STATEMENT

BEFORE THE

SUBCOMMITTEE ON

PERSONNEL

COMMITTEE ON ARMED SERVICES

UNITED STATES SENATE

BY

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AND

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MILITARY HEALTH SYSTEM

Curriculum Vitae and Organizational Disclosure Statements

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Colonel Partridge's military career spanned 31 years of enlisted and commissioned services in the reserve and active forces. He served in Vietnam, Germany, Korea and in several installations in the United States. Colonel Partridge served three tours in the Pentagon as a staff officer dealing with personnel matters. He also served as the Chief of Staff of the Army Intelligence and Security Command, Arlington, Virginia and as the Executive, Office of the Chief, Legislation Liaison, Secretary of the Army, Pentagon. He is a graduate of the Army War College, the Army Command and General Staff College, and has a Masters in Public Administration from Pennsylvania State University.

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Ms. Pugh went to work for Congressman John Mica (R-FL) in his Washington, D.C. office in the summer of 1994. After two years with Congressman Mica, she left to work for the American Medical Association's Congressional Affairs Division in May 1996.

Ms. Pugh assumed her current position as Deputy Legislative Director for the Retired Enlisted Association on March 17, 1997. She currently resides in Arlington, Virginia.

Disclosure

Neither the National Military Veterans Alliance, the National Association for Uniformed Services (NAUS) nor the Retired Enlisted Association have received a grant from (and/or subgrant) or a contract (and/or subcontract) with the federal government for the past three fiscal years.

INTRODUCTION

Mr. Chairman and distinguished members of the Committee, the National Military Veterans Alliance would like to express its appreciation to you for holding these important hearings. The testimony provided here represents the collective views of our members.

The National Military Veterans Alliance (NMVA) is a loosely confederated group of 21 different military and Veteran associations with a combined membership of 3.5 million nation wide. Collectively we represent all seven of the uniformed services, all ranks, all grades, all components, family members and survivors and we collectively work from an annual set of Alliance goals and objectives.

Medical care is one of the top concerns of the military community and the top concern of the Alliance. With base and hospital closures and the continual downsizing of medical personnel and military treatment facilities, the increasing lack of available health care continues to be a major concern to active and retired personnel alike.

We at NMVA want to thank the committee for its long standing interest in Military Health Care and we hope that significant improvements can be made this year.

BACKGROUND

The Military Health System has several missions, first and foremost is caring for active duty troops and maintaining military medical care readiness, readiness training and contingency operations as well as providing care for active duty family members; continuing to provide promised, lifetime medical care to military retirees, and their family members. To carry out these missions, top quality personnel to staff military medical units, hospitals and clinics are essential. These personnel are attracted to military medicine through the Uniformed Services University of the Health Sciences, the U.S. Health Profession Scholarship Program and quality graduate medical education programs sponsored by the various military medical services. Each is an important element of the system and are all linked together. Additionally, as we are seeing today with the recruiting shortages in all services except for the Marine Corps, keeping faith with the retirees by keeping the medical health care promise is vital to our strong all volunteer

force and to our national defense. In a 1999 *Christian Science Monitor* article addressing recruitment problems, Major General Evan Gaddis, the commander of the Army's Recruiting Command headquartered in Fort Knox made special note of the fact that "military retirees, upset over a steady erosion of benefits like health care and pensions, aren't talking up military careers to young adults as they might once have."

Earlier this month, Defense Secretary Bill Cohen and the Chairman of the Joint Chiefs of Staff, General Henry Shelton, testified before the Senate Armed Services Full Committee. Secretary Cohen had this to say:

"We have made a pledge, whether it's legal or not, it's a moral obligation that we will take care of all of those who served, retired veterans and their families, and we have not done so. There are big bills involved in this. This is no small matter."

In response to a question concerning retiree health care from Senator Chuck Robb, General Shelton said:

"Sir, I think the first thing we need to do is make sure that we acknowledge our commitment to the retirees for their years of service and for what we basically committed to at the time that they were recruited into the armed forces.

We've got – we've got actual recruiting posters that very vividly state that not only would they be taken care [of], but that their families would be taken care of. And of course, in their minds they – we have broken that commitment. And I think we have."

A military medical system is necessary to support not only the present active forces but also to meet future requirements. To attract, maintain and properly certify highly qualified medical professionals requires assuring them that they will have a complete range of patients with varied health problems to include older retirees. They can't be adequately trained treating only young (average age 23) service members and young family members. This means it is imperative to maintain a strong, vibrant, capable direct care system.

