



Statement of

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**NATIONAL MILITARY FAMILY ASSOCIATION**

Before the

**SUBCOMMITTEE ON PERSONNEL**

of the

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

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The National Military Family Association is the leading non-profit organization committed to improving the lives of military families. Our 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, Public Health Service and the National Oceanic and Atmospheric Administration.

Association Representatives in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteer Representatives 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: <http://www.MilitaryFamily.org>.

**Kathleen B. Moakler, Government Relations Director**

Mrs. Moakler has been associated with the National Military Family Association since 1995 as a member of the headquarters staff. She has served as Headquarters Office Manager and several positions in the Government Relations Department, including Deputy Director. In February 2007, Ms. Moakler was appointed as interim Government Relations Director and was permanently appointed as Director in October 2007. In that position, she monitors the range of issues relevant to the quality of life of the families of the seven uniformed services and coordinates a staff of 4 deputy directors. Mrs. Moakler represents the interests of military families on a variety of advisory panels and working groups, including the American Red Cross "Get to Know Us Before You Need Us" working group, the DoD/VA Survivors Forum, and the State Department Interagency Roundtable. Mrs. Moakler is co-chair of the Survivors Committee for the Military Coalition (TMC), a consortium of 35 military and veteran organizations and serves on the Retiree Committee. She is often called to comment on issues pertaining to military families for such media outlets as the NY Times, CNN, NBC news and the Military Times. She writes regularly for "Military Money" and Association publications.

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

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

Chairman Nelson and Distinguished Members of this Subcommittee, the National Military Family Association would like to thank you for the opportunity to present testimony on the quality of life of military families – the Nation’s families. You recognize the sacrifices made by today’s service members and their families by focusing on the many elements of their quality of life package: access to quality health care, robust military pay and benefits, support for families dealing with deployment, and special care for the families of the wounded, ill and injured and those who have made the greatest sacrifice.

We endorse the recommendations contained in the statement previously submitted to this subcommittee by The Military Coalition. In this statement, our Association will expand on several issues of importance to military families:

- I. Family Readiness
- II. Family Health
- III. Family Transitions

## **I. Family Readiness**

The National Military Family Association believes policies and programs should provide a firm foundation for families buffeted by the uncertainties of deployment and transformation. It is imperative full funding for these programs be included in the regular budget process and not merely added on as part of supplemental funding. We promote programs that expand and grow to adapt to the changing needs of service members and families as they cope with multiple deployments and react to separations, reintegration, and the situation of those returning with both visible and invisible wounds. Standardization in delivery, accessibility, and funding are essential. Programs should provide for families in all stages of deployment and reach out to them in all geographic locations. Families should be given the tools to take greater responsibility for their own readiness.

We appreciate provisions in the National Defense Authorization Acts of the past several years that recognized many of these important issues. The increased access to resources and programs provided by the Joint Family Support Assistance Program (JFSAP), now offered in all states and territories, allows families to receive added help when they need it during all cycles of deployment. The Military Family Readiness Council held its first informal meeting in December. We feel this will be an effective tool in identifying programs that work and in helping to eliminate overlapping or redundant programs as the Council reviews existing resources for military families. Our Association is proud to represent military families as a member of the Council.

### **Child Care**

The Services – and families – continue to tell us more child care is needed to fill the ever growing demand, including hourly, drop-in, respite, and after-hour child care. We’ve heard stories like this:

*Child care facilities on base are beyond compare – for spouses and military members who work nine to five. In our increasingly service-oriented economy, the job I have has me working until at least seven most days, and usually as late as midnight one to two days a week. When my husband deploys or has a stint on second shift, I run out of options quickly. I have been unable to get another, more conventional job in the two years I have been in this area....there are minimum requirements as to what shifts I need to work to maintain full-time employment at my current workplace, and I cannot have those waived for an entire deployment.*

Innovative strategies are needed to address the non-availability of after-hour child care (before 6 a.m. and after 6 p.m.) and respite care. We applaud the partnership between the Services and the National Association of Child Care Resource and Referral Agencies (NACCRRA) that provides subsidized childcare to families who cannot access installation based child development centers. Families often find it difficult to obtain affordable, quality care especially during hard-to-fill hours and on weekends. Both the Navy and the Air Force have programs that provide 24/7 care. These innovative programs must be expanded to provide care to more families at the same high standard as the Services’ traditional child development programs. The Army, as part of the funding attached to its Army Family Covenant, has

rolled out more space for respite care for families of deployed soldiers. Respite care is needed across the board for the families of the deployed and the wounded, ill, and injured. We are pleased that the Services have rolled out more respite care for special needs families, but since the programs are new we are unsure of the impact it will have on families.

At our *Operation Purple® Healing Adventures* camp for families of the wounded, ill and injured, we were told there is a tremendous need for access to adequate child care on or near military treatment facilities. Families need the availability of child care in order to attend medical appointments, especially mental health appointments. Our Association encourages the creation of drop-in child care for medical appointments on the DoD or VA premises or partnerships with other organizations to provide this valuable service.

***Our Association urges Congress to ensure resources are available to meet the child care needs of military families to include hourly, drop-in and increased respite care for families of deployed service members and the wounded, ill and injured.***

### **Working with Youth**

Older children and teens must not be overlooked. School personnel need to be educated on issues affecting military students and be sensitive to their needs. To achieve this goal, schools need tools. Parents need tools, too. Military parents constantly seek more resources to assist their children in coping with military life, especially the challenges and stress of frequent deployments. Parents tell us repeatedly they want resources to “help them help their children.” Support for parents in their efforts to help children of all ages is increasing, but continues to be fragmented. New federal, public-private initiatives, increased awareness, and support by DoD and civilian schools educating military children have been developed. However, many military parents are either not aware such programs exist or find the programs do not always meet their needs.

Our Association is working to meet this pressing need through our *Operation Purple®* summer camps. Unique in its ability to reach out and gather military children of different age groups, Services, and components, *Operation Purple* provides a safe and fun environment in which military children feel immediately supported and understood. Last year, with the support of private donors, we achieved our goal of sending 10,000 military children to camp. We also were successful in expanding the camp experience to families of the wounded and bereaved. This year, we expect to maintain those numbers by offering 95 weeks of camp in 37 states and territories, as well as conducting several pilot family reintegration retreats in the National Parks.

Through our *Operation Purple* camps, our Association has begun to identify the cumulative effects multiple deployments are having on the emotional growth and well being of military children and the challenges posed to the relationship between deployed parent, caregiver, and children in this stressful environment. Understanding a need for qualitative analysis of this information, we contracted with the RAND Corporation in 2007 to conduct a pilot study aimed at the current functioning and wellness of military children attending *Operation Purple* camps and assessing the potential benefits of the OPC program in this environment of multiple and extended deployments. The results of the pilot study were published last spring and confirmed much of what we have heard from individual families. They also highlighted gaps in our current knowledge, including how family relationships are affected by deployment and reintegration. The study looked at differences in child and caregiver experiences based on Service component, such as how life is different during deployment for families from the Active Component compared to those in the Guard or Reserve.

