Report of the Military Compensation and Retirement Modernization Commission

Final Report

January 2015

MILITARY COMPENSATION AND RETIREMENT MODERNIZATION COMMISSION

CHAIRMAN
The Honorable Alphonso Maldon, Jr.

COMMISSIONERS
The Honorable Larry L. Pressler
The Honorable Stephen E. Buyer
The Honorable Dov S. Zakheim
Mr. Michael R. Higgins
General Peter W. Chiarelli, U.S. Army, Retired
Admiral Edmund P. Giambastiani, Jr., U.S. Navy, Retired
The Honorable J. Robert (Bob) Kerrey
The Honorable Christopher P. Carney

EXECUTIVE DIRECTOR
Mr. Robert B. Daigle

DEPUTY DIRECTOR
Ms. Nancy C. Crisman

ASSOCIATE DIRECTORS
Ms. Moira N. Flanders, U.S. Navy, Retired
Mr. Christopher T. Meyer, U.S. Navy, Retired
Ms. Susan Schleigh
Mr. James Graybeal, U.S. Navy, Retired
Mr. Christopher Nuneviller, U.S. Army, Retired

GENERAL COUNSEL
Ms. Elizabeth DiVecchio Berrigan, U.S. Army, Retired

Report of the Military Compensation and Retirement Modernization Commission

Final Report

January 29, 2015

COMMISSIONERS' LETTER

January 29, 2015

We are honored to submit to the President and the Congress of the United States the enclosed recommendations to modernize the Uniformed Services' (the Services) compensation and retirement system. We are confident these recommendations will ensure that the Services can maintain the most professional All-Volunteer Force possible, during both peacetime and wartime. Our confidence stems from our unwavering commitment to the interests of Service members and their families. In fact, our recommendations, which all members of this Commission unanimously support, are designed to protect both the overall value of the current benefits package and the quality of life of the 21st century Force—those who serve, those who have served, and the families that support them.

The Services' compensation system provides the Nation with an All-Volunteer Force without peer. This fact has been proven during the last 42 years and decisively reinforced during the last 13 years of war. After 42 years of an All-Volunteer Force, the President and the Congress agreed that it was time to study in detail the pay and benefits of the Services.

The Services require flexible, modern, and relevant compensation tools to continue to recruit and retain the high-quality men and women needed to protect and defend our Nation into the future. Consequently, the Services must be empowered with flexible personnel-management tools to shape the force as security needs change. Our proposed reforms provide additional, yet fiscally sustainable, options for Service personnel managers to design and manage a balanced force. Pursuant to the National Defense Authorization Act for Fiscal Year 2013, our recommendations are limited to compensation, retirement, and benefits modernization issues.

Our volunteer Service members are the strength of our military, and it is our continuous duty and obligation to ensure that the Services are properly resourced. National security is a Constitutional priority, and fiscal challenges facing our Nation cannot be solved by focusing solely on the military. Necessary resources include compensation and benefits for our Service members and their families, who also deserve long-term stability. It is our view that the current era of ongoing Service budget reductions and uncertainty is adversely affecting readiness and is increasing risks in our Nation's ability to meet growing national security requirements.

Our recommendations improve the efficiency and sustainability of compensation benefits, and they enhance the overall value of those benefits. Our military pay and retirement recommendations grandfather the retirement pay of existing retirees and those currently in the Force. They also maintain the majority of the existing retirement

structure, which is an important retention tool, while allowing members of a younger, more mobile work force to begin investing in their own future. To better meet the needs of our Reserve Component, we recommend streamlining Reserve Component duty statuses. We further recommend an increase in Service members' opportunity for coverage in the Survivor Benefit Plan.

In considering the military health benefit, we focused on sustaining medical readiness by recommending a new readiness command, supporting elements, and framework for maintaining clinical skills. This system would ensure that today's medically ready force would continue to provide the best possible combat care. Our recommendations also improve access, choice, and continuity of care for family members, Reserve Component members, and retirees. These recommendations maintain or reduce the cost of health care for the vast majority of families of active-duty Service members and establish a fund to lessen the burden of chronic and catastrophic conditions. We recommend ways to increase collaboration and resource sharing between the Departments of Defense and Veterans Affairs. The net result of these recommendations is a modernized health care system that should benefit our Service members, veterans, retirees, and family members far into the 21st century.

Our recommendations related to quality of life focus on enhancing benefits for Service members and their families, while improving cost-effectiveness. We recognize the historically transformative power of the GI Bill. In particular, the Post-9/11 GI Bill has been effective in improving the education level of numerous Service members, veterans, retirees, and their families. Our recommendations improve the sustainability of these education benefits.