The Defense Health System has undergone a significant downsizing in the past 10 years and continues to shrink. The number of normal beds has decreased by 41 percent (12,000), expanded beds have decreased by 46 percent (20,000), the number of hospitals has decreased by 35 percent (58) and the number of medical centers has decreased by 33 percent (6).

Additionally, military medical personnel have decreased by 13 percent while civilian medical personnel have decreased by 22 percent. Please contrast these reductions with the 10 percent reduction in the eligible serviced population (867,000) during the past 10 years. According to the Department of Defense "demand continues to exceed supply, especially among retirees" all the while, the "Medicare eligible population (is) growing 4 to 5 percent annually". And the various DoD medical departments continue to decrease their uniformed officer medical personnel.

Also, please remember that DoD has a responsibility to those men and women who have served in the uniformed services to provide a medical benefit to nearly 50 percent of the current retired military beneficiaries that were promised health care. The demographics have changed from the 1950's when retirees were only 7 percent of the military health care beneficiary population, therefore Congress needs to provide adequate funding to create a plan to administer a health care benefit to retirees. National expansion of the sites and number of enrollees in the current Federal Employees Health Benefit Plan (FEHBP) for Medicare Eligible Military Retirees Test program is needed and a step in the right direction to testing the viable health care options for retirees access to medical care in the future. As this committee is aware, this is only one part of the matrix for accessing health care, expansion of the current BRAC pharmacy benefit and the current test of Medicare subvention will help offer a complete medical benefit for Medicare eligible military retirees.

NMVA HEALTH CARE PLAN

The NMVA plan is founded upon strong, fully-funded and fully-staffed military treatment facilities (MTFs). Branching out from the MTF foundation, the NMVA plan supports a high quality TRICARE Standard (CHAMPUS) benefit for life. Complementing and completing the plan for military beneficiaries who do not have access to or for whom the MTF/TRICARE program does not meet their needs, NMVA supports the option of the Federal Employees Health Benefits Program (FEHBP).

TRICARE : FULL FUNDING FOR ALL MILITARY BENEFICIARIES

In order to ensure the viability of TRICARE for all eligible beneficiaries to the program, it is necessary that TRICARE funding reflect the number of beneficiaries eligible for military health benefits, not just the ever-declining number of people able to use the military system

the previous year. The overall Defense Health Program continues to have funding shortfalls, NMVA urges this committee to provide adequate funding for military readiness as well as the current peacetime component. Our active duty members need assurances that funding will enable access to quality health care for their families, as well as assuring incentives for these uniformed service members to be recruited and retained in the military. *Further*, the promise of this health care benefit must be kept for our military retirees that are over and under the age of 65.

Additional funding will be required to keep providers in TRICARE Prime networks as our members are experiencing physicians leaving the system. Most TRICARE managed care support contractors have negotiated TRICARE Prime reimbursement rates with network providers that are even lower than Medicare. The issue however is a combination of low rates and physicians not being paid in a timely manner due to claims processing. TRICARE is giving physicians two disincentives for not signing up in the networks, low payment and slow payment.

TRICARE Standard (CHAMPUS) reimbursement levels are still much too low to attract quality health care providers. There are also unreasonable delays in reimbursement for TRICARE Standard (CHAMPUS) claims. Members have reported that in the more rural areas, and even some urban areas, where providers do not depend on a military patient base, health care providers have become increasingly unwilling to accept TRICARE Standard (CHAMPUS) patients at all. NMVA feels that de-linking the CMAC (CHAMPUS maximum allowable charge) from the Medicare Schedule and directing higher payments to providers as necessary will improve access to quality care for our beneficiaries. The FY 00 Defense Authorization Act gave the Secretary of Defense the authority to go over the current CMAC rates to bring in providers into TRICARE networks, but NMVA has not seen this implemented. When CHAMPUS, now TRICARE Standard was enacted in 1966, Congress directed DoD to provide a benefit at least equal to FEHBP high option Blue Cross/Blue Shield, without imposing a premium. Over the years this benefit has been decimated. It is time to fix it.

The current claims processing system for TRICARE needs to be revamped in order to reduce the hassles of claims payment for physicians and beneficiaries. The beneficiaries end up getting caught in the middle when they receive collection notices from their creditors, even after they were told the claim would be paid by the TRICARE subcontractor. The FY 00 Defense Authorization Act moved to allow TRICARE

contractors to use electronic processing for claims and streamlining the information flow, this allowing two pieces of the claims puzzle to be fixed. This committee gave DoD the authority to bring the claims system to "the best industry standard", but NMVA has not seen any proposal or plan by DoD to implement a new program. We are requesting some accountability by the Secretary of Defense to this Committee.

