OFFICIAL STATEMENT OF

CMSGT (RET.) ROBERT L. FRANK
CHIEF EXECUTIVE OFFICER
AIR FORCE SERGEANTS ASSOCIATION

FOR THE SENATE COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON PERSONNEL

Healthcare Proposals of the Military Compensation and Retirement Modernization Commission

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AIR FORCE SERGEANTS ASSOCIATION
5211 Auth Road, Suitland, Maryland 20746
301.899.3500 | www.hqafsa.org
Email: staff@afsahq.org
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CURRICULUM VITAE

Chief Master Sgt. (Retired) Robert L. Frank is the Chief Executive Officer of the Air Force Sergeants Association. He oversees the daily operations, advocacy efforts, outreach and support on behalf of the Association's 110,000 dues-paying members worldwide. Mr. Frank served 26 years in the United States Air Force at numerous stateside and overseas locations. His last duty assignment was on the Air Staff as the First Sergeant Special Duty Manager in the Office of the Chief Master Sergeant of the Air Force. While there he led, established policy, and provided guidance for more than 2,500 Regular Air Force, Air National Guard and Air Force Reserve First Sergeants. Before joining the Air Force Sergeants Association, Mr. Frank served as the Veteran Outreach Specialist with the Consumer Financial Protection Bureau's Office of Servicemember Affairs where he established a new position and Veteran engagement strategy for this startup government agency. He assumed his current position on May 26, 2014.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Air Force Sergeants Association (AFSA) does not currently receive, nor has the association ever received, any federal money for grants or contracts. All of the Association's activities and services are accomplished completely free of any federal funding.

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Chairman Graham, Ranking Member Gillibrand, and members of this committee, thank you for this opportunity to present the views of the Air Force Sergeants Association (AFSA) on the military health care recommendations of the Military Compensation and Retirement Modernization Commission.

AFSA is a 110,000-member strong, federally chartered, worldwide veterans and military service association representing the quality-of-life interests of current and past enlisted Airmen as well as their families. We are in a unique position to understand the views of enlisted servicemembers as half of our membership is currently serving in uniform and half are retirees or veterans. We have chapters at every Air Force base around the world, as well as a variety of retiree chapters. As such, we have the pulse of our members and regularly receive feedback on a variety of important issues. The matter of military healthcare is of particular importance to military beneficiaries. Our members repeatedly tell us that looking forward to the retirement healthcare benefit is <u>the greatest incentive to serve a full military career</u>, a benefit rightfully earned after a physically challenging, at-risk, sacrifice-laden, long-term portion of their adult lives.

Mr. Chairman, members of the committee, allow me to be blunt: the proposed changes to the healthcare system <u>break faith</u> with those who have already honored their end of the contract…but also to those who have chosen to serve based on the system we have today. To pass these costs on is <u>the wrong thing to do</u>.

We agree with Secretary of Defense Ashton Carter's recent statement to *Stars & Stripes*: "Any change we make [should] be one that those who are in service don't have to [accept] if they don't want to, because I don't want to breach our understanding with you at the time you joined. That's not fair."

This Association is not against all changes to healthcare. Rather than resorting to demagoguery, we believe improvement is worth looking into and are willing to work with this committee to provide the enlisted perspective you should have when debating the topic of healthcare and benefits. We are not simply gargoyles sitting watch to make sure nothing changes, and we firmly believe that improving anything is worth a look, but not at the expense to the retiree that the commission's report outlines.

This proposal is clearly about saving money, and we don't support putting the effect of shaving the budget on the backs of retirees. The commission said up front this was about making things better, but the specific proposal to increase the out-of-pocket costs from 5% to 20% clears the smoke and moves the mirrors revealing the true nature of the proposal: to save $6.06 Billion annually. A shift of this nature will be an even greater financial burden on our retirees, as the proposed healthcare system will be more expensive, especially as the healthcare market has changed and the cost becomes exponentially higher the older a person gets. Many enlisted retirees, who have faithfully served their nation, will no longer be able to afford the very healthcare system they were promised.

Furthermore, the charge that TRICARE is broken is just not true. Examples provided by the commission have yet to indicate a reason to completely scrap a system that has successfully served countless military, retirees and family members for two decades. We agree there are opportunities for improvement, but we urge the committee to do two things: ensure any change is thoroughly studied, vetted, and tested before widespread implementation, and provided only as an option for current retirees and those serving.

The history of the military healthcare benefit has been one of budget targeting, benefit reduction, and uncertainty for those who serve. Despite denials of government officials, one promised benefit for a full military career (all the way into the early 1990s, based on government documents, recruiting and retention brochures, etc.) was that of free, lifetime healthcare if a member would service a full career of fighting wars, repeated deployments, subjection to unlimited liability, family separations, etc. However, starting in 1966, if they wanted healthcare, non-serving military beneficiaries had to, for the first time, begin contributing enrollment fees and copayments for their healthcare under a congressionally created program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). About twenty years ago, Congress once again looked at budget reduction challenges and, as usual, zeroed in on the military healthcare benefit. The result was a transition from CHAMPUS to TRICARE.