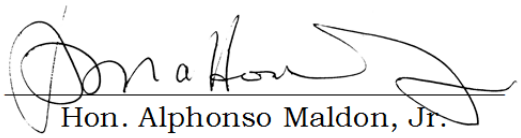
Many Service members, retirees, and their families articulated the importance of Department of Defense commissaries and exchanges. Our findings reflect their view, and we recommend ways to maintain these benefits at lower costs. We propose several enhanced benefits for Service members and their families, including additional coverage for exceptional family members, budgeting for child care facilities, academic monitoring of dependents in public schools, nutritional assistance coverage, access to space-available travel, and Service member transition support.

We thank all who have supported the efforts of the Commission, especially the many Service members, veterans, retirees, and family members who engaged with the Commission directly. The Commission has received, via in-person and survey responses, feedback from more than 100,000 active-duty Service members, Reserve Component members, veterans, retirees, and their families. We have met with more than 150 Government agencies, military advocates, research institutions, and related interest groups. We are confident that the recommendations put forward in this report offer an improved compensation and benefits package.

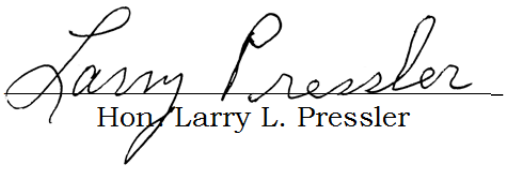
Ensuring Service members and their families are cared for is a sacred responsibility of a grateful Nation. Being part of the public discussion regarding how we, as a Nation, modernize their benefits and fulfill this obligation has been our great honor. We are confident that implementing these reforms will move the All-Volunteer Force toward a future that is in the best interest of our Nation's security and that can be fiscally sustained. We believe, for those who serve and have served to uphold the military's

highest traditions and heritage, and the families that support them, the Federal Government must fulfill its obligation with its enduring commitment in war and in peace.

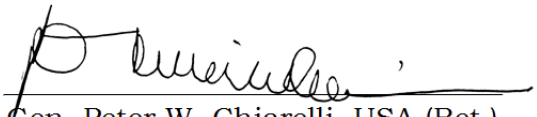
Respectfully submitted,



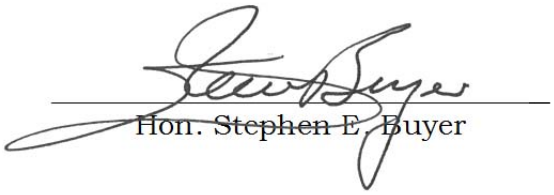
Hon. Alphonso Maldon, Jr.
Chairman



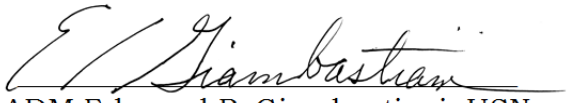
Hon. Larry L. Pressler



Gen. Peter W. Chiarelli, USA (Ret.)

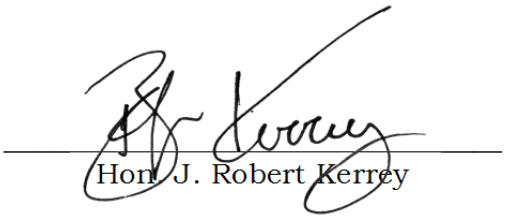


Hon. Stephen E. Buyer

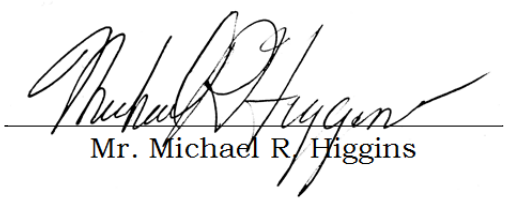


ADM Edmund P. Giambastiani, USN (Ret.)

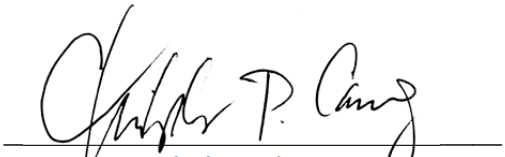
Hon. Dov S. Zakheim



Hon. J. Robert Kerrey



Mr. Michael R. Higgins



Hon. Christopher Carney

THIS PAGE INTENTIONALLY LEFT BLANK

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

THIS PAGE INTENTIONALLY LEFT BLANK

LIST OF ACRONYMS

ACRONYM	DEFINITION
AAFES	Army Air Force Exchange System
AAP	American Academy of Pediatrics
ABA	Applied Behavior Analysis
AC	Active Component
ADFM	Active-Duty Family Member
AIP	Assignment Incentive Pay
APF	Appropriated Funds
ACSI	American Customer Satisfaction Index
BAG	Budget Activity Group
BAH	Basic Allowance for Housing
BAHC	Basic Allowance for Health Care
BAS	Basic Allowance for Subsistence
BEC	Benefits Executive Committee
BOD	Board of Directors
CABG	Coronary Artery Bypass Grafting
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBO	Congressional Budget Office
CCHHS	Cook County Health and Hospital System
CDC	Child Development Center
CDP	Child Development Program
CEB	Cooperative Efforts Board
CFR	Code of Federal Regulations
CLS	Combat Life Saver
CMAC	CHAMPUS Maximum Allowable Charge
CP	Continuation Pay
C-STARS	Centers for Sustainment of Trauma and Readiness Skills (USAF)
DACMC	Defense Advisory Committee on Military Compensation
DB	Defined Benefit
DC	Defined Contribution
DeCA	Defense Commissary Agency

