accepted and practiced elsewhere in the health care system.

- **Lack of Choice**:
  - TRICARE's **uniform benefit** means that military families cannot choose from various coverage options to best meet their needs. This is frustrating for families who could benefit from nontraditional care such as chiropractic.
  - **Current Reserve Component options pose problems for families** during mobilization/demobilization. Switching to TRICARE when the service member is activated can result in disruptions in care, while maintaining the service member's employer-sponsored health insurance can lead to significant out-of-pocket costs. We have long advocated giving National Guard and Reserve members more flexibility to maintain their employer-sponsored coverage for their families during activation.

- **Customer Service**:
  - **TRICARE is slow to adopt customer service innovations** from the private sector such as the Nurse Advice Line. We advocated for a nurse advice line for several years and many commercial health plans offered nurse advice lines long before DHA rolled out their version in 2014.
  - **TRICARE's contracting process leads to customer service problems** during transitions between regional contractors. In April 2013, military families experienced issues with referral authorization and customer service during the West Region transition to a new managed care support contractor. These issues were compounded by what the Government Accountability Office determined was a lack of oversight by DoD.[1] It took months before beneficiary support was running smoothly under the new contractor.
  - **TRICARE beneficiary communications are inadequate** particularly when dealing with coverage changes. There are numerous instances of TRICARE implementing coverage changes without notifying beneficiaries and/or providers, resulting in beneficiary confusion and, in some instances, significant out-of-pocket expenses. For instance in January 2013, TRICARE ceased reimbursement for lab-developed tests including prenatal and preconception cystic fibrosis screenings. They failed to notify beneficiaries and providers that they were no longer covering this prenatal screening test that has been the standard of care for over ten years. As a result, these tests were not reimbursed and some beneficiaries faced $800 in out-of-pocket charges.

One main reason we support the MCRMC's concept of shifting military families to commercial health plans is that DoD has been well aware of these TRICARE problems, in some instances for years, but has failed to take corrective action.

TRICARE's pediatric coverage is a prime example of DoD's failure to address known issues. Based on urging from pediatric health care stakeholders, the NDAA FY13 mandated a DoD review of military kids' health care and related support. That report, *Study on Health Care and Related Support for Children of Members of the Armed Forces,* identified significant gaps and areas for

[1] **More-Specific Guidance Needed for TRICARE's Managed Care Support Contractor Transitions** GAO-14-505: Published: Jun 18, 2014. Publicly Released: Jun 18, 2014.

clarification related to TRICARE's pediatric reimbursement policies. The **TRICARE for Kids Stakeholder Coalition**, a group of pediatric provider organizations, military and veterans' service organizations (including our Association), disability groups, and military families, has urged DoD to share their plans for implementing solutions and help us identify areas where legislative fixes are necessary. Since the study's release in July 2014, we have met with DHA once to share our reactions to the report, but have not heard any details on next steps. DHA's seeming inability to move forward in a timely manner and engage in transparent communication lowers stakeholder and beneficiary confidence that improvements are possible.

Any discussion of beneficiary dissatisfaction must differentiate between TRICARE as a whole and the direct care system. While we believe most MCRMC findings on TRICARE beneficiary satisfaction are accurate, the report contains some examples (e.g., never seeing the same primary care provider or the inability to choose your providers) that military families tell us are issues most often in the direct care system, not necessarily TRICARE as a whole. It is important to note that the MCRMC's TRICARE Choice proposal does not address beneficiary complaints regarding the direct care system other than by allowing dissatisfied beneficiaries to seek care somewhere else in the hope competition will incentivize the MTFs to improve.

Additionally, it is important to acknowledge there is a segment of the beneficiary population that is satisfied with the current TRICARE system. Some have been fortunate enough never to experience the problems outlined above. Others accept these issues as part and parcel of getting "free" health care. As advocates for military families we focus on solving beneficiary problems and improving the Military Health System but, in the course of our work, we also hear from families who are content with the status quo and won't relate to the dissatisfaction areas outlined in the MCRMC's report. Our concern for these families centers on what could happen to their care if financial pressures take a greater toll on the MTFs or the TRICARE benefit over time. If the status quo is unsustainable, what will happen to their satisfaction with the system and the quality of their care?

Fiscal Sustainability

Year after year, DoD contends that the TRICARE program is fiscally unsustainable as currently structured. Officials highlight the limits Congress has placed on beneficiary cost shares while expanding benefits (e.g., TRICARE for Life). They cite statistics showing the health care budget is growing as a percentage of overall DoD spending. They contend that growing health care costs will limit DoD's ability to fund readiness and modernization. DoD's statistics can be debated, but there is no doubt about the relentless pressure to erode the TRICARE benefit by increasing fees and reducing available resources to the system.

The Defense Health Agency (DHA) points to purchased care as the largest driver of military health care spending. As currently configured, TRICARE has limited options for reducing purchased care spending in ways that won't negatively impact beneficiaries. TRICARE contracts are configured such that providers and beneficiaries have minimal incentives to manage utilization. In fact, certain TRICARE and MTF policies drive beneficiaries to more expensive venues for care. For instance, when acute care appointments are unavailable at the MTF (either because the MTF is closed or

completely booked), TRICARE requires a referral and authorization to seek Urgent Care from a network provider. Some MTFs go a step further and simply refuse to give any referrals to network Urgent Care. Beneficiaries who find themselves in this situation often have no choice but to seek more expensive care at the Emergency Room.

Despite DoD initiatives to become more efficient, cost cutting pressures will continue. Our Association fears attempts to reduce purchased care spending will result in erosion of network provider access and questionable coverage policies. Provider reimbursement rates will continue to decline, resulting in fewer providers participating in the TRICARE network. Alternatively, providers might further limit the number of TRICARE patients they will see due to low reimbursement rates. The result will be diminished access to care for military families. While maintaining the current TRICARE program gives the appearance of delivering a promised benefit, we fear that ongoing cost cutting measures will reduce TRICARE's value in ways that might not be readily apparent to beneficiaries until it's too late and they have no other options.

Our Association believes that growing TRICARE beneficiary dissatisfaction and increased cost cutting pressures warrant a reexamination of how DoD delivers the health benefit to military families.

Evaluating TRICARE Choice: Advantages for Military Families

Our Association believes the Commission's health care proposal has the potential to provide military families with a more robust and valuable health care benefit than they have today. Offering families a selection of high quality commercial health plans could provide them with better access to high quality care, a more comprehensive set of benefits, and the ability to tailor coverage options based on individual family needs. We also appreciate the Commission's efforts to maintain minimal out-of-pocket costs for active duty families. We also thank the Commission for its recommendation to keep the TRICARE for Life benefit for our Medicare-eligible beneficiaries as it is today. TRICARE for Life is working the way Congress intended.

Our Association supports the concept of transitioning active duty military families, as well as working-age retirees and their families and survivors, to a high quality DoD health benefit program since it would offer the following advantages:

- **Enhanced Access to Care**:
  - TRICARE Choice promises to offer beneficiaries **more robust provider networks** with greater access to primary care and specialists. Since commercial health plans reimburse providers at market rates versus the discounted Medicare rates TRICARE offers, they are able to attract more providers to their networks.
  - TRICARE Choice should **streamline access to specialty care**. Many commercial plans allow beneficiaries to direct their own health care. Even families who elect an HMO type plan should find less cumbersome referral and authorization processes than they currently face with TRICARE.
  - A selection of national commercial health plans should **streamline the transition of care during most PCS moves**. Under TRICARE Choice, families will not have to modify their

enrollment when moving from one area of the U.S. to another, assuming they have selected a TRICARE Choice plan with national coverage.
  - **Barriers to Urgent Care will be eliminated** with TRICARE Choice**.** Families will be able to elect plans that do not require a referral and authorization for Urgent Care.
  - **Beneficiaries retain access to MTFs** for medical care with TRICARE Choice. Many military families are familiar and comfortable with MTFs. Others value MTF providers' cultural competency and sensitivity to military family challenges. It is important that TRICARE Choice offers beneficiaries continued access to MTF care.