Certain efficiencies in the program can be implemented to cut costs and provide additional savings for the DoD health budget. A DoD study found that TRICARE administrative costs are far too high. Each Managed Care support contract proposal costs millions of dollars, each winner can expect a protest from the losers costing millions more. More money is being spent on medical administration and less on the patient. We believe this committee should direct a review of alternative means of procuring private sector healthcare to supplement the Military healthcare system. We understand these current contracts in the western region are being recompeted based on TRICARE 3.0. We believe that TRICARE 3.0, currently being rolled out, should be tested in Region 11, before being implemented nation-wide.

Please note that the administrative expenses associated with other federal health programs were computed and provided to the National Bipartisan Commission on the Future of Medicare by the General Accounting Office. GAO reported that the administrative expenses for Medicare, FEHBP and Medicaid were each 1 tenth of one percent of the total expenditures of the respective programs, whereas the Department of Defense's expenses were "not available".

NMVA believes that certain administrative efficiencies can improve quality of life service delivery for service members, retirees and their families while reducing costs. The Department of Defense and the Congress must embrace the benefits of internet-based technology to enhance efficiency and improve TRICARE services in such areas as marketing, enrollment, beneficiary and provider education, appointment setting, and claims processing. We encourage a consolidated internet strategy that would include both the MTFs and the prime contractors to insure success, high quality, and the least confusing environment for beneficiaries.

Members on this Committee, if we do not address these health care needs the response will be continued reduction in retention and recruiting. The shortcomings in the Defense Health Program for retirees are spilling over to the active force as well. Last year the Army's 5th Recruiting Brigade held a Family Symposium in St. Louis, Missouri. This symposium was one step in the Army's Family Action Plan and it brought together spouses to discuss issues of concern to recruiters, their families and the US Army. At the close of the meeting the delegates

voted on their top 5 issues. Issue #2 was "Timeliness of TRICARE Claims Payment". Issue #1 was "Lack of TRICARE Providers". Last fall, a member of the NAUS staff was attending the Chief of Staff, US Air Force's Retiree Council conducted at Randolph Air Force Base. While visiting the gymnasium, he met a young F-15 pilot who had just resigned his commission and accepted an appointment in the reserves. His reason for leaving the active force? Health care. While deployed in the Middle East, his spouse and their children could find no health care providers near his parents-in-law's home that would accept TRICARE Standard and, of course, there were no health care providers in a TRICARE Prime network. His new job with an airlines offered him trouble free health care that he and his spouse could depend on. The young man said his decision to leave wasn't about money, and in fact, he would have paid to fly the F-15 Eagle. He said it was all in how you take care of your people and health care was the most important part of that for him.

MTF Funding: The Department of Defense has directed that the military treatment facilities (MTFs) draw patients back into the military system to improve cost-effectiveness and to ensure medical readiness. To accomplish this, improved infrastructure and staffing additional funds are needed. Walter Reed Army Medical Center (WRAMC), the US Army's flagship medical center, is an ideal location to initiate a pilot program implementing this initiative. Savings from this effort can be significant. Funding for the necessary infrastructure improvement and increased staffing are needed and could begin by authorizing $20 million for WRAMC.

SPECIFIC IMPROVEMENTS TO TRICARE PRIME, EXTRA AND STANDARD

NMVA worked with the subcommittee during the FY 00 Defense Authorization Act focusing on issues to improve some of the inadequacies of TRICARE Prime. We appreciate your work last year, but there are aspects of the program that still need to be improved upon. Now that all 12 TRICARE regions have been up and running two years in June of this year, we request your support to:

- **Provide Tricare Prime Remote for active duty family members. *Included in S. 2087.***
- **Provide monetary reimbursement for transportation costs incurred by beneficiaries who travel over 100 miles to attain specialty care.**
- **Eliminate co-payments for active duty personnel and their family members enrolled in TRICARE Prime. *Included in S. 2087.***

- **Provide a proposal or direct the Department of Defense to give a proposal to create efficiencies in the payment of claims processing.** ***The FY00 Defense Authorization Act directed DoD to create a better mechanism for claim processing, but we have not seen any proposal or action on this issue. This continues to be a problem throughout the TRICARE regions, creating animosity for the program both from the beneficiaries and the providers.***
- **Ensure there is adequate quality control oversight of managed care systems (preferably by independent parties). Quality control oversight should include monitoring of patient satisfaction, assessment of clinical outcomes, adequate oversight of provider networks, and adherence to access standard in addition to utilization management.**
- **Ensure portability and reciprocity immediately for all beneficiaries under TRICARE Prime.** ***We are still hearing that active duty family members get caught in a gap while moving from region to region. Therefore, greater continuity within contracts on the issue of portability and reciprocity is essential for having a seamless transition of care upon moving in and out of regions.***
- **The TRICARE Point of Service (P.O.S.) option for enrollees in the PRIME program is too expensive at $300/$600 deductibles and 50% copayments. The P.O.S. option should be changed to the TRICARE Standard rate of $150/$300 and 25% copay. We have seen no evidence of abuse of the P.O.S. option and believe that the standard deductible and copays are enough to prevent frivolous use. Further, there should be no requirement to obtain advance authorization to use the P.O.S. option.**