ACRONYM	DEFINITION
DEERS	Defense Enrollment Eligibility Reporting System
DeRA	Defense Resale Activity
DFAS	Defense Finance and Accounting Service
DHA	Defense Health Agency
DIC	Dependency and Indemnity Compensation
DMDC	Defense Manpower Data Center
DoDI	DoD Instruction
DoDTR	Department of Defense Trauma Registry
DOL	U.S. Department of Labor
DRM	Dynamic Retention Model (RAND)
DVOP	Disabled Veterans' Outreach Program
EBT	Electronic Benefit Transfer
ECHO	Extended Care Health Option
EHHC	ECHO Home Health Care
EHR	Electronic Health Record
EFM	Exceptional Family Member
EFMP	Exceptional Family Member Program
EMC	Essential Medical Capability
ERISA	Employee Retirement Income Security Act
ESEA	Elementary and Secondary Education Act
FCC	Family Child Care
FDA	U.S. Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FFS	Fee-For-Service
FHCC	Federal Health Care Center
FMR	Financial Management Regulation
FMWG	Financial Management Working Group
FOC	Final Operating Capabilities
FSSA	Family Subsistence Supplemental Allowance
GAO	U.S. Government Accountability Office
HCBS	Home and Community-Based Services
HCSDB	Health Care Survey of DoD Beneficiaries
HEC	Health Executive Committee

ACRONYM	DEFINITION
HEDIS	Healthcare Effectiveness Data and Information Set
HMO	Health Maintenance Organization
IC3	Interagency Care Coordination Committee
IDA	Institute for Defense Analyses
iEHR	Integrated Electronic Health Record
IOC	Initial Operating Capabilities
IPO	Interagency Program Office
IT	Information Technology
JEC	Joint Executive Committee
JIF	Joint Incentive Fund
JMROC	Joint Medical Readiness Oversight Council
JRC	Joint Readiness Command
JSP	Joint Strategic Plan
JVSG	Jobs for Veterans State Grant
LES	Leave and Earnings Statement
LMI	Logistics Management Institute
LVER	Local Veterans' Employment Representative
MAP	Medical Advisory Panel
MCCS	Marine Corps Community Services
MCRMC	Military Compensation and Retirement Modernization Commission
MCSC	Managed Care Support Contract
MCX	Marine Corps Exchange
MERHCF	Medicare-Eligible Retiree Health Care Fund
MGIB	Montgomery GI Bill
MGIB-AD	Montgomery GI Bill Active Duty
MGIB-SR	Montgomery GI Bill Selected Reserve
MHS	Military Health System
MILCON	Military Construction
MILPERS	Military Personnel
MRF	Military Retirement Fund
MSO	Military Service Organization
MTF	Military Treatment Facility
MWR	Morale, Welfare and Recreation

ACRONYM	DEFINITION
NAF	Nonappropriated Funds
NCO	Non-Commissioned Officer
NCP	Normal Cost Payments
NDAA	National Defense Authorization Act
NEX	Navy Exchange
NEXCOM	Navy Exchange Command
NEXMART	Navy Exchange Market
O&M	Operations and Maintenance
OACT	Office of the Actuary (DoD)
OEF	Operation ENDURING FREEDOM
OIF	Operation IRAQI FREEDOM
OOP	Out-of-Pocket
OPM	U.S. Office of Personnel Management
PCM	Primary Care Manager
PFM	Personal Financial Management
PPBE	Planning, Programming, Budget, and Execution
PPO	Preferred Provider Organization
PTC	Pharmacy and Therapeutics Committee
PV	Perceived Value
PwC	PricewaterhouseCoopers
RC	Reserve Component
REAP	Reserve Education Assistance Program
RHPO	Regional Health Planning Organization
RI	Relative Importance
RSA	Resource Sharing Agreement
RVU	Relative Value Unit
SAC	School-Age Care
SBA	Small Business Administration
SBP	Survivor Benefit Plan
SDT	Second Destination Transportation
SMC	Specialized Military Condition
SNAP	Supplemental Nutrition Assistance Program (USDA)
SOCOM	Special Operations Command

ACRONYM	DEFINITION
STC	Shock Trauma Center
TA	Tuition Assistance
TAMP	Transition Assistance Management Program
TCCC	Tactical Combat Casualty Care
TFI	Total Family Income
TMA	TRICARE Management Activity
TRANSCOM	Transportation Command
TSP	Thrift Savings Plan
UETF	Unified Exchange Task Force
USDA	U.S. Department of Agriculture
USFHP	U.S. Family Health Plan
VA	U.S. Department of Veterans Affairs
VANF	VA National Formulary
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
VSO	Veterans Service Organization
WIC	Women, Infants and Children (USDA)
YOS	Years of Service