In May 2008, we embarked on phase two of the project – a longitudinal study on the experience of 1,507 families, which is a much larger and more diverse sample than included in our pilot study. RAND is following these families for one year, and interviewing the non-deployed caregiver/parent and one child per family between 11 and 17 years of age at three time points over that year. Recruitment of participants has been extremely successful because families are eager to share their experiences. RAND is currently gathering information from these families for the 6 month follow-up survey. Preliminary findings from the first round of surveys provide additional support for the pilot study results and identify new areas to

investigate. This includes examining the relationship between the total months of deployment that a family experiences and its association with non-deployed caregiver's mental health and child's well-being at school and at home. In addition, RAND is assessing the impact of reintegration on the families and how this varies by a service member's rank and Service component.

This study will provide valuable data to inform the future creation and implementation of services for children and families. More specifically, we hope this study will provide more detailed and clearer understanding of the impact of multiple and extended deployments on military children and their families. We expect to present the final study results in Spring 2010.

### **Dwell Time**

Reintegrating the service member back into the family is a critical transition for many military families. Unfortunately, high operation tempo and multiple training assignments have prevented many service members from this needed "dwell time". Military families tell us they do not have enough time to fully reintegrate as a family before the service member redeploys. We also hear from family members about their frustration of sending their service members back into theater when they haven't had enough time to recover mentally or physically from the previous deployment.

Legislation so far introduced to address this issue would track dwell time at the unit level, not by service member. To preserve the physical and mental well-being of the military family unit, all service members need time at home.

### **Military Expansion of FMLA**

Our Association appreciates the work that the Department of Labor did on behalf of military families when they crafted the regulations for the expansion of the Family and Medical Leave Act included in the 2008 NDAA. However, we were disappointed that leave allowing family members to take care of issues arising out of the deployment was not extended to active duty families. Active duty families are struggling with the same deployment issues that their Reserve Component counterparts are – the law should reflect that.

### **National Guard and Reserve**

Our Association would like to thank Congress for authorizing many provisions that affect our Reserve Component families, who have sacrificed greatly in support of our Nation. We continue to ask Congress to fully fund these programs so vital to the quality of life of our National Guard and Reserve families.

The National Military Family Association has long realized the unique challenges our Reserve Component families face and their need for additional support. This need was highlighted in the final report from the Commission on the National Guard and Reserves, which confirmed what we had always asserted: "Reserve Component family members face special challenges because they are often at a considerable distance from military facilities and lack the on-base infrastructure and assistance available to active duty families." While citing a robust volunteer network as crucial, the report also stated that family readiness suffers when there are too few paid staff professionals supporting the volunteers.

Our Association would also like to thank Congress for the provisions which allowed for the implementation of the Yellow Ribbon Reintegration program which is so crucial to the well-being of our Reserve Component families. We urge Congress to make the funding for this program permanent. We also believe that family members should be paid a travel allowance to attend these important reintegration programs. Furthermore, DoD and service providers need to move away from the one-size fits all approach to reintegration which does not work for all the Reserve Components due to the specific nature of each mission and the varying length of deployments.

***Our Association asks Congress to fully fund the Yellow Ribbon Reintegration program and other provisions affecting our Reserve Component families and to move away from the one-size fits all approach to reintegration.***

## **Military Housing**

Privatized housing is a welcome change for military families and we are pleased the FY 2009 NDAA called for an annual report that addresses the best practices for executing privatized housing contracts. With our depressed economy, increased oversight is critical to ensure timely completion of these important projects. Project delays negatively impact the quality of life of our families.

Commanders must be held accountable for the quality of housing and customer service in privatized communities. Housing areas remain the responsibility of the installation Commander even when managed by a private company. Services members who are wounded and must move to a handicap accessible home or break their lease provisions due to short-notice PCS orders should not be penalized. Service members should not languish on wait lists while civilians occupy housing. While privatization contracts permit other non-military occupants for vacant units, Commanders must ensure that privatized housing is first and foremost meeting the needs of the active duty population of the installation. In some cases, this will require modification or renegotiation of contracts. On an aesthetic and health care note, our Association asks that a minimum number of non-smoking quarters be designated at each installation. Non-smokers, especially in multi-family dwellings, are being forced to live with second hand smoke in far too many cases. Our Association has received complaints from families who are suffering health consequences of living with a neighbor's smoking habit. This is unacceptable.

Our Association feels there needs to be a review of BAH standards. While families who live on the installation are better off, families living off the installation are forced to absorb more out-of-pocket expenses in order to live in a home that will meet their needs. BAH standards are based on an outdated concept of what would constitute a reasonable dwelling. For example, in order to receive BAH for a single family dwelling a service member must be an E9. However, if that same service member lived in military housing, he or she would likely have a single family home at the rank of E6 or E7. BAH standards should mirror the type of dwelling a service member would occupy if government quarters were available.

## **Commissaries and Exchanges**

The commissary is a key element of the total compensation package for service members and retirees and is valued by them, their families, and survivors. Not only do our surveys indicate that military families consider the commissary one of their most important benefits, during this economic downturn, many families are returning to the commissary to help them reduce their grocery budget. In addition to providing average savings of more than 30 percent over local supermarkets, commissaries provide an important tie to the military community. Commissary shoppers get more than groceries at the commissary. They gain an opportunity to connect with other military family members and to get information on installation programs and activities through bulletin boards and installation publications. Finally, commissary shoppers receive nutrition information and education through commissary promotions and educational campaigns contributing to the overall health of the entire beneficiary population.

Our Association appreciates the provision included in the FY 2009 NDAA allowing the use of proceeds from surcharges collected at remote case lot sales for Reserve Component members to help defray the cost of those case lot sales. This inclusion helps family members, not located near an installation partake in the valuable commissary benefit.

Our Association is concerned there will not be enough commissaries to serve areas experiencing substantial growth, including those locations with service members and families relocated by BRAC. The surcharge was never intended to pay for DoD and Service transformation. Additional funding is needed to ensure commissaries are built or expanded in areas that are gaining personnel as a result of these programs.

The military exchange system serves as a community hub, in addition to providing valuable cost savings to members of the military community. Equally important is the fact that exchange system profits are reinvested in important Morale, Welfare and Recreation (MWR) programs, resulting in quality of life improvements for the entire community. We believe that every effort must be made to ensure that this important benefit and the MWR revenue is preserved, especially as facilities are down-sized or closed

overseas. Exchanges must also continue to be responsive to the needs of deployed service members in combat zones and have the right mix of goods at the right prices for the full range of beneficiaries.

### **Flexible Spending Accounts**

Flexible Spending Accounts have done a great deal to help federal employees and corporate civilian employees defray out-of-pocket costs for both their health care and dependent care needs. Our Association believes this important program should be extended to military service members, and urges Congress to work with the Department of Defense to accomplish this much needed change. It is imperative that we include active duty and Selected Reserve members in this cost saving benefit. This benefit would put more money into our families' pockets and help defray rising health care and child care costs.