TRICARE Standard the fee-for-service option needs improvement to be at least the quality and standard of care as provided under FEHBP standard fee-for-service by:

- **Reduce the catastrophic cap from $7,500 to $3,000.**
- **Eliminate the need for Non-availability statements (NAS) from military treatment facilities and clinics and completely eliminate the requirement for pre-authorization.**
- **Eliminate the 115% billing limit when TRICARE Standard is second payer to other health insurance.**
- **Base provider reimbursement rates on the Federal Service Benefit Plan.**

TRICARE FRAUD AND ABUSE

According to GAO Report HEHS-99-142, July 30, 1999, "There is general consensus in DoD and the health care industry that fraud and abuse could account for 10 to 20 percent of all health care costs. Given TRICARE managed care contract expenditures of $5.7 billion between 1996 and 1998, DoD could have lost over $1 billion to fraud and abuse

during this period…" Of the approximately 50 million claims processed between 1996-1998, the responsible contractors referred only 101 potential fraud cases for investigation by DoD. This low level of fraud identification has occurred because DoD contracts do not require contractors to aggressively identify and prevent fraud and abuse.

By acting immediately to solve this problem, some $1 billion can be made available to improve military health care for FY 2001 and beyond.

MEDICARE SUBVENTION: TRICARE SENIOR PRIME

NMVA would like to thank you for your support for the Tricare Senior Prime Test program, Medicare Subvention. With the favorable response to this program by military retirees in those six designated test sites, NMVA is asking for nation wide implementation of TRICARE Senior Prime. Senator Phil Gramm (R-TX) introduced S. 915 to make the TRICARE Senior Prime program permanent on a phased - in basis. The bill would expand Senior Prime to ten additional locations with full-service military hospitals by January 1, 2000 and then across the remaining TRICARE Prime catchment areas no later than October 1, 2002. We are requesting that this committee enact legislation in the DoD authorization to expand the Tricare Senior Prime Test nationwide to be effective Jan. 1, 2001. The test program terminates on December 31, 2000, we need legislative action in the FY 2001 Defense Authorization to move this program forward.

Many of our Medicare-eligible retirees have received letters from hospitals stating that "space availability" no longer exists or is extremely limited due to downsizing of staff at MTFs. Allowing Medicare-eligible military retirees to use Medicare at MTFs will provide them with yet another option for health care. Though it should be understood that this is not the complete solution to the current problem, as it would provide health service to only about 33% of the 1.3 million retirees over 65 now, but is an important piece to solving the whole health care dilemma for these beneficiaries.

The connotation of "TEST" has deterred some of our members from enrolling in TRICARE Senior Prime. Though they want to participate, they have a lack of trust for the MTF that turned them away years ago only to welcome them back again with no guarantees of health care past the three year test.

NMVA understands that the Senate bill S.2087 gives DoD authority to expand TRICARE

Senior Prime, but it does not direct DoD to follow through on this request. NMVA urges the support for funding from this committee to expand TRICARE Senior Prime to a permanent program. This committee's support would ensure expanding TRICARE Senior Prime to 10 additional sites by January 1, 2001 and national expansion on October 1, 2002 to provide a true health care benefit to military retirees that still reside near MTFs.

In the meantime, there are other looming difficulties with the TRICARE Senior Prime program. HCFA has provided $43 million in interim payments to DoD and DoD will be allowed to retain $6 million despite the fact that DoD has already paid out $40 million in claims. In our opinion, the reimbursement rates and rules between HCFA and DoD should be renegotiated. Also, at the present time, DoD hospitals are providing services of $187 more per enrollee per month than they are receiving in HCFA reimbursements. With over 30,000 enrolled retirees and their family members, this is over $5.6 million per month. The simple fact of the matter is that if health care is to be provided to military retirees, dollars must be provided to MTFs from HCFA and the DHP. Since care provided in MTFs is less expensive than in the civilian sector, this is a good investment and is good for the taxpayer.