THIS PAGE INTENTIONALLY LEFT BLANK

1. EXECUTIVE SUMMARY

The Military Compensation and Retirement Modernization Commission was established by the National Defense Authorization Act (NDAA) for FY 2013 to provide the President of the United States and the Congress specific recommendations to modernize pay and benefits of the Uniformed Services.[1] The Commission's legislative mandate, coming after 42 years with an All-Volunteer Force and 13 years of war, was to provide recommendations that:

- *ensure the long-term viability of the All-Volunteer Force by sustaining the required human resources of that force during all levels of conflict and economic conditions;*
- *enable the quality of life for members of the Armed Forces and the other Uniformed Services and their families in a manner that fosters successful recruitment, retention, and careers for members of the Armed Forces and the other Uniformed Services; and*
- *modernize and achieve fiscal sustainability for the compensation and retirement systems for the Armed Forces and the other Uniformed Services for the 21st century.*[2]

The President issued a set of eight guiding principles to the Commission.[3] This report addresses those mandates and principles, discusses in detail the areas where reform is required, states the considerations that should guide reform, and offers specific recommendations to solve the problems that were identified. For example, the Commission recommends moving from a purely defined benefit to a blended defined benefit and defined contribution retirement system. It proposes a new command dedicated to the oversight of joint readiness, especially readiness of the medical force. It recommends improving access, choice, and value of the health benefit for active-duty families, Reserve Component members, and retirees.[4] It also outlines ways to sustain Service-member education programs and strengthen numerous family support programs. These recommendations respond to the preferences of a new generation of Service members by improving choice and flexibility within their compensation package. The Commission made a conscious decision that its focus would not be budget driven. Nevertheless, these recommendations offer efficiencies that substantially reduce government expenditures. This approach ensures pragmatic

[1] Throughout this report, "Services" refers to the Uniformed Services, which include the Army, Marine Corps, Navy, Air Force, Coast Guard, and the Commissioned Officer Corps of the National Oceanographic and Atmospheric Administration and U.S. Public Health Service (see Armed Forces, 10 U.S.C. § 101(a)(5)). References to the Military Services or Armed Forces include the Army, Marine Corps, Navy, Air Force, and Coast Guard (see Armed Forces, 10 U.S.C. § 101(a)(4)).

[2] National Defense Authorization Act for FY 2013, Pub. L. No. 112-239 subtitle H, 126 Stat. 1632, 1787 (2013) (as amended by National Defense Authorization Act for FY 2014, Pub. L. No. 113-66, § 1095(b), 127 Stat. 672, 879 (2013)).

[3] The President's guiding principles can be found in Section 4. Government Printing Office, *Principles for Modernizing the Military Compensation and Retirement Systems: Message from the President of the United States*, accessed November 21, 2014, http://www.gpo.gov/fdsys/pkg/CDOC-113hdoc60/html/CDOC-113hdoc60.htm.

[4] A retiree is any person who has served at least 20 years in a Service and has been permanently released from duty or a person who has been released from duty before 20 years of service and declared by the Service to be retired because of medical condition or disability. *See* Armed Forces, 10 U.S.C. §§ 3911, 3914 (Army); Armed Forces, 10 U.S.C. §§ 6323, 6330 (Navy); Armed Forces, 10 U.S.C. §§ 8911, 8914 (Air Force); Coast Guard, 14 U.S.C. §§ 291, 355 (Coast Guard); Navigation and Navigable Waters, 33 U.S.C. § 3044 (NOAA Commissioned Officer Corps); The Public Health and Welfare, 42 U.S.C. § 212 (U.S. Public Health Service Commissioned Corps).

fiscal sustainability. Although there may be additional opportunities to identify efficiencies in personnel and force structure programs, the NDAA for FY 2013 limited the Commission's review to compensation modernization issues.

The profound and constant change that has affected our Nation since the inception of the All-Volunteer Force, coupled with an unprecedented 13 years of war, offer a compelling backdrop for compensation reform. The Commissioners—comprising more than 140 years of military service experience among them—have completed a comprehensive review and analysis of the current benefits of Uniformed Service members. The Commissioners concluded that several key features of the compensation system continue to meet the needs of the All-Volunteer Force. The basic pay table provides simplicity, equity, and transparency, and the targeted changes to the pay tables in 2000-2001 proved valuable during the 13 years of war. The system of allowances is appropriate and strikes the correct balance between Service member compensation and financial assistance for expenses. TRICARE for Life continues to ensure high-quality health care for retired Service members across the country.