- **Better Coverage Policies**: Commercial health plans should reduce problems with TRICARE coverage, such as questionable pediatric reimbursement policies and lack of coverage for emerging technologies and treatment protocols. Coverage decisions would no longer be subject to rigid TRICARE regulations regarding medical necessity, the hierarchy of reliable evidence, and, in some cases, the additional step of requiring Congressional approval for a new benefit. While beneficiaries certainly want safe and effective treatment, commercial plans would offer more comprehensive coverage for services and procedures widely accepted by the medical community that don't meet TRICARE's rigid standards. Whether or not a procedure is medically necessary would no longer be a DoD decision.

- **Greater Choice**:
  - TRICARE Choice would allow military families to **tailor coverage** to best meet their needs versus the current TRICARE benefit that provides uniform coverage and meets some families' needs better than others.
  - TRICARE Choice plans would offer **coverage options that are currently unavailable** such as vision, chiropractic, and acupuncture.
  - More robust provider networks should give beneficiaries **greater choice in selecting their providers**.
  - We appreciate that the MCRMC recognized the patient care management tools used by **US Family Health Plan (USFHP)**. USFHP knows our community and has high satisfaction among beneficiaries. We agree with the MCRMC suggestion that some USFHP plans could continue as TRICARE Choice options for military families since we believe most USFHP families would like to retain their coverage.
  - **National Guard and Reserve members will have more attractive options** under TRICARE Choice.
    - We have long advocated for more flexibility in allowing Guard and Reserve members to retain their employer sponsored health plan for their families while activated. The Basic Allowance for Health Care (BAHC) gives them the option of applying BAHC to their employer plan premiums. This will enable Reserve Component families to maintain continuity of medical care during service member activation.
    - For families that prefer using TRICARE during activation, a menu of commercial plans will better serve Guard and Reserve members in areas not near a military installation where current TRICARE networks may be particularly weak.

- **Minimal Active Duty family out-of-pocket costs** (in principle)**.** Although we are not convinced the current MCRMC proposal completely insulates active duty families from excessive medical expenses, we appreciate that the Commission acknowledges the principle of minimal out-of-pocket costs for active duty families and proposes the creation of the Basic Allowance for Health Care to give families a way to cover their health care costs.

Underpinning our assessment of TRICARE Choice advantages is the assumption that the menu of commercial plans would be comparable to or better than those offered via the Federal Employee Health Benefit Program (FEHBP.) We believe this is a valid assumption since the MCRMC uses FEHBP as a point of reference in their report and suggests that the Office of Personnel Management (OPM) manage the DoD program due to their proven track record with FEHBP.

Our Association believes the Commission's TRICARE Choice health care proposal has the potential to provide military families with a more robust and valuable health care benefit than they have today. However, while we are open to the idea of transitioning military families to commercial health plans, the MCRMC report raises questions and concerns that must be addressed before we can fully support the Commission's health care proposal.

Evaluating TRICARE Choice: Areas of Concern and Clarification
First, we believe a change of this magnitude demands a more thorough analysis of the potential impact on MTF caseload to avoid unintended consequences for beneficiaries and military medical readiness. Second, some segments of the military family community will incur significantly higher out-of-pocket costs versus the current system. Third, implementation details are sparse for important aspects of the plan.

1. TRICARE Choice's Impact on MTFs/Military Medical Readiness is Unclear
Even though the MTFs will remain an integral component of military family health care delivery under the MCRMC's proposal, the report contains very few details on the potential impact TRICARE Choice might have on the direct care system. We have the following concerns:

- The MCRMC report contains **no analysis of TRICARE Choice's impact on MTF caseload.** TRICARE Choice makes two radical changes to beneficiary health care. It introduces a co-pay for MTF treatment and it provides unfettered access to civilian providers. Yet, there is no analysis of the potential impact these changes might have on MTF beneficiary caseload.
  - From a beneficiary standpoint, will DoD still insist on the option of employing "sticks" to drive beneficiaries back into the MTFs if the lower co-pay "carrot" is insufficient motivation? DoD has frequently employed the "stick" approach to pull the patients it needs into the direct care system, most recently in the "MTF recapture" efforts that limited TRICARE Prime beneficiaries' ability to enroll with a civilian network Primary Care Manager even if they had already established a relationship with that doctor. It's been our experience that many military medical providers believe they must maintain the ability to force military families into the MTFs in order to maintain needed skills and patient loads.
  - From a readiness standpoint, what happens if a significant percent of family members and retirees elect to leave the MTF and receive care in the civilian market and the MTFs no

longer have means to force them in when they need the bodies for training and maintaining provider proficiencies? Will the MTFs remain viable? The MCRMC recommendation seems to assume MTFs will respond to patients' new opportunities for choice by improving quality and other enhancements to draw beneficiaries in. What happens if their efforts aren't enough?

- The Joint Readiness Command (JRC) is charged with attracting a different mix of medical cases into MTFs to better support combat-care training and medical readiness. We are pleased the Commission emphasized that care for active duty service members is a key part of readiness and so proposed no changes in how they would get their care. We hope the readiness focus they propose will improve the care and readiness of service members for their missions. We understand and appreciate the goal of bringing new Essential Medical Capability (EMC) cases into the MTFs as part of that readiness focus. However, **we are skeptical the tools the MCRMC suggests for the JRC will be sufficient in attracting the necessary caseload**, particularly if currently enrolled beneficiaries leave the MTFs in great numbers.
  - The ability to adjust MTF reimbursement rates is cited as one tool to attract EMC cases, but decisions on where to seek medical care, particularly in trauma and complex cases, typically do not involve price. Since price shopping isn't currently a significant factor in consumer behavior for medical care decisions, we question how much impact alternative prices would have in attracting EMC cases to MTFs.
  - Another tool the MCRMC outlines for the JRC is establishing commercial reimbursement rates and associated billing systems, improving authorities, and allowing greater access to veterans and civilians with relevant complex cases and trauma. However, the MTFs would be competing for these cases with established medical systems that employ marketing departments and campaigns as well as established relationships in the local community. Simply opening the MTFs to the broader community may not be enough to attract the desired EMC cases.
  - The MCRMC report states that financial incentives, specifically lower co-pays at MTFs versus those for civilian providers, would encourage beneficiaries to seek care at the MTFs. However, beneficiaries currently pay nothing out-of-pocket for MTF care and it is unclear what impact a co-pay will have on beneficiary decisions regarding where to seek care.

- **From a JRC implementation standpoint, it is unclear who would be responsible for working out the details at the individual MTF level.** Who sets the standards for what services and medical specialties will be available at the MTF? Is that an MTF commander decision? A Service decision? A Joint Medical Command might have had more authority over MTF implementation. It seems there is high potential for inconsistencies and lack of coordination on readiness needs.

- The MCRMC report is **unclear on the magnitude of the desired shift from beneficiary care to EMC cases**. If the goal is a major shift away from beneficiary care (such as labor/delivery/newborn care), is there sufficient civilian medical capacity to absorb increased demand for care from military families, particularly in remote locations with significant troop

concentrations, such as Twentynine Palms, California; Fort Polk, Louisiana; and Fort Riley, Kansas?

- **TRICARE Choice does nothing to address access and quality issues within the MTFs.** Although the MCRMC report highlights areas where beneficiaries are unsatisfied with the direct care system, their proposal does nothing to address those complaints other than to say beneficiaries can now vote with their feet and go elsewhere for care. In fact, the renewed emphasis on combat casualty care skill building, while critically important for military medical readiness, might actually exacerbate problems with care for family members and other beneficiaries. What will the process be for determining the level at which MTFs will participate as network providers in the TRICARE Choice civilian plans and for managing that participation as MTF staffing and focus on the EMCs evolves?

TRICARE Choice introduces radical changes to the beneficiary health benefit with no estimate of the impact on MTF caseload. While the Joint Readiness Command proposal calls for a strategic shift to EMC cases in the MTFs, details on this transition are sparse. We believe a change of this magnitude demands a thorough analysis, including a forecast of beneficiary demand for MTF services under TRICARE Choice and an estimate of the likely increase in EMC cases within the direct care system.