FEE-FOR-SERVICE MEDICARE SUBVENTION

We would like to see another Medicare reimbursement option added on a fee-for-service basis. I would like to add that Senator Gramm's bill, S. 915, would give DoD the option to provide a fee-for-service Medicare option at certain MTFs if this would be more cost effective for those facilities. This test would allow Medicare eligible military beneficiaries to keep their standard Medicare benefit, and when using the MTFs "ON A SPACE AVAILABLE BASIS" to present their Medicare Card to the MTF. The MTF would bill Medicare as other providers do, except that it would be on a discounted basis to reflect the lower cost of care provided by the MTFs.

This would save Medicare Trust funds while making more efficient use of MTFs and use capacity that otherwise would not be used. This also supports our contention that Medicare eligible military medical beneficiaries earned the promised lifetime medical care for themselves and their eligible family members in MTFs and they paid for Medicare Part A coverage through mandatory deductions from their military and civilian pay checks. The combined earned and paid for health care access is clear justification for this fee-for-service option.

FEHBP OPTION

In order to have a fair and accurate test, we need to provide the opportunity for Medicare eligible military retirees to increase enrollment in the FEHBP test for the November 2000 open enrollment season. As we testified last year before this committee, we know that not all military retirees will enroll in this program, but we need to give them the option to make that choice in order to determine the future of providing care for those that have served in the military. NMVA is urging this subcommittee to increase the number of demonstration sites, as well as the number of enrollees eligible to participate in the program effective for the November 2000 open enrollment season. We feel that S. 2087 gives DoD authority to expand the sites, but does not direct and make them accountable to open up additional sites. It is absolutely essential that we give these retirees an equitable benefit that is as good or as equal to federal retirees.

DEMONSTRATION PROBLEMS: DoD did not market the program in a timely manner. Marketing by DoD was essential to determining the future success of the FEHBP test. The marketing timeline dates set up by the TRICARE Management Activity (TMA) office overseeing the program were not all met. The first notification of the program for eligible beneficiaries was via a postcard due out on July 15, but was not sent until August 15, 1999. Secondly, the "Health Fairs" that were sponsored by DoD were not put in place until the first week of November, which was a month late. These eligible beneficiaries in these 8 test sites were not properly marketed to on the FEHBP test program.

Proper education on the fundamental characteristics of FEHBP benefits was necessary to obtain accurate data on the first year of the test. Remember that this program services a population of beneficiaries new to FEHBP, unlike retired Federal Employees who understand the program. It was essential that they knew about how FEHBP works as a wrap around health care coverage to Medicare, as well as the protections for their Medigap plans during this 3 year test. NMVA believes that by marketing to an increased number of eligible beneficiaries with new and improved education tools,the data necessary to prove that this is a viable program for military retirees in the future will be obtained.

The three year test deterred Medicare Eligible Military Retirees from participating in the program. This is a population of beneficiaries who cannot take risks in their health care; they are reluctant to go into a three year test with no protection if the program ends. The

continuity of health care for this senior population is not guaranteed in three years, therefore we request that these individuals who are both in the program or will be enrolling in the program be grandfathered into the FEHBP test regardless of the success of the program.

The FY 99 Defense Authorization Act subtitle C Section 721 *Demonstration Project to include certain covered beneficiaries within Federal Employees Health Benefits Programs* clearly defined the eligibility and number of enrollees for the test program. As printed in legislation the total number of enrollees may not exceed 66,000, this was interpreted by the DOD as 66,000 total persons eligible to enroll in the test program. We knew that these designated 66,000 eligible participants would not all enroll because of the limited 3 year test. Judging by the number of enrollees – 2,310 as of February 18, 2000 – our arguments on implementing a fair test are correct; it hasn't happened and any conclusions inferred from such a small data base must be viewed with suspicion.

Some of these participants had employer provided insurance, Medicare Risk HMOs, Medigap policies, or were enrolled in TRICARE Senior Prime as in the case of the Dover, DE program. DoD made the assumption that 70% would enroll out of 66,000, even though we went on record as military associations indicating that a limited 3 year test, poor marketing material, and other health benefits that service this population would provide a low enrollment number of eligible beneficiaries to the program. NMVA would like to see the program expanded nation wide and the number of participants increased.