The recommendations in this report are informed by the valuable insights of a broad range of Service members, veterans,[5] retirees, and their families. The Commission surveyed more than 1.5 million Service members and retirees. It developed an ongoing working relationship with more than 30 military and veteran service organizations. It also received input from numerous research institutions, private firms, and not-for-profit organizations. The Commission and its staff reviewed nearly 350 distinct benefits across the U.S. Government, including programs administered by departments of Defense, Veteran Affairs, Homeland Security, Treasury, Health and Human Services, Education, Labor, and others. The *Military Compensation and Retirement Modernization Commission Interim Report*,[6] issued in June 2014, documents these benefits in detail.

This final report focuses on reforming compensation programs to improve Service members' choice of and access to benefits. The recommendations contained within it enhance the flexibility of the compensation system for the Services, which have the responsibility to recruit and retain balanced forces and for Service members. The recommendations improve the cost-effectiveness of delivering high-quality benefits. Within this framework, the report evaluates each program in light of key changes in the cultural, generational, and technological landscape since the advent of the All-Volunteer Force. Though many programs continue to serve their intended purpose, several are duplicative, and many should be more responsive to the needs of the contemporary workforce from which the Services draw their personnel. Based on these findings, this report offers 15 recommendations that have one thing in common: these recommendations were formulated with the benefit to the Service members, and the families who support them, as a top priority.

[5] A veteran is defined as a "person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." Veterans' Benefits, 38 U.S.C. § 101(2).
[6] The *Report of the Military Compensation and Retirement Modernization Commission: Interim Report* is available for download at http://www.mcrmc.gov.

PAY AND RETIREMENT

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

The current Uniformed Service retirement system is a useful retention tool for midcareer Service members, but does not provide retirement savings to the overwhelming majority of Service members. Under the current system, 83 percent of the enlisted men and women serving our Nation will never benefit from a traditional 20-year Uniformed Service retirement.[7] The Services' retirement system should be restructured to provide retirement benefits to more than one million current Service members who would otherwise leave service without any Government-sponsored retirement savings. Doing so eases the transition of Service members to civilian life by providing them with retirement savings similar to those of their private-sector peers. This recommendation blends the recruiting benefits of a modern 401(k)-type plan, with the retention benefits of the current retirement annuity, lump sum career continuation pay, and retention bonuses paid at important career milestones in the lives of Service members. Modeling has demonstrated that such a blended system would maintain the Services' current force profiles. It also provides additional flexibilities to the Services to adjust force profiles if desired to maintain a balanced force. It would also sustain, and may improve retention and increase lifetime earnings of retirees.

2. Provide more options for Service members to protect their pay for their survivors

The Survivor Benefit Plan (SBP) has steadily become more attractive as a low cost way to provide lifetime benefits to retirees' survivors. The Commission received many Service member complaints about SBP because of the associated offset from VA Dependency and Indemnity Compensation (DIC). To help address this concern, a new SBP option should be implemented for which Service members would fully fund SBP costs but would no longer be subject to the DIC offset. The existing SBP program with the DIC offset should be maintained for Service members who want to retain lower-cost coverage.

3. Promote Service members' financial literacy

The lack of choice in current pay and benefit programs results in complacency and insufficient knowledge among Service members with regard to managing their personal finances. According to the 2013 Blue Star Families Annual Lifestyle Survey, only 12 percent of Service member respondents indicated they received financial information from their command or installation.[8] DoD should increase the frequency and strengthen the content of financial literacy training. This enhancement is especially important because the Commission's recommendations on retirement and health care require new financial decisions to be made by Service members. Improved

[7] Department of Defense, *Valuation of the Military Retirement System; September 30, 2012*, 24, accessed December 10, 2014, http://actuary.defense.gov/Portals/15/Documents/MRF_ValRpt2_2012.pdf.
[8] Blue Star Families, *2013 Military Family Lifestyle Survey, Comprehensive Report,* accessed December 10, 2014, http://www.mcrmc.gov/public/docs/report/pr/BlueStarFamilies_2013MilitaryFamilyLifestyleSurvey_Comprehensive_Report_May2013_p34_FinLit_FN_12-13-24.pdf.

financial literacy would also assist Service members from being exploited by predatory lenders and other financial manipulators.

4. Increase efficiency within Reserve Component status system

Despite the Services' operational dependence on the Reserve Component (RC) during the recent conflicts in Iraq and Afghanistan, the current RC status system "is complex, aligns poorly to current training and mission support requirements, fosters inconsistencies in compensation, and complicates rather than supports effective budgeting."[9] The RC status system causes members to experience disruptions in pay and benefits as they transition among different duty statuses.[10] Mobilization difficulties also impede operational commanders who need to employ RC personnel. There are 30 unique statuses under which RC members can be called to duty. The number of duty statuses should be streamlined to just six to benefit Service members and ease the Services' management and operational use of RC forces.