***Our Association requests that a flexible spending account benefit be extended to military service members.***

### **Financial Readiness**

Financial readiness is a critical component of family readiness. Our Association applauds DoD for tackling financial literacy head-on with their Financial Readiness Campaign. Financial literacy and education must continue to be on the forefront. We are strong supporters of the Military Lending Act (MLA). With the depressed economy, many families may turn to payday lenders. DoD must continue to monitor the MLA and its effectiveness of derailing payday lenders.

Military banks and credit unions must continue to develop alternatives to payday loans. Small dollar, short-term loan products through reputable lenders are needed to pull families away from predatory lenders. We encourage DoD to continue to educate military service members and their families aware of the need to improve their money management skills and avoid high cost credit cards and other lenders. DoD must continue to monitor high cost, low value financial products targeted at military families.

### **Family Care Plans and Custody Concerns**

As the war has progressed, we hear from service members about custody concerns. A frequent scenario is that the service member, as part of his/her family care plan, places his/her children in the care of a non-custodial parent or other family member. The non-custodial parent chooses the time of deployment as a time to sue for a change in custodial status, often citing abandonment by the service member as a reason for change. We know that protections for the custodial parent can be improved by changes to the Servicemembers' Civil Relief Act, but wonder if there is any other relief that might come under the jurisdiction of this subcommittee to address the needs of these service members. The American Bar Association is trying to address this problem as well and is tracking the state initiatives that are addressing this issue. We are unsure if better education of the service member on protecting his/her custodial rights might be the answer or if it falls completely in the realm of a state issue. We suggest you consider directing DoD to conduct a study on how prevalent this problem is for service members and what solutions might be implemented.

We have heard from single parent and dual military families about the expenses incurred when they have to relocate their children to another location when they are activated for deployment. This issue was raised within the Army Family Action Plan process. Service members requiring activation of Family Care Plans are not compensated for the travel of dependents and shipment of the dependent's household goods. Some items such as infant equipment, computers and toys are necessary for the emotional and physical well-being of the children in their new environment during an already stressful time. Implementation of the Family Care Plan should not create additional financial hardship and emotional stress on the service member and family.

***We recommend that DoD conduct a study on how the deployment affects custody arrangements for service members and how these arrangements can be protected. We also recommend that changes be made to the DoD Joint Travel Regulations to provide for travel and***

***shipment of household goods to fulfill the needs of a deploying service member's Family Care Plan.***

## **II. Family Health**

Family readiness calls for access to quality health care and mental health services. Families need to know the various elements of their military health system are coordinated and working as a synergistic system. Our Association is concerned the DoD military health care system may not have all the resources it needs to meet both the military medical readiness mission and provide access to health care for all beneficiaries. It must be funded sufficiently, so the direct care system of military treatment facilities (MTF) and the purchased care segment of civilian providers can work in tandem to meet the responsibilities given under the TRICARE contracts, meet readiness needs, and ensure access for all military beneficiaries.

### **Military Health System**

#### **Improving Access to Care**

In an interview with syndicated *Military Update* columnist Tom Philpott in December of 2008, MG (Dr.) Elder Granger, deputy director of TRICARE, gave the Military Health System (MHS) an overall grade of "C-plus or B-minus". His discussion focused on access issues in the direct care system – our military hospitals and clinics - reinforcing what our Association has observed for years. We have consistently heard from families that their greatest health care challenge has been getting timely care from their local military hospital or clinic. In previous testimony before this subcommittee we have noted the failure of MTFs to meet TRICARE Prime access standards and to be held accountable in the same way as the TRICARE contractors are for meeting those standards in the purchased care arena.

In discussions with families the main issues are: access to their Primary Care Managers (PCM); getting appointments; getting someone to answer the phone at central appointments; having appointments available when they finally got through to central appointments; after hours care; getting a referral for specialty care; being able to see the same provider or PCM; and having appointments available 60, 90, and 120 days out in our MTFs. Families familiar with how the MHS referral system works seem better able to navigate the system. Those families who are unfamiliar experienced delays in receiving treatment or decide to give up on the referral process and never obtain a specialty appointment.

Case management for military beneficiaries with special needs is not consistent across the MHS, whether within the MTFs or in the purchased care arena. Thus, military families end up managing their own care. The shortage of available health care providers only adds to the dilemma. Beneficiaries try to obtain an appointment and then find themselves getting partial health care within the MTF, while other health care is referred out into the purchased care network. Meanwhile, the coordination of the military family's care is being done by a non-synergistic health care system. Incongruence in the case management process becomes more apparent when military family members transfer from one TRICARE region to another and is further exasperated when a special needs family member is involved. Each TRICARE Managed Care Contractor has created different case management processes. There needs to be a seamless transition and a warm handoff between TRICARE regions for these families and the establishment of a universal case management process across the MHS.

Our wounded, ill, and injured service members, veterans, and their families are assigned case managers. In fact, there are many different case managers: Federal Recovery Coordinators (FRC), Recovery Care Coordinators, each branch of Service, TBI care coordinators, VA liaisons, etc. The goal is for a seamless transition of care between and within the two governmental agencies: DoD and the VA. However, with so many to choose from, families often wonder which one is the "right" case manager. We often hear from families, some who have long since been medically retired with a 100 percent disability rating or others with less than one year out from date-of-injury, who have not yet been assigned a FRC. We need to look at whether the multiple, layered case managers have streamlined the process, or have only aggravated it. Our Association still finds these families alone trying to navigate a variety of complex health care systems trying to find the right combination of care. Many qualify for and use Medicare, VA,

DoD's TRICARE direct and purchased care, private health insurance, and State agencies. Does this population really need all of these different systems of receiving health care? Why can't the process be streamlined?

### **TRICARE**

While Congress temporarily forestalled increases over the past two years, we believe DoD officials will continue to support large increased retiree enrollment fees for TRICARE Prime combined with a tiered system of enrollment fees, the institution of a TRICARE standard enrollment fee and increased TRICARE Standard deductibles. Two reports, the *Task Force on the Future of the Military Health Care* and *The Tenth Quadrennial Review of Military Compensation Volume II*, recently recommended the same.

We acknowledge the annual Prime enrollment fee has not increased in more than 10 years and that it may be reasonable to have a mechanism to increase fees. With this in mind, we have presented an alternative to DoD's proposal should Congress deem some cost increase necessary. The most important feature of our proposal is that any fee increase be no greater than the percentage increase in the retiree cost of living adjustment (COLA). If DoD thought \$230/\$460 was a fair fee for all in 1995, then it would appear that raising the fees simply by the percentage increase in retiree pay is also fair. We also suggest it would be reasonable to adjust the TRICARE Standard deductibles by tying increases to the percentage of the retiree annual COLA. We stand ready to provide more information on this issue if needed.