Due to the continued downsizing of MTF staff, base closures, decreasing dollars for DOD health care, and capitated budgeting, the Medicare Eligible Military Retirees continue to be pushed out of military health care. We need solutions to these problems. And as we know, there is no one solution. Therefore, testing alternative options for those that live near MTFs or of those residing outside the catchment areas, through the Medicare subvention test and FEHBP demonstration, will enable DoD to figure out how to administer health care to its aging heroes and heroines in the future. Even with full Medicare Subvention, TRICARE Senior Prime, DoD will only be able to serve about 33% of the overall population of military retirees over the age of 65. Some 17% of our retirees have employer sponsored health care, and 10% are already in Medicare Risk HMOs, leaving 32% to 41% of the 1.3 million population (no more than 533,000) to possibly access FEHBP. The number of age 65 and over military retirees will not decrease but continue to grow in numbers until it peaks at 1.6 million in 2004.

Costs could be controlled if necessary by capping the program. Our estimates indicate that fewer than 30% of retirees would select the FEHBP option. The death rate of older military retirees, especially those of WWII and Korea is close to 3,200 per month. They need access to health care now, not five years from now when it will be too late. Now is the time to act. We must not continue to allow the decline in availability of medical care to disenfranchise military retirees and their families.

TRICARE Senior Supplement Demonstration Program:

With an effective start date of April 1, 2000, for the TRICARE Senior Supplement Demonstration (TSSD) program, and with enrollment beginning March 1, 2000, NMVA has concerns over the protections placed on Medicare Supplemental plans for Medicare Eligible Military Retirees. This program is being tested in both Cherokee County, TX and Santa Clara, CA to obtain data on TRICARE as a supplement to Medicare. Since this is a limited test it is imperative to place protections on Medicare supplements for those who choose to enroll in this short term program. These aging retirees do not need be concerned over pre-existing conditions or increased supplemental costs if they drop the TSSD and revert back to their original coverage. This committee will see inadequate data results and low participation for those concerned about protecting their current supplemental care. In the current test programs of both FEHBP Test and TRICARE Senior Prime, a provision was placed in the language under the terms and conditions placed in the Medicare plus choice section of the Balance Budget of 1997 that would allow participants to revert, without penalty or pre-existing conditions, to their previous medical insurance program. Please include this protection for the TSSD program.

As experienced by disabled Medicare Eligible military retirees under 65, TRICARE is not an effective second payer to Medicare because it only covers the 115% cost after Medicare. Knowing that the TSSD is not a true Medicare Supplement as viewed by HCFA standards, this could create some concerns on the gaps in coverage.

PHARMACY ISSUES

We are requesting that this committee to extend the BRAC (Base Realignment and

Closure) pharmacy benefit to include all Medicare eligible military retirees regardless of location. The BRAC pharmacy program provides a National Mail Order Pharmacy (NMOP) benefit at a cost of an $8 co-payment for a 30-90 day prescription, as well as a 20% charge for retail pharmaceuticals at TRICARE network pharmacies.

The April 29, 1999 DoD Pharmacy Benefit Report in section 2 "Pharmacy Redesign Approach and Results" subsection 2.3 estimated the cost for a NMOP and retail pharmacy benefit for 1.4 military retirees over age 65 at 400 million dollars.

We are requesting this pharmacy benefit as a result of the implementation of the FY 99 DoD Authorization Bill, public law 105-261, sec. 723: (a) in general. Not later than October 1, 1999, the Secretary of Defense shall implement, with respect to eligible individuals described in subsection (e) who reside in an area selected under subsection (f) the redesign of the pharmacy system under TRICARE including the mail-order and retail pharmacy benefit under TRICARE to incorporate "best business practices" of the private sector in providing pharmaceutical….(eligibility included Medicare Eligible Military Retirees).

After the law was passed, DoD met with military associations in meetings to discuss the pharmacy redesign. In January 1999, all military associations were dropped out of DoD discussions. It was not until August 1999 that DoD proposed the Pharmacy Pilot Program begin enrollment in April 2000 and not the required date of October 1, 1999.

The proposal included the BRAC pharmacy benefit with a $500 dollar enrollment per couple. The high enrollment fee would skew the number of participants in Fleming , KY and Okeechobee, FL, simply because those who have high usage rates of pharmaceuticals would participate , therefore increasing the overall enrollment cost in the future due to adverse selection. Also, this could jeopardize the current BRAC pharmacy benefit that has no enrollment fee, but the same benefits as the Pharmacy Pilot Program with a NMOP and a 20% retail pharmacy network benefit.

The National Military Veterans' Alliance, with support of the Military Coalition, went to Congress to request a re-evaluation of the pilot program. In response, Congress directed DoD to come up with a different proposal to submit to them, changing the payment structure of the pharmacy program. On November 17, Dr. Sue Bailey, Asst. Secretary for Health Affairs for DoD, met with TREA, TROA, NMFA, NAUS, NCOA, AUSA, and FRA to state that the Pilot Pharmacy Program would not change and would be implemented in

April 2000. The enrollment fee was later reduced to $400 per couple.