HEALTH BENEFITS

5. Ensure Service members receive the best possible combat casualty care

The vast majority of Service members who were wounded on the battlefield were able to return home from the wars in Iraq and Afghanistan. Many of them are continuing to serve our Nation because of the exceptional care they received from our military health care providers in the field. This medical expertise, honed during more than a decade of saving lives in combat, must be maintained and further improved whenever possible. Evidence shows it may be difficult to sustain these combat medical capabilities with the typical mix of cases seen in the military health care system during peacetime. The Secretary of Defense, together with the Chairman, Joint Chiefs of Staff, should seek to enhance dedicated oversight of medical readiness through the creation of a joint medical component within a newly established joint readiness command, as well as a medical directorate in the Joint Staff. The Congress and DoD should define and measure essential medical capabilities (EMCs) to promote and maintain critical capabilities within the military medical force. DoD should be granted additional authorities to attract EMC-related cases into military treatment facilities to best support their mission as a training platform for military medical personnel.

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

TRICARE often limits access to care by confining beneficiaries to a lengthy and frustrating process for obtaining specialty care and to weak networks of civilian health care providers. The adverse effect of weak provider networks is even more profound for beneficiaries living in remote locations, including RC members. The Congress should replace the current health care program with a new system that offers beneficiaries a selection of commercial insurance plans. Costs of these plans should be offset for active-duty families with a new Basic Allowance for Health Care (BAHC) and a fund to lessen the burden of chronic and catastrophic conditions. Mobilized RC members

[9] Office of the Assistant Secretary of Defense for Reserve Affairs, *Review of Reserve Component Contributions to National Defense, December 2002*, 77.
[10] Dolfini-Reed, Michelle and Darlene E. Stafford, *Identifying Duty Status Reforms Needed to Support an Operational Reserve*, CRM D0021656.A2 (Alexandria, VA: CNA, 2010), 1.

should also receive BAHC to cover the costs of a plan from the new system or of their existing insurance plan. All members of the RC should be able to purchase a plan from the DoD program at varying cost shares. Non-Medicare-eligible retirees should continue to have full access to the military health benefit program at cost contributions that gradually increase over many years but remain lower than the average Federal civilian employee cost share as recognition of their military service. Medicare-eligible retirees should continue to have access to the current TRICARE for Life program to supplement Medicare benefits.

7. Improve support for Service members' dependents with special needs

Although the Services provide substantial support for exceptional family members through various programs, State programs offer differing and additional services. Unfortunately, Service members often lose access to these state-based programs when they move between duty stations because of long waiting lists in some states. To provide continuous support services, benefits offered through the military's Extended Care Health Option program should be expanded to include services provided through state Medicaid waiver programs.

8. Improve collaboration between Departments of Defense and Veterans Affairs

DoD and VA expend tremendous national resources to ensure that Service members and veterans receive world-class health care. Yet there remain substantial opportunities for enterprisewide collaboration through standardization, elimination of barriers, and implementation of best practices. Differences in drug formularies for transitioning Service members continue to disrupt effective care. Several DoD–VA resource sharing projects have generated efficiencies for both organizations, but these efforts are mostly local, isolated arrangements. Medical information cannot yet be shared seamlessly between DoD and VA, hindering effective care for Service members and veterans. To resolve these issues, the current DoD–VA Joint Executive Committee should be strengthened with additional authorities and responsibilities to standardize and enforce collaboration between the organizations.

QUALITY OF LIFE PROGRAMS

9. Protect both access to and savings at DoD commissaries and exchanges

DoD commissaries and exchanges provide valued financial benefits to Service members and should be maintained. According to the 2013 Living Patterns Survey conducted by Defense Manpower Data Center, more than 90 percent of active-duty Service members use commissaries and exchanges.[11] Although there are many differences between commissaries and exchanges, the Commission found these two activities perform similar missions, for similar patrons, with similar staff, using similar processes. DoD commissaries and exchanges should be consolidated to leverage these similarities. The merger of many back-end operation and support functions, alignment of incentives and policies, and consistent implementation of best practices should achieve significant efficiencies while maintaining the value of the benefits for Service members and their families.

[11] Defense Manpower Data Center, *Living Patterns Survey, Tabulation of Responses*,18, http://www.mcrmc.gov/public/docs/report/qol/2013_DMDC_LivingPatternSurvey_Commissary_Usage.pdf .

10. Improve access to child care on military installations

Service members' operational readiness is directly related to their ability to be at work. Access to quality, convenient, and affordable childcare is an important part of readiness. Yet the Commission found that demand for military child care often exceeds availability, resulting in more than 11,000 children on waiting lists as of September 2014.[12] The Congress should reestablish the authority to use operating funds for minor construction projects up to $15 million for expanding or modifying child development program facilities serving children up to 12 years of age.[13] DoD should standardize reporting and monitoring of child care wait times across all types of military child care facilities. DoD should also streamline child care personnel policies to help ensure proper staffing levels.