### **Support for Special Needs Families**

We applaud Congress and DoD's desire to create a robust health care and educational service for special needs children. But, these robust services do not follow them when they retire. We encourage the Services to allow these military families the opportunity to have their final duty station be in an area of their choice. We suggest the Extended Care Health Option (ECHO) be extended for one year after retirement for those already enrolled in ECHO prior to retirement.

There was discussion last year by Congress and military families regarding the ECHO program. The FY09 NDAA included a provision to increase the cap on certain benefits under the ECHO program to \$36,000 per year for training, rehabilitation, special education, assistive technology devices, institutional care and under certain circumstances, transportation to and from institutions or facilities, because certain beneficiaries bump up against it. The ECHO program was originally designed to allow military families with special needs to receive additional services to offset their lack of eligibility for state or federally provided services impacted by frequent moves. We suggest that before making any more adjustments to the ECHO program, Congress should direct DoD to certify if the ECHO program is working as it was originally designed and has been effective in addressing the needs of this population. We need to make the right fixes so we can be assured we apply the correct solutions.

### **National Guard and Reserve Member Family Health Care**

National Guard and Reserve families need increased education about their health care benefits. We also believe that paying a stipend to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan may prove to be more cost-effective for the government than subsidizing 72 percent of the costs of TRICARE Reserve Select for National Guard or Reserve members not on active duty.

### **TRICARE Reimbursement**

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. As the 111<sup>th</sup> Congress takes up Medicare legislation, we request consideration of how this legislation will impact military families' health care, especially access to mental health services.

National provider shortages in the psychological health field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographic challenges-- for example large populations in rural or traditionally underserved

areas. Many psychological health providers are willing to see military beneficiaries on a voluntary status. However, these providers often tell us they will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. More must be done to persuade these providers to participate in TRICARE and become a resource for the entire system, even if that means DoD must raise reimbursement rates.

We have heard the main reason for the VA not providing health care and psychological health care services is because they cannot be reimbursed for care rendered to a family member. However, the VA is a qualified TRICARE provider. This allows the VA to bill for services rendered in their facilities to a TRICARE beneficiary. There may be a way to bill other health insurance companies as well. The VA needs to look at the possibility for other methods of payments.

### **Pharmacy**

We caution DoD about generalizing findings of certain beneficiary pharmacy behaviors and automatically applying them to our Nation's unique military population. We encourage Congress to require DoD to utilize peer-reviewed research involving beneficiaries and prescription drug benefit options, along with performing additional research involving military beneficiaries, before making any recommendations on prescription drug benefit changes, such as co-payment and tier structure changes for military service members, retirees, their families, and survivors.

We appreciate the inclusion of federal pricing for the TRICARE retail pharmacies in the FY 2008 NDAA. However, we need to examine its effect on the cost of medications for both beneficiaries and DoD. Also, we will need to see how this potentially impacts the overall negotiation of future drug prices by Medicare and civilian private insurance programs.

We believe it is imperative that all medications available through TRICARE Retail Pharmacy (TRRx) should also be available through TRICARE Mail Order Pharmacy (TMOP). Medications treating chronic conditions, such as asthma, diabetes, and hypertension should be made available at the lowest level of co-payment regardless of brand or generic status. We agree with the recommendations of *The Task Force on the Future of Military Health Care* that OTC drugs be a covered pharmacy benefit and there be a zero co-pay for TMOP Tier 1 medications.

### **National Health Care Proposal**

Our Association is cautious about current rhetoric by the Administration and Congress regarding the establishment of a National health care insurance program. As the 111<sup>th</sup> Congress takes up a National health care insurance proposal, we request consideration of how this legislation will also impact TRICARE, military families' access to health care, and especially recruitment and retention of our service members at a time of war.

### **DoD Must Look for Savings**

We ask Congress to establish better oversight for DoD's accountability in becoming more cost-efficient. We recommend:

- Requiring the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality health care in a cost-effective manner;
- Creating an oversight committee, similar in nature to the Medicare Payment Advisory Commission, which provides oversight to the Medicare program and makes annual recommendations to Congress. *The Task Force on the Future of Military Health Care* often stated it was unable to address certain issues not within their charter or the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.
- Establishing a Unified "Joint" Medical Command structure, which was recommended by the Defense Health Board in 2006.

Our Association does not support the recommendation of the *Task Force on the Future of Military Health Care* to carve out one regional TRICARE contractor to provide both the pharmacy and health care benefit. We agree a link between pharmacy and disease management is necessary, but feel this pilot would only further erode DoD's ability to maximize potential savings through TMOP. We were also disappointed to find no mention of disease management or a requirement for coordination between the pharmacy contractor and Managed Care Support Contractors in the Request for Proposals for the new TRICARE pharmacy contract. The ability certainly exists for them to share information bi-directionally and should be established.

Our Association believes optimizing the capabilities of the facilities of the direct care system through timely replacement of facilities, increased funding allocations, and innovative staffing would allow more beneficiaries to be cared for in the MTFs, which DoD asserts is the most cost effective. The Task Force made recommendations to make the DoD MHS more cost-efficient which we support. They conclude the MHS must be appropriately sized, resourced, and stabilized; and make changes in its business and health care practices.

***Our Association suggests this Subcommittee DoD reassess the resource sharing program used prior to the implementation of the T-Nex contracts and take the steps necessary to ensure Military Treatment Facilities (MTF) meet access standards with high quality health care providers.***

***We also suggest this Subcommittee direct the Department to make case management services more consistent across the direct and purchased care segments of the MHS.***

***Our Association recommends a one year transitional active duty ECHO benefit for the family members of service members who retire.***

***We believe tying increases in TRICARE enrollment fees to the percentage increase in the Retiree Cost of Living Adjustment (COLA) is a fair way to increase beneficiary cost shares should Congress deem an increase necessary.***

***We oppose DoD's proposal to institute a TRICARE Standard enrollment fee and believe Congress should reject this proposal because it changes beneficiaries' entitlement to health care under TRICARE Standard to just another insurance plan.***

***Our Association strongly believes an enrollment fee for TFL is not appropriate.***

***We believe that Reserve Component families should be given the choice of a stipend to continue their employer provided care during deployment.***

## **Behavioral Health Care**

Our Nation must help returning service members and their families cope with the aftermaths of war. DoD, VA, and State agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs. Partnering will also capture the National Guard and Reserve member population, who often straddle these agencies' health care systems.

### **Full Spectrum of Care**

As the war continues, families' need for a full spectrum of behavioral health services—from preventative care to stress reduction techniques, to individual or family counseling, to medical mental health services—continues to grow. The military offers a variety of psychological health services, both preventative and treatment, across many agencies and programs. However, as service members and families experience numerous lengthy and dangerous deployments, we believe the need for confidential, preventative psychological health services will continue to rise. It will also remain high for some time even after military operations scale down.