Either the old enrollment fee ($500 per couple) or the new enrollment is too high. When expected co-payments are included, new Pharmacy initiative represents a significant out of pocket expense for retirees whose average retired pay is under $16,000 per year. (Please see Exhibit A). For those retirees 65 and older that can access a NMOP BRAC program now, only 17% of that population actually access it. Also, if retirees have a pharmacy benefit through a Medicare HMO, employer sponsored health care, or spouse, then they cannot access the BRAC benefit

NMVA cannot stress enough the concern over the access of pharmaceuticals to our Medicare eligible military retirees due to cost and increasing use of drugs for our senior citizens. We are requesting additional funding to be allocated to expand the BRAC pharmacy benefit to Medicare-eligible military retirees for the NMOP and access to the local retail pharmacy benefit. In addition, we are asking for funding to provide a complete national formulary that addresses the drug utilization of our aging war heroes and heroines.

S. 2087: Military Health Care Act 2000

NMVA appreciates the work from this committee to address the needs of Active Duty members and their dependents. Providing TRICARE Prime Remote and eliminating TRICARE co-payments for active duty family members is essential and needed. Increasing the funding level for custodial care to 100 million dollars, 60 million more than the budget request, is greatly appreciated by those military families.

As just mentioned in our discussion of the pharmacy benefit, we are extremely disappointed that this bill provided deductibles and enrollment fees to be applied to the pharmacy benefit. Further, there is no access provided in this bill for the Medicare eligible retiree outside a BRAC site to gain access to a retail pharmacy network with the 20% copays as is done for BRAC beneficiaries. This should be included in any future military health care legislation. Further, the retail benefit should be an open formulary.

NMVA is continually concerned for the over 65 military retirees that are dropped by military health care. The message from our members continues to be that they will never see the benefit of a test program if they are not here to use it. The result of extending these

tests for an additional two to three years creates anxiety with our members that may not live to see a true benefit being implemented nationwide. The pharmacy benefit will meet the needs of those beneficiaries without any coverage for their drugs, but this committee must understand that the need for acute drugs purchased in the retail pharmacy are needed too. The pharmacy redesign project should be no less generous than the BRAC benefit.

S. 2003, KEEP OUR PROMISES TO AMERICA'S MILITARY RETIREES ACT

This Senate bill has strong grass roots support because it comes closer than any other pending legislation before Congress to answering the military health care promise to America's military retirees, especially her older retirees. Today it has 17 cosponsors in the Senate. The House companion bill to S. 2003, H.R. 3573, has over 200 cosponsors. Both S. 2003 and H.R. 3573 have been pushed to the forefront by a huge wave of grass roots support that continues to grow. Mr. Chairman and members of the Committee, we ask you to consider the fact that the World War II era military retirees are dying at a rate of over 1,100 a month. Continued testing and demonstrations will not assist most military retirees. S. 2003 would provide retirees a choice – the Federal Employees Health Benefits Program to military retirees, at no cost to those who entered the service before June of 1956, and at the same subsidized rate for those who entered after. It would also extend the current TRICARE program to Medicare eligible retirees and their families. These older retirees and their families have no guaranteed DoD health benefit once they reach age 65, the only federal employees who lose their health care once they become Medicare eligible. As mentioned earlier in this testimony, the Defense Health Program is on life support with few signs of improvement because of continued under-funding and other factors. We urge Congress to solve the health care crisis this year.

S. 2013 – HONORING HEALTH CARE COMMITMENTS TO SERVICE MEMBERS PAST AND PRESENT

Like S. 2003, this bill is a comprehensive bill that would significantly improve the military health care system. The bill would establish a nationwide mail-order pharmacy service and community-based pharmacy network to serve the prescription drug needs of over-age 65 military retired members and their dependents. This provision would expand the mail-order and TRICARE retail pharmacy benefit nationwide to all Medicare-eligible uniformed services beneficiaries beginning October 1, 2000. The bill would allow

Medicare-eligible retirees to enroll in the Medicare subvention benefit and expands TRICARE Senior Prime nationwide beginning October 1, 2000. It would also provide military retirees who began their service prior to June 1956 the same priority of access inside the MTF as is provided to active duty members. The bill would allow Medicare-eligible retirees to enroll in the Federal Employees Health Benefits Program (FEHBP) and expands FEHBP benefits worldwide effective with the fall 2000 open enrollment period with coverage beginning January 1, 2001. It would require 6 additional major improvements to the TRICARE program and finally it would establish an account within the Treasury called the "Uniformed Services Retirees Health Care Account" that helps fund the added cost of this new benefit for age-65 uniformed services retirees.