2. Potential for Significant Out-of-pocket Costs

Active Duty Families

The MCRMC report acknowledges that TRICARE Choice will result in increased out-of-pocket costs and these higher costs would effectively reduce overall active duty compensation if they were not offset with the creation of the Basic Allowance for Health Care (BAHC). Although we appreciate the MCRMC's attempt to address this issue, we are not convinced the current proposal sufficiently insulates active duty families from excessive out-of-pocket health care expenses for the following reasons:

- **TRICARE Choice's Catastrophic Cap is Unspecified**: A key advantage of the current TRICARE plan is a low catastrophic cap. By limiting annual out-of-pocket expenses to $1,000 per family, the current TRICARE benefit limits the financial risk currently serving families face from health care costs. The catastrophic cap amount for TRICARE Choice plans is not specified, so we have no way of assessing the financial risk families would face under the MCRMC's proposal. We must have details on this element of TRICARE Choice to complete our evaluation.

- **Details are Sparse on the Chronic/Catastrophic Program:** The MCRMC proposes that active duty families facing chronic or catastrophic conditions and resulting copayments that substantially exceed their BAHC could receive assistance from a new catastrophic fund. But, the report provides very few details on this program. How would eligibility be determined? What process would families follow to apply for the fund? Would there be an appeals process? What portion of costs exceeding BAHC would be reimbursed? There is no mention of adjusting the program based on lessons learned. Implementation must include a mechanism for adjusting policies and processes to ensure the program achieves the desired outcomes. We fear that

applying for this fund would become another hurdle for families facing already challenging circumstances. More importantly, given one of the main benefits of TRICARE Choice is removing DoD from the coverage determination process, we are opposed to giving DoD authority over coverage decisions for families with chronic or catastrophic conditions.

- **The BAHC Formula Raises Concerns**:
  - BAHC is calculated to cover the premium cost share of the health plan selected in the prior year by the *median active duty family*. This methodology introduces risk that the BAHC will be eroded over time if families scrimp on their choice of plans. We contend **there should be a high standard for the type of plan that is appropriate for military families** given the impact of family member health on service member readiness. The quality of health plans for military families should also be commensurate with the extraordinary sacrifices made by service members and their families. The level of the BAHC should be set based on the costs of plans available for their location in the current year and not on what families chose in the prior year.

  - Under the TRICARE Choice plan, **large families become vulnerable to higher out-of-pocket expenses**. The portion of BAHC intended to cover out-of-pocket costs is calculated as the average copayment amount by all active duty family member beneficiaries in the prior year. Although details are limited, the MCRMC has confirmed to us BAHC would not vary based on family size. While there would be no difference in family premiums based on family size, a large family will almost certainly incur higher copayment expenses than the "average" family and those additional expenses will not be covered by BAHC. The current TRICARE benefit provides a zero out-of-pocket cost option for health coverage for all active duty families regardless of family size. TRICARE Choice should be modified to minimize out-of-pocket costs for larger than average families.

To move beyond the principle of minimal out-of-pocket costs and gain more visibility on the financial impact of TRICARE Choice on actual military families, we would like to see more data on out-of-pocket expenses for a variety of family circumstances (family size plus high/med/low health care utilization) crossed against a variety of plan types to get a better understanding on potential out-of-pocket expenses.

Although the MCRMC states its goal is to minimize out-of-pocket expenses for active duty families to avoid a reduction in overall active duty compensation, several elements of the TRICARE Choice proposal could lead to significant out-of-pocket costs for some families. The BAHC calculation must ensure a baseline of excellent medical coverage with minimal out-of-pocket expenses for all active duty families. The MCRMC must also be more transparent about the risk of out-of-pocket costs by providing specifics on TRICARE Choice plans' catastrophic cap(s) and the chronic/catastrophic program.

Non-Medicare Eligible Retirees

The MCRMC report acknowledges that beneficiaries will incur higher out-of-pocket expenses with TRICARE Choice versus the current benefit. For active duty families, as outlined above, the MCRMC seeks to mitigate these higher costs with BAHC so as to avoid reducing overall active duty compensation. Retirees would not receive BAHC and would thus be fully responsible for premiums and cost shares. The Commission's proposal focuses on the advantages of choice and states that military retirees should pay a lower premium than civilian employees as a recognition of their service. However, it does not address the perceived reduced value of the military retirement package resulting from TRICARE Choice. While our Association has not opposed moderate TRICARE fee hikes in the past, we believe out-of-pocket expenses for retirees under TRICARE Choice could become too high and diminish the value of the earned retirement benefit unless safeguards are written into law.

- **Premiums and Out-of-pocket Expenses Will Be Significantly Higher than TRICARE as it stands today**: Although the MCRMC report does not provide specifics on premium costs, an ultimate 20 percent premium cost share (after a 15-year ramp-up), higher out-of-pocket expenses, and copays associated with the civilian could be as much as thousands of dollars more per year than retirees currently pay for TRICARE Prime. We agree with the Commission, however, that the availability of additional benefits and automatic coverage of adult children up to age 26 at no additional premium may partly close the gap between what retirees currently pay under TRICARE and what they would pay under TRICARE Choice when fully implemented.

- **TRICARE Choice's Catastrophic Cap is Unspecified**: A key advantage of the current TRICARE plan for retirees is a low catastrophic cap. By limiting annual out-of-pocket expenses to $3,000 per family, the current TRICARE benefit limits the financial risk military retiree families face from health care costs. The catastrophic cap amount for TRICARE Choice plans is not specified, so we have no way of assessing the financial risk retiree families would face under the MCRMC's proposal. We must have details on this element of TRICARE Choice to complete our evaluation, but it's important to acknowledge that DoD has proposed increases to the retiree catastrophic cap under the current system.

As we have stated, we believe pressures on the current system will result in increased beneficiary costs and so understand an accurate forward-looking "apples to apples" comparison between TRICARE as it might be in ten years vs. TRICARE Choice does not exist. We do appreciate the Commission recognized the need for a fifteen-year transition to the 20 percent cost share ceiling for working-age retirees and that they recognized the government's responsibility to absorb a higher level of the premium costs for military retirees than for civilians in recognition of their military service. However, current retirees and currently serving career military members developed an understanding of the value of their retirement health care benefit based on over two decades of TRICARE history. Just as higher out-of-pocket costs associated with TRICARE Choice would reduce overall active duty compensation if not offset by BAHC, even higher premium and out-of-pocket costs for non-Medicare eligible retirees reduces the value of the earned retirement benefit package. While we accept the inevitability working age retirees will pay more for their health care in the

future, we believe TRICARE Choice, as proposed by the Commission, may go too far in undercutting the earned retirement benefit.

Wounded Warriors/Medically Retired Service Members

The MCRMC's TRICARE Choice proposal makes no mention of wounded warriors or medically retired service members. This omission must be addressed before we can fully assess TRICARE Choice. We do have two main concerns regarding TRICARE Choice for wounded warriors as it is currently presented:

- **Out-of-pocket Expenses**: Currently, non-Medicare eligible medically retired service members receive the same TRICARE benefit as all other non-Medicare eligible retirees. We believe any changes to the TRICARE benefit must maintain minimal out-of-pocket costs for medically retired service members. The MCRMC's TRICARE Choice proposal, with its high out-of-pocket expenses for non-Medicare eligible retirees, is not an acceptable benefit for wounded warriors and their families. We also need more information on how TRICARE Choice plans will work for the families of retired wounded warriors and other military retirees who may receive some or all of their care from the VA or be eligible for Medicare Part B because of their injuries.

- **Severely Injured Wounded Warriors**: We are disappointed that the MCRMC proposal does not address out-of-pocket expenses the severely wounded currently face to maintain their medical coverage. Specifically, if an individual is so severely injured that he/she qualifies for Social Security Disability Insurance (SSDI) for 2 years, he automatically qualifies for Medicare Part B. Qualified individuals **MUST** take Part B in order to maintain TRICARE status. If an individual fails to enroll in Part B, he **LOSES** both TRICARE and Medicare coverage and must wait an extensive period of time and pay significant penalties to re-enroll. For many severely injured individuals, this means they lose all access to their previous healthcare providers and/or options for other healthcare needs. The current cost for Part B coverage is approximately $110/month. This amount increases regularly.