### **Access to Behavioral Health Care**

Our Association is concerned about the overall shortage of psychological health providers in TRICARE's direct and purchased care network. DoD's *Task Force on Mental Health* stated timely access to the proper psychological health provider remains one of the greatest barriers to quality mental health services for service members and their families. While families are pleased more psychological health providers are available in theater to assist their service members, they are disappointed with the resulting limited access to providers at home. Families are reporting increased difficulty in obtaining appointments with social workers, psychologists, and psychiatrists at their MTFs and clinics. The military fuels the shortage by deploying some of its child and adolescent psychology providers to combat zones. Providers remaining at home report they are overwhelmed by treating active duty members and are unable to fit family members into their schedules. This can lead to compassion fatigue, creating burnout and exacerbating the provider shortage problem.

We have seen an increase in the number of psychological health providers joining the purchased care side of the TRICARE network. However, the access standard is seven days. We hear from military families after accessing the psychological health provider list on the contractor's websites that the provider is full and no longer taking patients. The list must be up-to-date in order to handle real time demands by families. We need to continue to recruit more psychological health providers to join the TRICARE network and we need to make sure we specifically add those in specialty behavioral health care areas, such as child and adolescence psychology and psychiatrists.

Families must be included in mental health counseling and treatment programs for service members. Family members are a key component to a service member's psychological well-being. We recommend an extended outreach program to service members, veterans, and their families of available psychological health resources, such as DoD, VA, and State agencies. Families want to be able to access care with a psychological health provider who understands or is sympathetic to the issues they face.

Frequent and lengthy deployments create a sharp need in psychological health services by family members and service members as they get ready to deploy and after their return. There is also an increase in demand in the wake of natural disasters, such as hurricanes and fires. We need to maintain a flexible pool of psychological health providers who can increase or decrease rapidly in numbers depending on demand on the MHS side. Currently, Military Family Life Consultants and Military OneSource counseling are providing this type of service for military families on the family support side. We need to make the Services, along with military family members, more aware of resources along the continuum. We need the flexibility of support in both the MHS and family support arenas.

### **Availability of Treatment**

Do DoD, VA and State agencies have adequate psychological health providers, programs, outreach, and funding? Better yet, where will the veteran's spouse and children go for help? Many will be left alone to care for their loved one's invisible wounds resulting from frequent and long combat deployments. Who will care for them when they are no longer part of the DoD health care system?

The Army's Mental Health Advisory Team (MHAT) IV report links reducing family issues to reducing stress on deployed service members. The team found the top non-combat stressors were deployment length and family separation. They noted soldiers serving a repeat deployment reported higher acute stress than those on their first deployment and the level of combat was the major contribution for their psychological health status upon return. These reports demonstrate the amount of stress being placed on our troops and their families.

Our Association is especially concerned with the scarcity of services available to the families as they leave the military following the end of their activation or enlistment. Due to the service member's separation, the families find themselves ineligible for TRICARE, and are very rarely eligible for healthcare through the VA. Many will choose to locate in rural areas lacking available psychological health providers. We need to address the distance issues families face in finding psychological health resources and obtaining appropriate care. Isolated service members, veterans, and their families do not have the benefit

of the safety net of services and programs provided by MTFs, VA facilities, Community-Based Outpatient Centers and Vet Centers. We recommend:

- using alternative treatment methods, such as telemental health;
- modifying licensing requirements in order to remove geographic practice barriers that prevent psychological health providers from participating in telemental health services outside of a VA facility; and
- educating civilian network psychological health providers about our military culture as the VA incorporates Project Hero.

### **National Guard and Reserve Members**

The National Military Family Association is especially concerned about fewer mental health care services available for the families of returning National Guard and Reserve members as well as service members who leave the military following the end of their enlistment. They are eligible for TRICARE Reserve Select, but as we know, National Guard and Reserve members are often located in rural areas where there may be no mental health providers available. Policy makers need to address the distance issues that families face in linking with military mental health resources and obtaining appropriate care. Isolated National Guard and Reserve families do not have the benefit of the safety net of services provided by MTFs and installation family support programs. Families want to be able to access care with a provider who understands or is sympathetic to the issues they face. We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.

### **Wounded, Ill, and Injured Families**

When designing support for the wounded, ill, and injured in today's conflict, our Association believes the government, especially DoD, VA, and State agencies, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded service member must also consider the needs of the spouse, children, parents of single service members, siblings, and other caregivers. Family members are an integral part of the health care team and recovery process.

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded service members and veterans, such as physical, psychosocial, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DoD and VA health care providers because they tend to the needs of the service members and the veterans on a regular basis. And, their daily involvement saves DoD, VA, and State agency health care dollars in the long run. Their long-term psychological care needs must be addressed. Caregivers of the severely wounded, ill, and injured services members who are now veterans have a long road ahead of them. In order to perform their job well, they will require access to mental health services.

The Vet Centers are an available resource for veterans' families providing adjustment, vocational, and family and marriage counseling. The VA health care facilities and the community-based outpatient clinics (CBOCs) have a ready supply of mental health providers, yet regulations restrict their ability to provide mental health care to veterans' families unless they meet strict standards. Unfortunately, this provision hits the veteran's caregiver the hardest. We recommend DoD partner with the VA to allow military families access to mental health services. We also believe Congress should require the VA, through its Vet Centers and health care facilities to develop a holistic approach to care by including families when providing mental health counseling and programs to the wounded, ill, or injured service member or veteran.

The Defense Health Board has recommended DoD include military families in its mental health studies. We agree. We encourage Congress to direct DoD to include families in its Psychological Health Support survey; perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members); and sponsor a longitudinal study,

similar to DoD's Millennium Cohort Study, in order to get a better understanding of the long-term effects of war on our military families.

### **Children**

Our Association is concerned about the impact deployment and/or the injury of the service member is having on our most vulnerable population, children of our military and veterans. Multiple deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not "rock the boat." They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve members face unique challenges since there are no military installations for them to utilize. They find themselves "suddenly military" without resources to support them. School systems are generally unaware of this change in focus within these family units and are ill prepared to lookout for potential problems caused by these deployments or when an injury occurs. Also vulnerable, are children who have disabilities that are further complicated by deployment and subsequent injury of the service members. Their families find stress can be overwhelming, but are afraid to reach out for assistance for fear of retribution to the service member's career. They often choose not to seek care for themselves or their families.

The impact of the wounded, ill, and injured on children is often overlooked and underestimated. Military children experience a metaphorical death of the parent they once knew and must make many adjustments as their parent recovers. Many families relocate to be near the treating Military Treatment Facility (MTF) or the VA Polytrauma Center in order to make the rehabilitation process more successful. As the spouse focuses on the rehabilitation and recovery, older children take on new roles. They may become the caregivers for other siblings, as well as for the wounded parent. Many spouses send their children to stay with neighbors or extended family members, as they tend to their wounded, ill, and injured spouse. Children get shuffled from place to place until they can be reunited with their parents. Once reunited, they must adapt to the parent's new injury and living with the "new normal."