[NOTE: The Non Commissioned Officers Association (NCOA) supports S. 2003 and S. 2013 with the exception of the provisions concerning pre June 7, 1956 retirees. NCOA believes that all generations of military retirees must be treated the same].

CARE FOR THE DISABLED

The Department of Defense (DOD) has routinely promulgated regulations and policies which have the affect of baring the permanently disabled from the Military Health System. When challenged before either Congress or a Federal Court DOD's actions have been over turned, and the department has been expressly ordered to deliver care to the disabled.

Changes in DOD's policy and regulations regarding the disabled were ordered by The Defense Authorization Act for FY 2000 and the Defense Appropriations Act for FY 2000. However, the Department has yet to fully implement these changes, nor has it provided the public an opportunity to participate as required by law. There is concern, grounded in the Departments' previous treatment of the disabled, that meaningful change is unlikely without further Congressional oversight, directives and remedial legislation.

The recently proposed S. 2087 appears to be a good first step, inasmuch as it continues Congresses objections to the transition of the disabled out of the Military Health System. However, more work is necessary. Congress should require DOD to redraft its custodial care definition in a manner consistent with other federal health programs and related case law. Congress should require DOD to, at a minimum, provide military families with the same amount of basic health services that are available through the FEHBP. DOD should be

prohibited from sending Military families to welfare programs by gaming technical provisions. Congress must assure that those categories of beneficiaries for whom disability is the basis of eligibility in the military health system have access to a meaningful benefit.

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

NMVA thanks this committee for its strong support for providing necessary funding for the continued operations of the Uniformed Services University of the Health Sciences. Study after study has shown that when all factors are considered USUHS is more cost effective that the US Health Profession Scholarship Program. We urge you to continue your support for this school which is a national resource.

There is currently an $8.3 million Navy Military Construction Project request to construct academic facilities to redress the overcrowding of the existing small class room facilities and to meet current and projected demands for specialized educational support and the associated administrative spaces necessary to conduct accredited graduate-level medical education. This Committee's support in adding those funds to the MILCON portion of the Defense Health Program's budget would be greatly appreciated. The ability of the University to maintain its accreditation and unique commitments to the TRISERVICE healthcare community will continue to be negatively impacted by temporary, inefficient, and costly space fixes which fail to deliver students, faculty, and staff unfettered access to the primary assets of the University, its people and interactions available on campus.

MEDICARE PART B WAIVER FOR MILITARY RETIREE 65+

Retirees were counseled by MTF advisors not to enroll in Part "B" because they resided near MTFs and would be able to access their free health care. These retirees should not be punished with late enrollment fees due to the fact that the local MTF has closed. NMVA is requesting the Committee to authorize the waiver of the penalty for not enrolling in Medicare Part "B" for Medicare-eligible military retirees

NMVA believes that this small investment will enable retirees to enroll in health care programs which require Medicare Part B for eligibility such as TRICARE Senior Prime and the Fee-for-Service Option plans in FEHBP. Currently, we have military retirees that are either paying a high penalty for Medicare Part B, or just cannot enroll because it is to costly.

RETIREE DENTAL PROGRAM

The Retiree Dental plan does not provide coverage of crucial benefits, such as bridges and crowns which are needs characteristic of our members. Currently, the contract is not subsidized by DoD, which would mean that increasing the benefit level now would make the program to costly to are aging retirees. Therefore, NMVA is requesting funding for a subsidy for the DoD Retiree Dental plan's premium to expand the benefit schedule to military retirees.

CONCLUSION

Every one of these problems cited here has a common thread – save money by eliminating or reducing care provided. The fewer beneficiaries served means the fewer DoD dollars needed to provide health care and increases the dollars available for equipment and weapons systems. Regardless of the promises made and of all the intentions of this Congress, health care for military retirees is not treated as a benefit and it certainly is not treated as an entitlement. Health care for military retirees, their families and their survivors is merely a line item expense in the DoD budget to be squeezed for more pressing needs by comptrollers and budget analysts who do not rely on the Defense Health Program for their health care.

A solution recommended by NMVA to partially address this concern is to make the funding mechanism for military retiree health care the same as it is for other federal retirees -- adding it to the entitlement's portion of the budget – and to stop making retiree health care compete for the same Defense dollars used in weapons programs, research and development or operations and maintenance.

Exhibits:

A – COMPARISON Annual Costs for Medicare Eligible
B – NMVA Roster