Our Association requests more information from the Commission on how TRICARE Choice will be configured for medically retired service members and their families. We also ask the Commission to consider the problems the severely wounded face in accessing their health care benefit as part of their modernization proposal.

The MCRMC must be more transparent and detailed about the potential out-of-pocket costs faced by all beneficiary categories.

- ***The BAHC calculation must be modified to ensure it covers out-of-pocket expenses for an excellent baseline plan for all active duty families regardless of family size.***

- ***TRICARE Choice's out-of-pocket expenses for non-Medicare eligible retirees must not reduce the value of the earned retirement benefit package.***

- ***Finally, consideration must be given to how TRICARE Choice will work for medically retired service members to ensure minimal out-of-pocket costs for wounded warriors and their families.***

3. Concerns Regarding TRICARE Choice Implementation Details

Many TRICARE Choice implementation details are lacking in the Commission's proposal. We have identified several issues, which must be addressed to ensure successful implementation of a complex program:

- **Ensuring Coverage Meets Unique Military Family Needs**: We appreciate that the MCRMC proposal says DoD should provide OPM with recommendations on the unique needs of the eligible Uniform Services beneficiary population. However, we would like assurances on some specifics:
  - For military families who move frequently, a variety of high quality national plans is critical. Selecting a national plan will be the only way for mobile families to avoid a deductible and catastrophic cap reset with each move. National plans will also maintain coverage consistency and lessen disruption and hassle during geographic moves.
  - It is important coverage DoD has already deemed necessary and appropriate for military beneficiaries, via inclusion in the current TRICARE benefit, is part of TRICARE Choice commercial plans. For instance, TRICARE covers Applied Behavior Analysis (ABA) for beneficiaries regardless of location, whereas FEHB plans only cover ABA in states that mandate ABA coverage. ABA coverage that varies from state to state is not suitable for a mobile military population. Similarly, TRICARE offers beneficiaries access to behavioral health care without referral or prior authorization. We would expect similar accommodations for behavioral health care access in TRICARE Choice Plans.
  - It is essential commercial plans and BAHC policies take into account the unique situations military families face. Many families geo-bach—that is, the service member lives in a different location from his/her family members due to the spouse's career, kids' education or other considerations. Other families relocate during lengthy service member deployments. Policies must be in place to ensure these unique situations do not put military families at risk for higher costs or coverage lapses.

- **Beneficiary Education and Communication**: TRICARE Choice would require an unprecedented level of beneficiary communication and education.
  - Under TRICARE Choice, service members continue to receive care through the military, but the spouse and family members are covered under the new health plans. Therefore, the service member AND spouse must be educated on how to select the best plan for their family. This includes the basics of commercial health insurance (e.g., definitions of premium, deductible, cost share, co-pay), tools to help select the best plan for the family, and scenario planning to help families understand the trade-offs and potential out-of-pocket expenses associated with various options.
  - This education process must be ongoing, as many families will face new health plan choices every 2-3 years with PCS moves. They will not only need refreshers on the basics of selecting the right health plan, but they will need information on how coverage varies based

on location, to include what care will be available through the MTFs as network providers in the civilian plans. MTFs must be involved in the education process.

- **Financial Planning Guidance**: BAHC paid directly to service members will be difficult to manage for some. It is critical that financial education prompts service members to create a plan for BAHC that helps them apply the allowance to out-of-pocket medical expenses versus other discretionary spending. The success of the Basic Allowance for Housing has been cited as evidence service members can successfully direct an allowance to its intended purpose. However, unlike housing expenses that are stable and regularly recurring, medical bills are highly variable in amount and timing, requiring more sophisticated budgeting skills.

Given the role spouses play in health care decisions and family finances, it is critical that education and communication programs and resources are designed to accommodate spouses as well as service members. Child care and evening/weekend options are critical factors to achieve spouse participation in any in-person classes. If the service member is responsible for selecting a plan and that service member is deployed, how will the spouse—who in all likelihood will be the person managing the family's use of the health plan—be involved in the decision on which plan to choose?

While all Americans face a learning curve when making health insurance decisions, it is imperative service members and their families are prepared to successfully navigate TRICARE Choice's commercial health plan options. Military families lead complicated, stressful lives. We cannot set them up for additional challenges related to health care and finances. Additionally, the impact of poor choices, including limited access to health care or financial problems associated with unpaid medical bills, has the potential to reverberate beyond the individual family and negatively impact military readiness. Providing effective education on health care choices for service members and their spouses while they on active duty will ultimately benefit them as they make the transition to civilian life after their service.

Concluding Thoughts on the MCRMC's TRICARE Choice Proposal

Recent media coverage and Congressional hearings, together with the legislative language included in the report, imply the MCRMC report should be viewed as a turnkey plan, ready for implementation. Given the number of unanswered questions regarding the health care proposal, we view the TRICARE Choice proposal as a first step in a needed process toward change. While we believe the MCRMC health care concept has merit and we support the idea of moving military families to high quality commercial health plans, the MCRMC proposal requires much more analysis and concept optimization before it could be implemented. The statute authorizing TRICARE Choice must also set clear baseline standards that ensure families have access to high quality plans that meet their unique needs at the best possible cost.

Furthermore, change of this magnitude will take some time to implement. In the meantime, we encourage Congress and DoD to seek solutions to the many problems described by the MCRMC report as they relate to military family health care. These issues deserve to be addressed without

waiting for wholesale change. Ensuring the current system is still held accountable, while developing ideas for the future is a very important way Congress and the DoD can build and repair trust with the families who depend on their military health care benefit.

MCRMC Recommendations We Support

We appreciate the opportunity to comment on other recommendations from the Commission report that affect the quality of life of military families.

Recommendation 7: Improve Support for Service Members Dependents with Special Needs

Expand Benefits Available through ECHO

The Commission's proposal to improve support for military families with special needs family members by increasing benefits available through the Extended Care Health Option (ECHO) program is a critical step in easing challenges faced by these families. **Our Association supports this proposal without reservation.**

Additionally, we ask: 1) Congress consider extending ECHO eligibility to families for one year after retirement or separation to ensure they have access to much-needed care and services for their special needs family member, and 2) DoD review procedures for accessing care through ECHO to remove unnecessary requirements and ease the process for vulnerable military families.

Caring for children with complex medical needs can be incredibly expensive. Such children often require nutritional support, incontinence supplies, and other costly items vital to their care but non-medical in nature and therefore not covered by some insurance plans, including TRICARE. Most families in this situation ultimately turn to state Medicaid programs, which provide this kind of assistance through waiver programs to individuals whose families do not qualify based on income. Because the demand for these services far outstrips the supply, lengthy waiting lists to receive assistance are common in most states. For that reason, these services are often out of reach for a military family who must relocate every two to three years. A military family who places their special needs child on a Medicaid waiver waiting list must start again at the bottom of the waiting list whenever they move to a new state.

The ECHO program was designed in part to address this imbalance, by allowing military families with a special needs child or spouse to access non-medical services not covered under TRICARE. According to TRICARE's website, benefits covered under ECHO include "training, rehabilitation, special education, assistive technology devices, institutional care in private nonprofit, public and State institutions/facilities and, if appropriate, transportation to and from such institutions/facilities, home health care and respite care for the primary caregiver of the ECHO-registered beneficiary." However, in practice military families have found it difficult to obtain services through the program.

This reality was reflected in TRICARE's May 30, 2013 report, "The Department of Defense Report to Congress on Participation in the Extended Care Health Option (ECHO)," detailing military families' usage of the ECHO benefit. In 2012, DoD reported 99 percent of funds expended through the ECHO program were spent on Applied Behavioral Analysis (ABA) therapy and ECHO Home Health Care (EHHC)[2]. Although these services are important and popular with special needs families, it is impossible to see this statistic and not wonder why families are not accessing the long list of other services ostensibly available to them under ECHO.