11. Safeguard education benefits for Service members

The Military Services have repeatedly emphasized the importance of using education benefits as recruiting and retention tools. Ensuring the robustness of these programs is one of the best ways to guarantee the future of the All-Volunteer Force. There are duplicative and inefficient education benefits that should be eliminated or streamlined to improve the sustainability of the overall education benefits program. The Montgomery GI Bill Active Duty and the Reserve Education Assistance Program should be sunset in favor of the Post-9/11 GI Bill. Service members who reach 10 years of service and commit to another 2 years should be allowed to transfer their Post-9/11 GI Bill benefits to dependents. The housing stipend of the Post-9/11 GI Bill should be sunset for dependents, as should unemployment compensation for anyone receiving a housing stipend.

12. Better prepare Service members for transition to civilian life

Transitioning from the Military Services to civilian life is more challenging than it needs to be. Unemployment is still a challenge facing far too many of our veterans, especially for veterans aged 18 to 24, who had higher unemployment rates in 2013 than nonveterans of the same age group (21.4 percent and 14.3 percent, respectively).[14] To better support transition and veteran employment, DoD should require mandatory participation in the Transition GPS education track. The Department of Labor should permit state departments of labor to work directly with state VA offices to coordinate administration of the Jobs for Veterans State Grant program. The Congress should require One-Stop Career Center employees to attend Transition GPS classes to develop personal connections between transitioning veterans and One-Stop Career Centers.

13. Ensure Service members receive financial assistance to cover nutritional needs

The Commission recognized that some Service members, particularly those with large families, will continue to need financial help to purchase nutritious food for their families. The Department of Agriculture's Supplemental Nutrition Assistance Program

[12] Department of Defense and Services Child Development Program Managers, briefing to MCRMC, August 8, 2014. DoD, e-mail to MCRMC Staff, September 9, 2014.
[13] *See* National Defense Authorization Act for FY 2006, Pub. L. No. 109-163, § 2810 (2006). The authority originally expired in 2007, but was extended until 2009, when it was allowed to expire. *See* National Defense Authorization Act for FY 2008, Pub. L. No. 110-181, § 2809 (2008). *See also* Armed Forces, 10 U.S.C. § 2805.
[14] U.S. Department of Labor, Bureau of Labor Statistics, *Economic News Release, Table 2A: Employment Status of Persons 18 Years and Over by Veteran Status, Age, and Period of Service, 2013 Annual Averages*, accessed September 24, 2014, http://www.bls.gov/news.release/vet.t02A.htm.

(SNAP), better known as food stamps, should be the means by which they receive that help in the United States. The Family Subsistence Supplemental Allowance (FSSA), the Military Services' alternative to SNAP, served only 285 Service members in FY 2013,[15] in large part because SNAP is more generous and creates fewer potential social stigmas for recipient families. FSSA should be retained for Service members in overseas locations where SNAP assistance is unavailable, but should be sunset in the U.S. and other locations where SNAP is available.

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

Dependents of Service members who are deployed for more than 120 days can fly, unaccompanied, on military aircraft when there is space available. But shorter deployments are becoming routine for some. The quality of life of Service members' dependents should be improved by providing access to unaccompanied travel on military aircraft for deployments of 30 days or more.

15. Measure how the challenges of military life affect children's school work

Children of active-duty Service members are not being identified separately in nationwide reporting of student performance. These children experience unique stresses associated with parental deployments and frequent relocations that can adversely affect academic performance. A military dependent student identifier should be implemented through Elementary and Secondary Education Act reporting to identify students who are children of active-duty Service members. This identifier would enable consistent reporting on the academic performance of military dependents, as well as identification of the support required to meet their needs.

[15] Director of Military Compensation, Office of Personnel and Readiness, e-mail to MCRMC, August 5, 2014.

THIS PAGE INTENTIONALLY LEFT BLANK

2. GENERAL CONCLUSIONS

The Commission drew six overarching conclusions regarding the current and future state of Uniformed Service compensation. These conclusions reflect general trends and overall findings that were observed during the past 18 months of data gathering and analysis. They serve as a core framework for the specific recommendations for modernization that follow in this report.

Core Compensation Structure. Though individual compensation programs would benefit from modernization, as detailed in the following sections of this report, the overall structure of the current compensation system is fundamentally sound and does not require sweeping overhaul. A combination of pay, health care, retirement, and ancillary benefits is normal for large organizations. Thus, reforms to the current compensation package should be judicious, targeted improvements that "do no harm" to the bulk of the system. Changes should focus on improving value and outcomes through the modernization of specific programs no longer meeting the full requirements of the 21st century All-Volunteer Force.