When TRICARE came into being, it required even more out-of-pocket dollars for military healthcare. Over the 20-year history of TRICARE we saw the promise of TRICARE Prime becoming available all across our nation was never fulfilled. We saw repeated tinkering with the benefit, including services available, copayment levels, increased costs of the pharmacy benefits,

etc.—in each case to reduce spending on the healthcare benefit.

From the beginning of the pay-for-health care era, our oldest military retirees, their family members, and their survivors lost their entitlement to a unique military healthcare benefit that recognized their extraordinary service and sacrifice--as they were thrown out of TRICARE when they reached Medicare eligibility. That changed about 14 years ago when Congress wisely created TRICARE for Life (TFL), not really part of TRICARE (and its three healthcare choices), but a separate Medicare "wraparound" program. Obviously, there is no longer any free, lifetime healthcare for those who have served. And today we are once again looking at the matter of reducing the value (by increasing out-of-pocket expenses) of the military medical benefit.

A Need for Stability. Mr. Chairman, military stakeholders are uncertain, worried that those who control their very lives are bent on continuing to target their benefits, their futures. We would contend the need for strong, stable, enabling support of servicemembers has not changed and will not change in the future—and this includes the healthcare benefit.

This nation considers a number of things as requiring mandatory, guaranteed spending--things such as Medicaid, the SNAP (food stamps) program, major elements of the Affordable Care Act, Social Security, Medicare, federal and military pensions, etc. However, the benefits supporting those who are willing to fight and die to preserve freedom and liberty, and the stability of the programs that support their families are consistently considered spending-reduction targets. In other words, the benefits that military members can depend upon as a condition of employment are always subject to the political philosophies and the exigencies of the economy in effect at a particular time.

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Today, the Administration is once again considering a <u>major</u> change in the military healthcare benefit for the obvious purpose of budget reduction. We urge this Congress to very carefully consider these healthcare benefit recommendations—before deciding the most prudent way to proceed.

Paramount should be the health and the future of the All-Volunteer Force and the morale of those who uniquely give so much to this nation. It would seem to us that the decision to entirely break the current healthcare system because of funding, rather than to correct institutional deficiencies in the TRICARE system (which would most likely reduce costs) is an option fraught with risk.

During this statement, I want to point out a few concerns, make a few observations, and ask a few questions about the military healthcare proposals made by the Commission. We applaud them for their exhaustive efforts. However, we ask this Congress to consider carefully how you decide to change military healthcare benefits--as this will be changing a major aspect of the military benefits package which has proven to serve us very well during the entire 41-year history of the All-Volunteer Force. The change would be so major, it would be very difficult to correct should this be a bad decision.

MCRMC Affirmation of TRICARE for Life. From the outset we want to commend the Commission for recommending that the TRICARE for Life program be left alone—that it is a deserved, well-warranted program for our oldest and our most frail military retirees, family members, and survivors now facing their final years. Many have labeled the congressionally produced program of TRICARE for Life a "blessing." Again, we applaud the Commission's confirmation that there should be a zero cash premium for those eligible for the TFL benefit—their payment of Medicare Part B is certainly enough for them to pay.

Recommendation 5: Proposal to Establish a Joint Readiness Command. We understand establishing a joint readiness command for the primary reasons stated by the Commission. However, the details of the proposal as presented by the Commission beg a few important questions and call for certain observations we ask this Congress to examine:

- What would be the specific budgetary authority of this joint command? Would it have a major input in budgetary decisions, or would it be subject to constant reaction to the budgetary decisions of others?

- We would oppose copayments for beneficiaries who are able to get care in military treatment facilities (MTFs). This would be especially important if MTFs will continue to want older beneficiaries for trauma and surgery "practice," and for other needs. In any case, care in an MTF for non-active duty members should be without cost to the beneficiary.

- Would military treatment facilities (MTFs) be downsized and those in remote areas more likely be eliminated? The proposal is unclear on this but seem to suggest it.

- The suggestion in the proposal is that use of MTFs will no longer be a part of the military healthcare benefits package, but rather availability of the MTF to beneficiaries will only be as an optional readiness/training tool to benefit the purposes of the joint command. We would oppose this.

- If catchment areas are eliminated (as in the proposal) would distance of travel be eliminated as a consideration for MTF care?

- If MTFs are opened to non-DoD eligibles (as in the proposals) this would most likely reduce available care in those MTFs for military beneficiaries.

- If MTFs are going to be focused readiness tools, and the other Commission proposals are adopted (Recommendation 6, in particular), why should MTFs not be offered as a partner of insurers to be used as an HMO's provider for certain surgical and other medical procedures that would especially develop combat readiness?