In our Association's view, there are two reasons why special needs military families are not utilizing the ECHO program. First, as the Commission also noted, ECHO simply does not cover many of the products and services needed by special needs families. For example, many families need larger than normal diapers for their disabled children. ECHO deems diapers a convenience item and will not pay for them, although state Medicaid programs regularly pay for incontinence supplies. Aligning ECHO benefits more closely with state Medicaid programs, as the Commission recommends, would provide much needed support to special needs military families.

ECHO services are also under-utilized due to the procedural hurdles TRICARE has put in the path of those seeking benefits. An example is the policy regarding respite care. For families with special needs children, the time away afforded by respite care is vital. Access to quality respite care allows families to run errands, spend time with other children, and simply recharge. Respite care is ostensibly available through the ECHO program, but TRICARE policies limit its utility. Specifically, TRICARE requires families use another service through ECHO in any month that respite care is also provided. We are grateful the Commission recommended eliminating this requirement, which creates an artificial barrier preventing families from accessing needed care.

We have heard reports that special needs families may soon find their access to respite care limited as the military Services eliminate or reduce respite care they provide through the Exceptional Family Member Program (EFMP). Each Service operates its own EFMP program designed to assist special needs families with assignment coordination, referral and family support. As part of their family support, the Services' EFMP programs provide respite care for military families with eligible special needs family members. We have been told that the Army intends to eliminate this program and the other Services may soon follow suit. Given this cutback, it is even more important to ensure families can access much-needed respite care using their ECHO benefit.

Need for Transitional Care

We also note the ECHO program is only available to currently serving military families. Families who transition out of the military, whether through retirement or separation, immediately lose eligibility for ECHO benefits. This abrupt cutoff places an undue burden on families who are already coping with the stress of caring for a special needs family member. While families may eventually

[2] The Department of Defense Report to Congress on Participation in the Extended Care Health Option (ECHO), May 30, 2013, available at http://tricare.mil/tma/congressionalinformation/downloads/ExpansionEvaluationEffectivenessTRICAREProgramECHO.pdf

be able to access services through state Medicaid programs, they often face long waiting lists, which leads either to gaps in treatment or financial hardship for a family trying to pay for needed care. As more service members and families transition out of the military, this problem will become more widespread. To ease the hardship for families in this situation, we recommend ECHO eligibility be extended for one year following separation or retirement to provide more time for families to obtain services in their communities or through employer-sponsored insurance.

Impediments to Accessing ECHO

Our Association has identified other TRICARE policies that inhibit families' use of ECHO. TRICARE mandates families first use public assistance where available before accessing services through ECHO and requires families to submit a Public Facility Use Certificate explaining why public assistance is unavailable or insufficient when requesting ECHO benefits. Families seeking a respite care provider must find one who meets the strict requirements for such providers set by ECHO. These conditions can be confusing for families already coping with the stress of caring for a disabled family member. We suggest Congress review this and other requirements associated with accessing benefits through ECHO as you evaluate the MCRMC proposal, with the goal of streamlining the process for special needs military families.

Recommendation 10: Improve Access to Child Care on Military Installations

Military Families Need Affordable, Accessible Child Care Where They Live

We are gratified the Commission recognized the importance of high quality, affordable child care to military families. Their recommendation to exempt child care providers from furloughs and hiring freezes is a common sense solution to an issue that has been a source of anxiety for families during recent budget crises. We also appreciate the Commission's concern about the lengthy waiting lists families often confront when seeking care at installation Child Development Centers (CDCs) and agree that funds should be available to expand or modify facilities to increase the number of child care spaces. However, we also note a large number of military families—more than 70 percent—do not reside on an installation. For these families, on-base CDCs may not be the best solution.

According to the *2013 Demographics Profile of the Military Community,* more than 40 percent of service members have children. Of the nearly two million military-connected children, the largest cohort—almost 38 percent—is under age five.[3] 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 that 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.

[3] *2013 Demographics Profile of the Military Community*. Rep. Office of the Deputy Assistant Secretary of Defense (Military Community and Family Policy), http://www.militaryonesource.mil/12038/MOS/Reports/2013-Demographics-Report.pdf

For all of these reasons, many military families rely on child care provided through their installation (either CDCs or in Family Child Care (FCC) homes). Yet, the demand for child care exceeds the supply. Statistics cited by the Commission are supported by the experiences military families share with us: in many locations, the waiting list for care is so long that the CDC is essentially not an option for many families. The problem is exacerbated by the frequent moves associated with military life. Following each Permanent Change of Station (PCS) move, a military family must restart the process of looking for care in their new community and frequently find themselves again at the bottom of the waiting list.

There are three factors contributing to the long waiting lists at installation CDCs: lack of physical space, staffing shortages, and wait list management. We support the Commission's recommendation that Congress reestablish the authority to use operating funds to construct or renovate CDCs. Streamlining the process to build new facilities and/or renovate existing ones could provide the physical space to ensure that more military families can access installation child care. Although, we wonder where funding to operate these new facilities will be found.

We also welcome the Commission's simple, common-sense recommendation to exempt child care providers from hiring freezes and furloughs. High rates of employee turnover are not uncommon at child care centers, both at DoD facilities and in the civilian world. However, high turnover combined with a hiring freeze can make it impossible for CDC directors to staff their facilities appropriately. We also heard from many families in 2013 concerned about how they would find child care if CDC employees were furloughed due to sequestration. No military family should have to worry about losing needed child care because of a budget crisis.

We agree with the Commission that CDCs should improve the procedures they use to manage their waiting lists. Currently lists are unreliable, making it difficult for families to know whether it is worth waiting for a space to open at the CDC or if they should seek care elsewhere. At the same time, if the Services do not have reliable information about the length of their waiting lists it is impossible to ascertain if they are meeting their own standards or allocating resources appropriately.

As stated above, less than 30 percent of military families live on installations, which can make installation child care an inconvenient choice. Many families prefer to seek care near their homes or close to a spouse's job. However, families seeking child care in civilian communities often find the costs are extremely high, much more so than on-base care. For those families, the fee assistance program offered by the Services is invaluable, allowing them to afford quality child care in their communities. We urge the Services to continue funding this program and to expand eligibility so families are assured of finding quality child care regardless of their location.

Recommendation 13: Ensure Service Members Receive Financial Assistance to Cover Nutritional Needs by Providing Them Cost-Effective Supplemental Benefits

Meeting Military Families' Nutritional Needs

We are pleased the Commission chose to address the issue of financial assistance for low-income military families. We have long recognized that, while the majority of military families are able to make ends meet, some families struggle financially. This is especially true of junior enlisted service members with larger families. The Family Subsistence Supplemental Allowance (FSSA) was designed to assist those families by increasing their household income until it reaches 130 percent of the Federal poverty level. However, we agree with the Commission that military families needing nutrition support are better off seeking this aid through the Department of Agriculture (USDA) Supplemental Nutrition Assistance Program (SNAP), both because it is often easier to qualify for SNAP and because that program provides a higher benefit. For this reason, we agree with the Commission that the FSSA program should sunset in the United States, although the program must be maintained overseas. We also agree that more information about the number of military families relying on SNAP is needed. In addition, we also ask Congress to evaluate available nutritional support programs to determine if they are adequately meeting the needs of low-income military families, whatever their location.

The Commission reports just 285 service members received FSSA benefits during fiscal year 2013. At the same time, the number of families receiving benefits through SNAP was much higher, according to figures cited by the Commission based on estimates by the U.S. Department of Agriculture. We agree the low number of families seeking aid through FSSA may be due in part to the application process, which requires the approval of the service member's commanding officer. The anonymity of applying for food stamps and not having your command know about your financial straits may appeal more to the service member.

While SNAP is indeed a significant help to many military families, we note the program's inclusion of Basic Allowance for Housing (BAH) paradoxically means families living in high cost locations do not qualify for assistance while families of similar size and service member rank do in places with lower housing costs. Because BAH only covers the cost of rent and utilities, it does not help families with the higher cost of food, gasoline, and other necessities in areas such as Hawaii, southern California, and Washington, D.C. We ask Congress to evaluate the SNAP program to see if this disparity can be addressed in a way to better meet the needs of low-income military families. We agree DoD needs better visibility over data that can provide information on families on the financial edge who would benefit from food support programs. And, they must analyze the data to determine what other assistance might be needed to support these families.