We encourage partnerships between government agencies, DoD, VA and State agencies and recommend they reach out to those private and non-governmental organizations who are experts on children and adolescents. They could identify and incorporate best practices in the prevention and treatment of mental health issues affecting our military children. We must remember to focus on preventative care upstream, while still in the active duty phase, in order to have a solid family unit as they head into the veteran phase of their lives. School systems must become more involved in establishing and providing supportive services for our nation's children.

### **Caregivers**

In the seventh year of the Global War on Terror, care for the caregivers must become a priority. Our Association hears from the senior officer and enlisted spouses who are so often called upon to be the strength for others. We hear from the health care providers, educators, rear detachment staff, chaplains, and counselors who are working long hours to assist service members and their families. They tell us they are overburdened, burnt out, and need time to recharge so they can continue to serve these families. These caregivers must be afforded respite care; given emotional support through their command structure; and, be provided effective family programs.

### **Education**

The DoD, VA, and State agencies must educate their health care and mental health professionals of the effects of mild Traumatic Brain Injury (mTBI) in order to help accurately diagnose and treat the service member's condition. They must be able to deal with polytrauma—Post-Traumatic Stress Disorder (PTSD) in combination with multiple physical injuries. We need more education for civilian health care providers on how to identify signs and symptoms of mild TBI and PTSD.

The families of service members and veterans must be educated about the effects of mTBI and PTSD in order to help accurately diagnose and treat the service member/veteran's condition. These

families are on the “sharp end of the spear” and are more likely to pick up on changes attributed to either condition and relay this information to their health care providers.

### **Reintegration programs**

Reintegration programs become a key ingredient in the family’s success. Our Association believes we need to focus on treating the whole family with programs offering readjustment information; education on identifying mental health, substance abuse, suicide, and traumatic brain injury; and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties.

Successful return and reunion programs will require attention over the long term, as well as a strong partnership at all levels between the various mental health arms of DoD, VA, and State agencies.

DoD and VA need to provide family and individual counseling to address these unique issues. Opportunities for the entire family and for the couple to reconnect and bond must also be provided. Our Association has recognized this need and is piloting two family retreats in the National Parks to promote family reintegration following deployment.

***We recommend an extended outreach program to service members, veterans, and their families of available psychological health resources, such as DoD, VA, and State agencies.***

***We encourage Congress to request DoD to include families in its Psychological Health Support survey; perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members); and sponsor a longitudinal study, similar to DoD’s Millennium Cohort Study, in order to get a better understanding of the long-term effects of war on our military families.***

***We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.***

***Caregivers must be afforded respite care; given emotional support through their command structure; and, be provided effective family programs.***

### **Wounded Service Members Have Wounded Families**

Our Association asserts that behind every wounded service member and veteran is a wounded family. It is our belief the government, especially the DoD and VA, must take a more inclusive view of military and veterans’ families. Those who have the responsibility to care for the wounded, ill, and injured service member must also consider the needs of the spouse, children, parents of single service members and their siblings, and the caregivers. We appreciate the inclusion in the FY08 NDAA Wounded Warrior provision for health care services to be provided by the DoD and VA for family members. DoD and VA need to think proactively as a team and one system, rather than separately; and addressing problems and implementing initiatives upstream while the service member is still on active duty status.

Reintegration programs become a key ingredient in the family’s success. In the spring of 2008, our Association held a focus group composed of wounded service members and their families to learn more about issues affecting them. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes we need to focus on treating the whole family with programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process. We must provide

opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases. We piloted a *Operation Purple® Healing Adventures* camp to help wounded service members and their families learn to play again as a family and plan one more in the summer of 2009.

Brooke Army Medical Center (BAMC) has recognized a need to support these families by expanding in terms of guesthouses co-located within the hospital grounds and a family reintegration program for their Warrior Transition Unit. The on-base school system is also sensitive to issues surrounding these children. A warm, welcoming family support center located in guest housing serves as a sanctuary for family members. The DoD and VA could benefit from looking at successful programs like BAMC's which has found a way to embrace the family unit during this difficult time.

### **Transitioning for the Wounded and Their Families**

Transitions can be especially problematic for wounded, ill, and injured service members, veterans, and their families. The DoD and the VA health care systems, along with State agency involvement, should alleviate, not heighten these concerns. They should provide for coordination of care, starting when the family is notified that the service member has been wounded and ending with the DoD, VA, and State agencies working together, creating a seamless transition, as the wounded service member transfers between the two agencies' health care systems and, eventually, from active duty status to veteran status.

Transition of health care coverage for our wounded, ill, and injured and their family members is a concern of our Association. These service members and families desperately need a health care bridge as they deal with the after effects of the injury and possible reduction in their family income. We have created two proposals. Service members who are medically retired and their families should be treated as active duty for TRICARE fee and eligibility purposes for three years following medical retirement. This proposal will allow the family not to pay premiums and be eligible for certain programs offered to active duty, such as ECHO for three years. Following that period, they would pay TRICARE premiums at the rate for retirees. Service members medically discharged from service and their family members should be allowed to continue for one year as active duty for TRICARE and then start the Continued Health Care Benefit Program (CHCBP) if needed.

### **Caregivers**

Caregivers need to be recognized for the important role they play in the care of their loved one. The VA has made a strong effort in supporting veterans' caregivers. The DoD should follow suit and expand their definition. Caregivers of the severely wounded, ill, and injured services members have a long road ahead of them. In order to perform their job well, they must be given the skills to be successful. This will require the caregiver to be trained through a standardized, certified program, and appropriately compensated for the care they provide. The time to implement these programs is while the service member is still on active duty status.

Our Association proposes that new types of financial compensation be established for caregivers of injured service members and veterans that could begin while the hospitalized service member is still on active duty and continue throughout the transition to care under the VA. This compensation should recognize the types of medical and non-medical care services provided by the caregiver, travel to appointments and coordinating with providers, and the severity of injury. It should also take into account the changing levels of service provided by the caregiver as the veteran's condition improves or diminishes or needs for medical treatment changes. These needs would have to be assessed quickly with little time delay in order to provide the correct amount of compensation. The caregiver should be paid directly for their services, but the compensation should be linked to training and certification paid for by the VA and transferrable to employment in the civilian sector if the care is no longer needed by the service member. Our Association looks forward to discussing details of implementing such a plan with Members of this Subcommittee.

Consideration should also be given to creating innovative ways to meet the health care and insurance needs of the caregiver, with an option to include their family. Perhaps, caregivers of severely

injured service members or veterans can be given the option of buying health insurance through the Federal Employees Health Benefit Program or through enrollment in CHAMPVA. A mechanism should also be established to assist caregivers who are forced out of the work force to save for their retirements, for example, through the federal Thrift Savings Plan.

There must be a provision for transition for the caregiver if the caregiver's services are no longer needed, chooses to no longer participate, or is asked by the veteran to no longer provide services. The caregiver should still be able to maintain health care coverage for one year. Compensation would discontinue following the end of services/care provided by the caregiver.