Recommendation 6: Eliminate TRICARE and, instead, offer FEHBP-like insurance plans (HMOs, PPOs, fee for service plans, with varied premiums, deductibles, and copays) with fees similar to those paid by civilians, but with the government picking up the cost of annual premiums.

Overarching Concerns about this Proposal:

- ***Permanence of the Premium Payment Feature?*** Will Congress make the full payment of beneficiary enrollment premiums for the members' healthcare program choice mandatory in law, and not subject to future debate and reduction? In other words, will those serving have some sense of stability that these changes will be dependable, guaranteed-in-law, and not subject in future years to targeting as a potential budget reduction tool? This is a critical question since the payment of enrollment fees would become the only remaining military retiree and family member healthcare benefit. Past history would suggest that once this program is in place, future leaders will seek to reduce the portion of the enrollment fees paid by the government and further increase beneficiaries' out-of-pocket expenses.

- ***Consistency of Out-of-Pocket Costs?*** For those currently serving, to what extent will they be able to depend on the portion of their dependents' healthcare costs they will have to pay out-of-pocket? What about those who are "working-age retirees?" This is particularly important since we live in an era where even annual military pay raises are not guaranteed to keep up with the economy in which they must live (for two years in a row, Congress has approved military pay adjustments below private sector wage growth, with the Administration proposing several more reduced annual pay adjustments). Increasing out of-pocket healthcare expenses in such a fiscally restrained environment is a real problem.

- ***Transparency***. To get stakeholders to buy into the changes, we believe our government leaders should honestly explain (with examples, etc.) how much more an average military beneficiary will have to pay out-of-pocket or his/her overall healthcare, should the Commission recommendations be adopted.

Specific Questions and Concerns:

- Would the TRICARE pharmacy benefit be maintained? It would seem the conversion to civilian healthcare choices for plans (which usually incorporate pharmacy plans) would set the stage for abandonment of the TRICARE pharmacy as a cost-reduction tool. Or would the OPM-administered plans not include prescription coverage?

- Who would be the final arbiter in deciding choices which would now involve OPM/federal civilian/military beneficiary issues?

- The Commission's assertion that reducing the benefit value and raising beneficiary costs is warranted because it will discourage unnecessary beneficiary usage is an unsupportable argument and ignores the many reasons for usage of the benefit among those who have served.

- The 20 percent (albeit phased-in) cost share for military beneficiaries is too high, ignores the extremely unique risk and value provided to this nation by military members, and virtually eliminates the health care package as the major draw to staying in the military for a full career.

- The MCRMC plan is unclear about healthcare for beneficiaries who reside overseas. Would they be disenfranchised from this military healthcare plan? TRICARE certainly would no longer be available to them.

- The plan also fails to mention how it would provide healthcare to severely disabled servicemembers once they are retired from service, including Chapter 61 retirees.

- What would be the logistics and procedures used for the MTFs' role in the overall plan for military beneficiaries? Some aspects of this question were touched upon above in regard to Recommendation 5. This question should be directly decided by Congress rather than leaving it up to those who want to avoid budgetary obligations for beneficiaries in MTFs.

Recommendation 7: Addressing Health Care Issues of Special-Needs Military Family Members. AFSA supports the Commission's recommendation but believes there will need to be a transitional benefit period for those currently served by the Extended Care Health Option (ECHO) since once the member retires, the dependent will most likely find him/herself at the bottom of state Medicaid lists. So, aligning services offered within the ECHO to those of state Medicare waiver programs might well put the children/dependents of those who served at a disadvantage.

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Mr. Chairman and members of this committee, our members have made it clear that they are very concerned about their current retirement and healthcare systems being devalued and replaced. We believe it is wrong to discount the morale of those serving who look to take care of their families following more than 20 years of high deployment tempos and war, and who look to the future with uncertainty in terms of their retirement--specifically because of the yearly

budgetary targeting of their benefit programs. Again, our members are not clamoring for a change, and our members do consider the healthcare benefit piece as a critical enticement to a military career.

Our members are very aware that it is not the intent/proposal of the Commission for the healthcare benefit changes to be grandfathered—but that they (the servicemembers and their families) will be directly and immediately impacted by these decisions. Again, we maintain our nation must not rush into these changes, if at all. Time must be taken to properly and seriously consider and gauge the potential impact on the future success of the All-Volunteer Force.

In the coming months this Committee will exercise its collective wisdom to decide if a major departure from the current healthcare system is justified and appropriate. We do not envy you in that regard and we fully recognize the burden of leadership you carry out on behalf of this nation. As such, we pledge our cooperation, participation, and support of your effort to make the right decisions for the great men and women who serve to protect and defend the interests of the American people.

(end of statement)