Recommendation 14: Expand Space-Available travel to more families of Service members

Supporting Military Families During Deployments

We appreciate that the Commission listened to military families in the town halls by responding to their requests for greater access to Space-Available travel during separations. We believe that the ability to change this policy already exists, but raising the issue in the Commission report may bring it higher visibility.

Recommendation 15: Measure how the Challenges of Military Life Affect Children's School Work by Implementing a National Military Dependent Student Identifier

Tracking Military Children's Education Progress

For years, our Association has advocated for creating a national student identifier for military-connected children in public schools. While we have been pleased to see several states begin tracking military students in their classrooms, we agree with the Commission that in order to obtain reliable, consistent data this initiative should be implemented at the federal level. A military student identifier will allow researchers and policy makers to better understand the impact of military life on academic achievement and enable them to direct resources more effectively to support military children.

Our own research has shown that experiencing the repeated, prolonged deployment of a parent can lead military children to show symptoms of stress and anxiety at higher rates than their civilian counterparts[4]. Military children are also more mobile than other students, moving an average of six to nine times between kindergarten and their senior year. There is no data on military students' attendance, graduation rates, performance on standardized tests or other commonly measured indicators of academic achievement. Creating a report-only subgroup of children who have parents or guardians serving on active duty in the seven Uniformed Services, as the Commission suggests, would fill this gap and allow policy makers to more effectively direct programs and services to support military students.

Recommendations We Cannot Support

While we support many of the Commission's recommendations, several of their proposals concern us. We cannot support the Commission's recommendation on the Survivor Benefit Plan, as it does nothing to eliminate the SBP-DIC offset for today's survivors and imposes additional costs on some of the most vulnerable military families. We believe Congress should preserve the full Post 9-11 GI Bill for military families whose service members have already transferred the benefit.

Recommendation 2: Provide more options for service members to protect their pay for survivors

We Need the DIC Offset Eliminated for Today's Surviving Spouses

We appreciate the Commission listening to the concerns of retirees and surviving spouses about the inequity of the Department of Veterans Affairs Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP) annuity. However, we cannot support the recommendation put forth by the Commission giving retired service members the option of funding the elimination of the offset by paying a higher premium.

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[4] Chandra, Anita. *Views from the Homefront: The Experience of Youth and Spouses from Military Families*. Rep. RAND Corporation, http://www.rand.org/pubs/technical_reports/TR913.html

Our Association has long believed the benefit change that will provide the most significant long-term advantage to the financial security of all surviving families would be to end the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP). 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 DoD, reflects the longevity of the service of the military member. It is ordinarily calculated at 55 percent of retired pay. Military retirees who elect SBP pay a portion of their retired pay to ensure 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 have concerns about the Commission's proposed changes to the SBP premium structure. It would leave the 60,000 surviving widows/widowers who currently absorb the offset in the same situation they are now—continuing to have their SBP annuity offset by their DIC payment. **We need Congress to address the elimination of the offset to those who pay the premium and don't receive their complete benefit now!** Only 8 percent (4580) of SBP/DIC recipients are active duty death surviving spouses. Over 57,500 are the surviving spouses of retirees who have paid SBP premiums subsidized by DoD[5].

As stated, the SBP annuity and the DIC annuity are paid for two separate purposes. The retiring service member chooses to ensure the financial security of his/her surviving spouse by enrolling in the Survivor Benefit Plan. There is a chance the retiree may die of a service- connected disability. We maintain the payment of the DIC is the responsibility of the VA regardless of what other insurance or annuity the survivor may be eligible for. No other survivors of federal employees (former military members) are subject to the offset when they receive both a survivor annuity and the DIC. Surviving children receiving SBP are not subject to the offset. Since the retiree already pays a premium for SBP, why should he/she also subsidize the payment of the VA DIC annuity?

The Commission notes in its report the increased election of SBP by retired service members, comparing an election rate of 52 percent in 1993 to an election rate of 79 percent in 2013. This increase is due in great part to the elimination of the Social Security offset authorized by the National Defense Authorization Act for Fiscal Year 2005 (Public Law 108-375) and phased in over a three year period ending in 2008. Increasing the SBP premium to 11.25 percent would discourage retirees from signing up for the higher coverage unless they were severely disabled and had no other options. Those with severe disabilities who have been medically retired may be least financially able to pay higher premiums even though their survivors would have the greatest stake in having the offset eliminated.

[5] Department of Defense Office of the Actuary...09-30-14

We are especially concerned the Commission did not address how the survivors of those who die on active duty would be affected if this recommendation would be enacted. Would they continue to experience the DIC offset to SBP? For many of the survivors of junior service members, the DIC completely offsets the SBP annuity. We have questions where the funding would come from to fully fund both the DIC and SBP benefits for these survivors? How would the proposed changes to the retirement system figure into this?

We are encouraged at the suggestions the Commission has made on providing an analysis of the costs and benefits of the options to the retiring service member and their spouse. Again, it is important to have all the information to make an informed decision on retirement and survivor plans. **But, we cannot support asking the retiree to fund both the unsubsidized portion of the SBP and the VA provided DIC payment on the chance he/she may die of a service-connected disability.**

Recommendation 11: Safeguard education benefits for Service members by reducing redundancy and ensuring the fiscal sustainability of education programs.

Honor the Contract with Those Who Have Already Transferred the Benefit
As anyone who has pursued higher education can attest, tuition is only a fraction of the cost of attending college. Living expenses, books and fees add significantly to students' costs. Recognizing this reality, Congress included a living stipend in the Post 9-11 GI Bill. This valuable benefit has allowed many service members to complete their educations and launch careers. Other service members judge the best choice for them and their families is to transfer the benefit to a dependent spouse or child. Service members incur an additional service obligation with the understanding the entire benefit—to include the living stipend—will transfer to their designated recipient.

In the Commission's view, it is time to evaluate the effectiveness of transferability of the Post 9-11 GI Bill on retention and better align the benefit to meet retention goals. However, they fail to acknowledge many service members have already transferred the benefit—and met their additional service obligation—but their dependents have not yet had the opportunity to use their earned GI Bill benefits. Service members with young children accepted an additional service obligation with the understanding their families would have full use of the Post 9-11 GI Bill benefit. They made financial arrangements and savings plans based on those provisions. They made difficult choices and possibly passed on other opportunities to ensure their earned benefit became one their dependents could use. **These service members honored their part of the contract. Now we ask Congress to do the same and preserve the full Post 9-11 GI Bill for those military families who have already transferred the benefit.** .

It is worth noting service members who transfer their Post 9-11 GI Bill benefits and fail to meet the required service obligation are required to repay the benefit. The VA recognizes in transferring the benefit the service member has entered into a contract and must meet the terms of the agreement. Should service members expect any less? We acknowledge the Post 9-11 GI Bill is an exceptionally valuable benefit. In a time of fiscal constraint, Congress may have to make difficult decisions

regarding its future viability. However, the contracts of those who have already earned the benefit must be honored.

Recommendations Requiring Further Study

We believe several MCRMC recommendations have promising elements, but will require more study and further questions in order for the Commission to answer our concerns. The proposals for the new retirement system and changes in health care call for service members and their families to make responsible choices that will require a robust financial training program. We wonder how DoD and the Services will accomplish this financial training for both the service member and his/her spouse. We also have concerns about the proposal to merge commissary and Exchange operations and about the effect this change would have on the military resale system. We will seek more information on how these proposals could be implemented and encourage Congress to do the same.

Recommendation 1: Help more service members save for retirement earlier in their careers, leverage the retention power of traditional Uniformed Service retirement, and give the Services greater flexibility to retain quality people in demanding career fields.

Taking Responsibility for Your Own Retirement

As advocates for the entire military family community, our Association is keenly aware of the inequities inherent in the current retirement system. The majority of the families we serve remain in the military for fewer than 20 years and thus leave with little or no retirement savings. Recognizing this disparity, we support the Commission's recommendation to create an employer match to service member Thrift Savings Plan (TSP) accounts, which would create a valuable, transportable retirement benefit for service members regardless of how long they spend in the military. At the same time, we strongly believe in the value of the defined benefit plan, both as a retention tool and as a vital element in retirees' financial well-being. We commend the Commission for creating a hybrid system that would maintain the majority of the defined benefit plan along with a defined contribution.