The VA currently has eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. DoD should evaluate these pilot programs to determine whether to adopt them for themselves. Caregivers' responsibilities start while the service member is still on active duty.

### **Relocation Allowance**

Active Duty service members and their spouses qualify through the DoD for military orders to move their household goods (known as a Permanent Change of Station (PCS)) when they leave the military service. Medically retired service members are given a final PCS move. Medically retired married service members are allowed to move their family; however, medically retired single service members only qualify for moving their own personal goods.

The National Military Family Association is requesting the ability for medically retired single service members to be allowed the opportunity to have their caregiver's household goods moved as a part of the medical retired single service member's PCS move. This should be allowed for the qualified caregiver of the wounded service member and the caregiver's family (if warranted), such as a sibling who is married with children or mom and dad. This would allow for the entire caregiver's family to move, not just the caregiver. The reason for the move is to allow the medically retired single service member the opportunity to relocate with their caregiver to an area offering the best medical care, rather than the current option that only allows for the medically retired single service member to move their belongings to where the caregiver currently resides. The current option may not be ideal because the area in which the caregiver lives may not be able to provide all the health care services required for treating and caring for the medically retired service member. Instead of trying to create the services in the area, a better solution may be to allow the medically retired service member, their caregiver, and the caregiver's family to relocate to an area where services already exist.

The decision on where to relocate for optimum care should be made with the Federal Recovery Coordinator (case manager), the service member's medical physician, the service member, and the caregiver. All aspects of care for the medically retired service member and their caregiver shall be considered. These include a holistic examination of the medically retired service member, the caregiver, and the caregiver's family for, but not limited to, their needs and opportunities for health care, employment, transportation, and education. The priority for the relocation should be where the best quality of services is readily available for the medically retired service member and his/her caregiver.

The consideration for a temporary partial shipment of caregiver's household goods may also be allowed, if deemed necessary by the case management team.

### **Medical Power of Attorney**

We have heard from caregivers of the difficult decisions they have to make over their loved one's bedside following an injury. We support the *Traumatic Brain Injury Task Force* recommendation for DoD to require each deploying service member to execute a Medical Power of Attorney and a Living Will.

***Provide transitioning wounded, ill and injured service members and their families a bridge of extended active duty TRICARE eligibility for three years, comparable to the benefit for surviving spouses.***

***Caregivers of the wounded, ill and injured must be provided with opportunities for training, compensation and other support programs because of the important role they play in the successful rehabilitation and care of the service member.***

***DoD should require each deploying service member to execute a Medical Power of Attorney and a Living Will.***

***Service members medically discharged from service and their family members shall be allowed to continue for one year as active duty for TRICARE and then start the Continued Health Care Benefit Program (CHCBP) if needed***

### **Senior Oversight Committee**

Our Association is appreciative of the provision in the FY 2009 NDAA continuing the DoD/VA Senior Oversight Committee (SOC) for an additional year. We understand a permanent structure is in the process of being established and manned. We urge Congress to put a mechanism in place to continue to monitor DoD and VA's partnership initiatives for our wounded, ill, and injured service members and their families, while this organization is being created.

***The National Military Family Association encourages the Armed Service Committee along with the Veterans' Affairs Committee to talk on these important issues. We can no longer be content on focusing on each agency separately because this population moves too frequently between the two agencies, especially our wounded, ill, and injured service members and their families.***

We would like to thank you again for the opportunity to provide information on the health care needs for the service members, veterans, and their families. Military families support the Nation's military missions. The least their country can do is make sure service members, veterans, and their families have consistent access to high quality mental health care in the DoD, VA, and within network civilian health care systems. Wounded service members and veterans have wounded families. The caregiver must be supported by providing access to quality health care and mental health services, and assistance in navigating the health care systems. The system should provide coordination of care with DoD, VA, and State agencies working together to create a seamless transition. We ask Congress to assist in meeting that responsibility.

### **III. Family Transitions**

Our Association will promote policies and access to programs providing training and support for families during the many transitions they experience.

#### **Survivors**

In the past year, the Services have been focusing on outreach to surviving families. In particular, the Army's SOS (Survivor Outreach Services) program makes an effort to remind these families that they are not forgotten. DoD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need, through all of VA's venues. New legislative language governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement or grief counseling. The goal is the right care at the right time for optimum treatment effect. DoD and the VA need to better coordinate their mental health services for survivors and their children.

We ask that the active duty TRICARE Dental benefit be extended to surviving children to mirror the active duty TRICARE medical benefit to which they are now eligible. We also ask that eligibility be expanded to those Reserve Component family members who had not been enrolled in the active duty TRICARE Dental benefit prior to the service member's death.

***Our Association recommends that surviving children be allowed to remain in the TRICARE Dental Program until they age out of TRICARE eligibility and that eligibility be expanded to those***

***Reserve Component survivors who had not been enrolled prior to the service member's death.. We also recommend that grief counseling be more readily available to survivors.***

Our Association still believes 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). 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 that 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.

Surviving active duty spouses can make several choices, dependent upon their circumstances and the ages of their children. Because SBP is offset by the DIC payment, the spouse may choose to waive this benefit and select the "child only" option. In this scenario, the spouse would receive the DIC payment and the children would receive the full SBP amount until each child turns 18 (23 if in college), as well as the individual child DIC until each child turns 18 (23 if in college). Once the children have left the house, this choice currently leaves the spouse with an annual income of \$13,848, a significant drop in income from what the family had been earning while the service member was alive and on active duty. The percentage of loss is even greater for survivors whose service members served longer. Those who give their lives for their country deserve more fair compensation for their surviving spouses.

We appreciate the establishment of a special survivor indemnity allowance as a first step in the process to eliminate the DIC offset to SBP.

We believe several other adjustments could be made to the Survivor Benefit Plan. Allowing payment of the SBP benefits into a Special Needs Trust in cases of disabled beneficiaries will preserve their eligibility for income based support programs. The government should be able to switch SBP payments to children if a surviving spouse is convicted of complicity in the member's death.

***We ask the DIC offset to SBP be eliminated to recognize the length of commitment and service of the career service member and spouse. We also request that SBP benefits be allowed to be paid to a Special Needs Trust in cases of disabled family members.***

### **Spouse Employment, Unemployment**

Our Association appreciates the expansion of the Military Spouse Career Advancement Accounts. We look forward to the rollout and full implementation of the expanded program and hope that the definition of "portable careers" is broad enough to support the diverse military spouse population. To further spouse employment opportunities, we recommend an expansion to the Workforce Opportunity Tax Credit for employers who hire spouses of active duty and Reserve component service members, and to provide tax credits to military spouses to offset the expense in obtaining career licenses and certifications when service members are relocated to a new duty station within a different state.

Our Association appreciates the 2008 Executive Order of Noncompetitive Appointment of Certain Military Spouses, but we are concerned that this will only assist a limited number of military spouses. We are also concerned this Executive Order has not yet been made effective. Many noncompetitive positions are temporary or term positions that will not afford the military spouse the opportunity to continue in Federal service when they move to a new duty station. Military spouses seek Federal employment due to the job stability and opportunities for employment as they move from one location to another.