While we would like to support the recommendation fully, we do have concerns. The proposal shifts both risk and responsibility for retirement savings from the government to the individual service member. In addition, the recommendation would lead to a significant income reduction for future working-age retirees compared to the current plan. We ask Congress to consider the following issues prior to making any decision about retirement changes.

The "Blended" Retirement System: Questions and Concerns

- **Increased responsibility for retirement while purchasing power is eroded:** The value of the TSP is tied directly to the level of individual contributions. If service members choose not to participate, or make smaller contributions, the value of the benefit is diminished. Currently 40 percent of service members choose to participate in TSP even though DoD provides no match. While under the proposal enrollment in the plan would be automatic,

service members would have the choice not to participate. To their credit, the Commission paired this recommendation with a call for improvements in service member financial literacy programs, arguing once service members understand the value of saving for retirement, especially with an employer match, there would be great incentive to participate. However, the reality is military families have experienced a series of cuts to their purchasing power in recent years, with higher out-of-pocket costs for housing and health care and pay raises that do not keep pace with inflation. TSP contributions will take another bite out of their disposable income. How many families will simply feel they cannot afford to save for retirement?

- **Higher risk for service members and families:** We are also concerned about the risk associated with a defined contribution plan, which we feel the Commission did not adequately address. Like all market-based funds, TSP accounts carry the risk of investment losses. In addition, a high rate of inflation would effectively diminish the value of TSP savings. Under this plan, the TSP would represent a significant share of retirement savings for a person who spends 20 or more years in the military, so the proposal imposes greater risk on those who stay for a full career. If there is a downturn in the market, retirees face losing a large share of their retirement savings. While some of that risk could be offset by a robust financial literacy program, risk is an intrinsic element of any defined contribution system.

- **Reduced income for working age retirees:** Our most pressing concern is the financial well-being of future working age retirees, who would face a significantly reduced income under this plan relative to the current one. According to the Commission, future retirees' pensions would be 20 percent less than provided under the current system. While the loss would be offset by the increased value of the TSP, service members would not be able to begin drawing from that until they reached age 59 ½. How much of a burden will this reduced income place on future working-age retirees? We also wonder what will happen to the Survivor Benefit Plan under this scenario. Will prospective retirees and their spouses feel they cannot afford to participate in SBP if their retirement income is reduced? Will Survivor Benefit Plan premiums and benefits be adjusted given the smaller retirement amounts and the availability of the Thrift Savings Plan as an asset for the survivor?

As more service members leave the military due to downsizing, our Association has increasingly focused on the issues families face as they transition to civilian life. In 2014, we surveyed military spouses who recently transitioned or were preparing to do so soon. What we have heard is that separating or retiring from the military is a difficult transition for many military families, often accompanied by significant financial hardship.

- *"Fortunately, we have been cautious about our spending and were financially prepared to live on retired pay if necessary which proved to be true."*

- *"Save every penny you can. Get out of debt before you separate. Brace yourself-it is harder than you can imagine. We are out of debt and have some savings, but my husband has been job hunting for 7 months."*
- *"I feel after 15 years in a career, he is starting from scratch and at the bottom of the barrel in the civilian workforce. I'm scared we'll be trying to support a family on minimum wage because nobody knows how to use an 0369 (military specialty designation) in the real world"*[6]

The prevailing view of the working-age retiree who moves seamlessly into civilian employment is frequently far from reality. Rather, it is not uncommon for working-age retirees to face a lengthy period of unemployment or underemployment, especially if their military skills do not translate directly into a civilian career. We are concerned that a reduced retirement annuity will add to the financial stress families commonly face during this transition.

The Commission's approach to this problem, offering service members the option of a lump sum payout in exchange for a reduced retirement annuity, is not an acceptable solution for the long-term well-being of the family. While the Commission does not detail the amount of the proposed payout or the how much would be cut from the annuity, similar proposals in the past have been detrimental to service members, providing much less total retirement compensation. This is especially true if the amount of the lump sum offered does not increase with inflation. Military retirees should not have to face a long-term financial disadvantage in order to address a short-term financial shortfall.

A 2014 RAND report, *Toward Meaningful Military Compensation Reform,* offered a proposal that would partially offset the reduced benefits for working-age retirees in the MCRMC plan. In its report, RAND suggests implementing a transition pay for service members leaving after 20 or more years of service. Including a transition payment for retiring service members would address two of our concerns by helping families through the financial challenges associated with transition and by offsetting some of the income lost by working-age retirees under a reduced defined benefit plan. In our view, this proposal merits further study for all transitioning service members receiving an honorable discharge.

We also note that the Commission does not address medical retirees in its proposal on retirement. How would these most vulnerable military families cope with a reduced annuity?

We recognize the majority of service members currently leave the service with no employer-provided retirement benefit and we commend the Commission for attempting to remedy this inequity while preserving most of the defined benefit plan. While we would prefer the annuity remain at its current level, we acknowledge that may not be feasible while also providing an employer match to the TSP. While we support the proposal in principle, we are concerned about the shift of risk and responsibility to service members and their families and about the impact on the

[6] Source: NMFA Transition Survey, May 2014

financial well-being of working-age and medical retirees. We believe there are steps Congress and DoD could take to mitigate these drawbacks—such as including a transition pay for service members—that would allow us to more wholeheartedly support the proposal.

Recommendation 3: Promote service members' financial literacy by implementing a more robust financial and health benefit training program.

More Training is Necessary to Make Good Financial Choices

We support the proposal to implement a more robust financial and health benefit training program. However, we question how some of the recommendations will truly improve financial literacy and must emphasize the importance of extending these training programs to the entire military family, particularly the spouse.

The MCRMC concluded that existing financial literacy training programs do not adequately educate service members. Yet, it maintains investing money in growing existing programs, with only slight changes, would better educate service members. We think it is important to note in many areas, service members are already miles ahead of their civilian counterparts in financial knowledge and management practices.

According to a survey done by FINRA Investor Education Foundation in 2012, 80 percent of service members believe they are good at dealing with day-to-day financial matters.[7] When compared to their civilian counterparts in age and demographic, service members were more likely to have an auto loan, carry a credit card balance, have a student loan, and a mortgage, but they were also less likely to use non-bank borrowing and have unpaid medical bills. Service members spent less than their income and had less difficulty covering their expenses than their civilian counterparts. They are more likely to save or have a retirement account. However, they were more likely to be underwater in their mortgage or have declared bankruptcy. These statistics bear more reflection and require adaptations in financial literacy programs that are specific to their military lifestyle challenges, like understanding the risk of investments in real estate when unable to homestead in one place.

It is absolutely critical changes in financial literacy focus on educating the entire military family. Spouses are often left in charge of the big financial decisions as they are more consistently present on the home front. Financial wellness and health care are often not executed by the service member. Mismanagement can result in far more devastating repercussions than a loss of security clearance: we have seen surprising use of food banks by military families; financial issues are a leading culprit in divorce and military suicide events; and unsurprisingly, morale is dropping after 14 years of war. The Commission's proposal must be considered in the light of how it can be applied to the entire family unit to best serve its purpose.

In considering improvements to financial literacy and health benefit training programs, opportunities to reach family members must embrace the lack of mandate the command and

[7] http://www.usfinancialcapability.org/downloads/NFCS_2012_Report_Military_Findings.pdf, page 28.

service have over family members. Dependent spouses or family members cannot be forced or tasked into education. Programs must be interesting, relevant, accessible, and innovative to reach our youngest families and entice them to participate. Provisions should be made to ensure attending or accessing good financial literacy counseling and education resources does not cost families money and can be performed at times convenient to them. We think the online budget planner is a good example of the great potential in this recommendation.