***Our Association urges Congress recognize the value of military spouses by expanding the military spouse hiring preference beyond the DoD to the entire Federal government.***

### **Families on the Move**

Our Association is concerned about the timely implementation of the Defense Personal Property Program, formerly titled "Families First." Worldwide rollout is still incomplete and it is unclear if customer satisfaction surveys are incorporated into the carrier ranking process. Full Replacement Value has been rolled out, but is handled differently by each carrier. Families are confused about how and where to file claims. Congressional oversight is needed to press for implementation of this program and deliver the best possible service to our families.

Our Association is grateful for the addition of the weight allowance for spousal professional materials. We ask that Congress broaden the language to require the Service Secretaries to implement this much needed benefit.

A PCS move to an overseas location can be especially stressful. Military families are faced with the prospect of being thousands of miles from extended family and living in a foreign culture. At many overseas locations, there are insufficient numbers of government quarters resulting in the requirement to live on the local economy away from the installation. Family members in these situations can feel extremely isolated; for some the only connection to anything familiar is the local military installation. Unfortunately, current law permits the shipment of only one vehicle to an overseas location, including Alaska and Hawaii. Since most families today have two vehicles, they sell one of the vehicles.

Upon arriving at the new duty station, the service member requires transportation to and from the place of duty leaving the military spouse and family members at home without transportation. This lack of transportation limits the ability of spouses to secure employment and the ability of children to participate in extra curricular activities. While the purchase of a second vehicle alleviates these issues, it also results in significant expense while the family is already absorbing other costs associated with a move. Simply permitting the shipment of a second vehicle at government expense could alleviate this expense and acknowledge the needs of today's military family.

***Our Association requests that Congress ease the burden of military PCS moves on military families by pressing for the full implementation of the Defense Personal Property Program and by authorizing the shipment of a second vehicle for families assigned to an overseas location on accompanied tours.***

### **Education of Military Children**

While our Association remains appreciative for the additional funding you provide to civilian school districts educating large numbers of military children, DoD Impact Aid still remains under-funded. We urge Congress to increase funding for schools educating large numbers of military children to \$60 million for FY 2010. We also encourage you to make the additional funding for school districts experiencing growth available to all school districts experiencing significant enrollment increases and not just to those districts meeting the current 20 percent enrollment threshold. The arrival of several hundred military students can be financially devastating to any school district, regardless of how many of those students the district already serves. This supplement to Impact Aid is vital to school districts that have shouldered the burden of ensuring military children receive a quality education despite the stresses of military life.

As increased numbers of military families move into new communities due to Global Rebasing and BRAC, their housing needs are being met further and further away from the installation. Thus, military children may be attending school in districts whose familiarity with the military lifestyle may be limited. Educating large numbers of military children will put an added burden on schools already hard-pressed to meet the needs of their current populations. With over 70,000 military families returning to the United States, at the same time the Army is moving over one third of its soldiers within the U.S., we urge Congress to authorize an increase in this level of funding until BRAC and Global Rebasing moves are completed.

Although it does not fall under the purview of this Subcommittee, we thank Congress for passing the Higher Education Opportunity Act of 2008, which contained many new provisions affecting military families. Chief among them was a provision to expand in-state tuition eligibility for military service

members and their families. Under this provision, colleges and universities receiving federal funding under the act will be required to offer in-state tuition rates for active duty service members and their families and provide continuity of in-state rates if the service member receives orders for an assignment out of state. However, family members have to be currently enrolled in order to be eligible for continuity of in-state tuition. Our Association is concerned that this would preclude a senior in high school from receiving in-state tuition rates if his or her family PCS's prior to matriculation. We urge Congress to amend this provision.

Our Association congratulates the DoD Office of Personnel and Readiness and the Council of State Governments (CSG) for drafting the *Interstate Compact on Educational Opportunity for Military Children* and for spearheading the adoption of this important legislation. Designed to alleviate many of the transition issues facing military children, the Compact has now been adopted in twenty States. In addition, Hawaii has a Compact bill awaiting their Governor's signature, and 11 other States are working active legislation this year. With ten States needed to enact the Compact, the first meeting of the Interstate Commission on Educational Opportunity for Military Children met in October 2008. Our Association is pleased to have been a member of both the Advisory Group and Drafting Team, and has been working actively to support the adoption of this Compact, which will greatly enhance the quality of life of our military children and families.

***We ask Congress to increase the DoD supplement to Impact Aid to \$60 million to help districts better meet the additional demands caused by large numbers of military children, deployment-related issues, and the effects of military programs and policies. We also ask Congress to allow all school districts experiencing a significant growth in their military student population due to BRAC, Global Rebasing, or installation housing changes to be eligible for the additional funding currently available only to districts with an enrollment of at least 20 percent military children.***

## **Spouse Education**

Since 2004, our Association has been fortunate to sponsor our Joanne Holbrook Patton Military Spouse Scholarship Program, with the generosity of donors who wish to help military families. In 2007, we published *Education and the Military Spouse: The Long Road to Success*, based on spouse scholarship applicant survey responses, identifying education issues and barriers specific to military spouses. The entire report may be found at [www.nmfa.org/education](http://www.nmfa.org/education).

The survey found military spouses, like their service members and the military as a whole, value education and set education goals for themselves. Yet, military spouses often feel their options are limited. Deployments, the shortage of affordable and quality child care, frequent moves, the lack of educational benefits and tuition assistance for tuition are discouraging. For military spouses, the total cost of obtaining a degree can be significantly higher than the cost for civilian students. The unique circumstances that accompany the military lifestyle have significant negative impacts upon a spouse's ability to remain continuously enrolled in an educational program. Military spouses often take longer than the expected time to complete their degrees. More than one-third of those surveyed have been working toward their goal for five years or more. The report offers recommendations for solutions that Congress could provide:

- Ensuring installation education centers have the funding necessary to support spouse education programs and initiatives,
- Providing additional child care funding to support child care needs of military spouse-scholars,
- Helping to defray additional costs incurred by military spouses who ultimately spend more than civilian counterparts to obtain a degree.

Our Association wishes to thank Congress for passing the Post 9/11 G.I. Bill for service members and for including transferability of the benefit to spouses and children. We will continue to monitor the implementation of this benefit, and hope to see the regulations posted soon.

## **Military Families – Our Nation’s Families**

We thank you for your support of our service members and their families and we urge you to remember their service as you work to resolve the many issues facing our country. Military families are our Nation’s families. They serve with pride, honor, and quiet dedication. Since the beginning of the war, government agencies, concerned citizens and private organizations have stepped in to help. This increased support has made a difference for many service members and families, yet, some of these efforts overlap while others are ineffective. In our testimony, we believe we have identified improvements and additions that can be made to already successful programs while introducing policy or legislative changes that address the ever changing needs of our military population. Working together, we can improve the quality of life for all these families