The MCRMC recommends several financial education ideas that are already in effect. For example, each Service provides financial management training to the service member at various stages in their career. They also provide financial counseling for service members and their families through a designated staff member at every installation. However, in some locations, this person may be shared among various installations or not be committed to financial literacy as a full-time responsibility. The MCRMC's proposal for more resources dedicated to financial education could expand availability of training personnel and programs.

The MCRMC's proposal recommends:

1. Increasing the frequency of and strengthening financial literacy content
2. Enhancing financial literacy content
3. Hiring firms to provide financial literacy training
4. Messaging from leadership
5. Mandatory annual Defense Manpower Data Center (DMDC) surveys
6. Strengthening partnerships with federal and nonprofit organizations
7. Provide an online budget planner for service members
8. Restructure the LES to reflect compensation changes proposed by the MCRMC

The Department of Defense (DoD) already provides financial counseling through Military OneSource confidential counseling number. Military OneSource counseling is also the most accessible tool currently available for spouses. DoD engages in a massive campaign called Military Saves to promote savings in cooperation with the Consumer Federation of America that includes memorandum and video messages from the Joint Chiefs and Enlisted Leaders encouraging service members to pledge to save. The DoD meets quarterly with federal and nonprofit organizations at the Defense Financial Readiness Roundtable to discuss programs and plans for reaching military families with financial literacy tools provided outside of DoD.

In 2003, DoD formally launched a financial readiness campaign to deal with financial habits that put members' readiness at risk, including financial management awareness, savings and protection against predatory practices. Since then, items 1, 2, 4, and 6 on the MCRMC list have been implemented. DMDC has surveyed service members about financial issues as recently as December 2013. With only items 3, 7 and 8 as new recommendations by the Commission, we feel this proposal leaves too many specifics to chance, especially with so many other moving parts in the health care and retirement proposals.

We would be remiss if we omitted the other financial challenges faced by military families. Between 2000 and 2012, Congress approved pay raises that exceeded the statutory requirement and set the standard that the Basic Allowance for Housing (BAH) would completely cover average housing expenses at each rank. For the past three years, however, DoD has proposed pay raises lower than the Employment Cost Index standard required in statute. DoD has also proposed a reduction in the BAH. The cumulative effect of these changes will severely impact the purchasing power of service members and their families. Financial literacy to promote financial readiness will be more important to help military families' dollars stretch further.

The MCRMC is proposing a massive overhaul of the health care system that would give service members the choices they have been craving, but could also result in out-of-pocket expenses for large families or those with extensive health care needs. They are also proposing a retirement system that would ask our younger and least equipped service members to carry a bigger burden in saving without giving them the extra tools to do so. According to a 2013 DMDC survey, approximately 10 percent of responding service members found it difficult or very difficult to cover expenses and pay all bills.[8] These 10 percent demonstrate that there is still a target number of service members who will not just benefit, but desperately need a different kind of financial management education.

We support the MCRMC's recommendation to promote better financial literacy for service members' through a more robust financial and health training program and feel that it is absolutely critical for the success of their other recommendations. We must emphasize that implementation must include family members. We would also like to see more information or study on how these proposals benefit the majority of service members who are already financially savvy, but challenged by other financial challenges of military service.

Recommendation 9: Protect both access to and savings at Department of Defense commissaries and Exchanges by consolidating these activities into a single defense resale organization.

The Savings are the Reason We Shop at the Commissary

In recent years, the commissary has been under siege. Budget proposals threaten to gut the program, eliminating a benefit that military families repeatedly tell us they value. In light of that, we are grateful to the Commission for affirming the importance of the savings military families receive from the commissary, and for emphasizing that DoD dollars must be used to support this valuable benefit. However, we are concerned by certain aspects of the Commission's proposal. While we understand that implementing certain efficiencies might protect the benefit in the long term, we are concerned that the Commission's recommendation would remove some of the protections that ensure the continued existence of the commissary and exchange. We believe additional details are needed before we can fully support the recommendation.

[8] Defense Manpower and Date Center, 2013 QuickCompass of Financial Issues, Question 73, pg. 138

- Currently, commissaries sell items at cost with a 5 percent surcharge that funds infrastructure investments. Operational costs are paid with appropriations. The exchanges sell items for profit, cover most of their operational costs with those profits, and provide the remainder to support Morale, Welfare, and Recreation (MWR) programs. The MCRMC proposes a new system that combines the exchange and the commissary systems into a new Defense Resale Agency (DeRA) and forces the surcharge and profit margins to fully fund the operational costs of both systems. The exchanges have already been yielding smaller and smaller profit margins. How many efficiencies will be needed in a combined system to cover costs AND provide the MWR support at desired levels?

- The recommendation states "MWR programs should continue to be funded from DeRA profits." What if there is a shortfall?

- DoD currently operates three exchange systems (NEXCOM, MCX, AAFES). Previous attempts to consolidate the exchanges into a single entity have failed due to logistical challenges and Service objections. How and why will it work this time?

- More than 60 percent of the employees working at the commissary and exchanges are military affiliated. Nearly 30 percent are military spouses. We do not know how these changes would affect their status. Civilian employees at the commissary would likely be converted to Non-Appropriated Fund (NAF) status, possibly reducing their pay and forcing a change in their benefits as they switch to a new system. What logistical challenges in merging employees from two distinct pay and benefit structures must be resolved and at what cost? How will the financial security of long-time commissary employees be protected?

- Consolidation may also remove the appropriated funds that cover second destination transportation costs for shipping commissary goods overseas. The new DeRA would be responsible for generating revenue to cover operating costs and second destination transportation at a cost of more than $340 million. Again, what if they can't? What's the protection for families who depend on overseas commissaries?

It remains unclear to us what will happen if the new blended system cannot cover operating costs. What are the second and third order effects on families around the world for providing healthy and familiar foods and goods? How will potential reductions in MWR revenues affect the morale of our military families at home or service members away from home?

As in our health care discussion, we must acknowledge that commissaries are under tremendous financial pressures and the appropriation that supports their operations—and by extension the savings military families need—is a constant target for budget-cutters. We are open to discussions on how to strengthen the resale entities in a way that protects customer savings and MWR revenues. We have concerns that restructuring the commissary and exchanges into a single entity could diminish each of these benefits. But, we hope this recommendation and the additional

commissary study Congress mandated in the FY2015 NDAA will provide a starting point for action on ways to strengthen the benefits and protect the military families who depend on them.

The commissary is an integral part of the military community. It is NOT just a grocery store. It is not just a convenient place to shop. It is a critical non-pay benefit for military families, and an institution charged with the health and welfare of our service members to provide safe, healthy, familiar provisions, no matter where they are around the world.

The Way Ahead

The National Military Family Association commends the Commission for its thoughtful consideration of many issues important to military family quality of life, as well as its comprehensive approach to military compensation. We are intrigued by the innovative recommendations regarding health care and retirement. We hope our questions will help inform a much-needed discussion, not just about the proposals, but also about current benefits and ultimately what will be best for service members and their families and the readiness of the force. We need more information on the impact of consolidating aspects of the military resale system on the savings military families experience at the commissary before embracing this recommendation. We especially thank the Commission for its recommendations regarding special needs military families, child care, nutritional support and military children in public schools. Their recommendations, if enacted, would address concerns that we often hear from military families and greatly enhance many families' well-being. While we cannot support the Commission's recommendations regarding the Survivor Benefit Plan or the Post 9-11 GI Bill, we do appreciate the efforts to preserve benefits important to service members and their families.

We ask Members of Congress to consider these recommendations thoughtfully as they respond to the budgetary challenges our Nation faces. We encourage Congress and DoD to seek solutions to the many issues raised by the MCRMC report and would welcome the opportunity to share additional input from the military families we serve. We must not delay the conversation on how to provide the best for our service members and the families who stand behind them! This report gives us a starting point.

Our Nation will continue to call on service members to address emerging threats and sustain peace around the world. Any change to the system of military compensation will have far reaching consequences and must recognize the unique challenges of military life. The government should ensure military families have the tools to remain ready and to support the readiness of their service members. Compensation and benefits for service members should reflect the singular service of military members and honor that service with a commensurate system of financial and medical support into retirement for them, their families and for their survivors.