The basic pay table should be retained in its current form. It has proved an effective cornerstone of the compensation system for decades. The pay table, coupled with the Services' personnel management policies, provides strong performance incentives. It is simple, transparent, and equitable, thereby contributing to cohesion within the Force. It should continue to be supplemented with various special and incentive pays with which the Services can adjust compensation levels based on changing economic conditions or labor market dynamics. Similarly, the Reserve Component (RC) pay system should remain in its current form, as it effectively compensated RC members during 13 years of war. It also strikes an appropriate balance between drill weekend compensation and ancillary responsibilities for which RC members may not be fully reimbursed.[1]

In addition, the system of allowances (e.g., Basic Allowance for Housing, Basic Allowance for Subsistence) should continue to supplement basic and specials pays. The Commission examined the allowance system in detail, considering features such as the tax-free nature of some allowances and the fairness and equity of differing allowance rates. The Commission also investigated whether eliminating the allowance system would improve the overall transparency of the compensation system. As currently designed, however, the allowance system strikes an appropriate compromise between representing compensation to Service members and assistance for their living expenses.

[1] The Commission reviewed policies associated with RC members in a nonpay status who drill for points for retirement purposes, particularly those of the Navy (BUPERSINST 1001.39F) because it represents many of these RC members. According to Navy Reserve manpower subject matter experts, most of these Navy RC members reached high-year tenure without accumulating 20 years of qualifying service for retirement purposes. Nonpay drilling allows these members to reach retirement eligibility requirements. Some members voluntarily request to be in a nonpay drilling status to accommodate their individual needs. Others are unable to find a vacant billet for which they would receive both pay and drill points, typically because they were promoted out of a paid billet during a time when promotions were not connected to vacancies at the next pay grade. Navy RC promotion policies have changed to generally prevent promotions independent of paid billets at the next pay grade. The Commission urges the Services to communicate policy concerning nonpay drilling to RC members earlier in their careers and to align RC manpower and personnel levels to further reduce nonpay drilling.

Health care benefits have been, and will continue to be, an important element of compensation. Health care should continue to be offered across the life-cycle of a military member. Active-duty Service members and their families should receive access to a health care benefit, as should eligible members of the RC. Retired Service members should also have access to health care, with TRICARE For Life to supplement Medicare benefits. These benefits should be modernized to provide beneficiaries with additional choice, access, and value. The military health system needs to be modernized with the best business practices to ensure the very best in access and delivery for an efficient and effective health care system.

Quality of life benefits play a valuable role in Service member compensation. They are designed to mitigate many of the effects on Service members and their families associated with frequent moves, assignments to difficult locations far away from extended family and other support networks, deployments of family members, demanding work schedules, and other military lifestyle challenges. Though the Commission explored several strategies to modernize quality of life programs, including monetizing all "in-kind" benefits, it recognizes these programs provide peace of mind with respect to Service members' families. Providing the actual benefit instead of additional cash compensation ensures important needs are met. Although this report contains recommendations related to some quality of life programs, the overall suite of benefits does not require sweeping reform.

Advantages of Targeted Modernization. Modernization of compensation programs would provide new substantial benefits to Service members while bending the Government's cost curve. The remainder of this report details recommendations to improve benefits and fiscal sustainability. Key examples of the advantages of modernization include:

1. Modernized Retirement System
   - maintains the Services' existing recruiting and retention levels, promoting the continuance of the All-Volunteer Force
   - provides new Government-sponsored retirement assets to the 83 percent of Service members who currently leave the Force without vesting for a defined benefit annuity
   - increases the expected value of Government-sponsored retirement assets for Service members who retire after reaching 20 years of service
   - reduces annual DoD budgetary costs and Federal outlays, in FY 2016 constant dollars, by $1.9 billion and $4.7 billion, respectively, after full implementation

2. Modernized Readiness Oversight
   - establishes a four-star Command to oversee joint readiness, especially the readiness of the military medical force
   - defines essential medical capabilities and clinical skill standards that must be sustained during peacetime to prepare for the next conflict
   - improves the workload and case mix in military hospitals to provide additional opportunities for military personnel to maintain clinical skills

3. Modernized Health Benefit
   - improves access and choice in health care by allowing Service members and retirees to select from a menu of commercial health care plans

- eliminates the existing TRICARE referral process, which is a source of substantial frustration to Service members and their families
- provides active-duty Service members with a new Basic Allowance for Health Care (BAHC) to offset costs for commercial health care, plus an additional program to further offset costs of chronic or catastrophic conditions
- reduces annual DoD budgetary costs and Federal outlays, in FY 2016 constant dollars, by $6.7 billion and $3.2 billion, respectively, after full implementation

4. Modernized Service Member Education Benefits
   - maintains the Post-9/11 GI Bill while eliminating redundant education programs
   - aligns transferability of education benefits to mid-career retention milestones
   - reduces annual Federal outlays, in FY 2016 constant dollars, by $4.8 billion after full implementation

Modernization Without Compensation Reductions. By focusing modernization reforms on the structure of various benefits, fiscal sustainability can be improved without reducing the value of benefits to Service members. The recommendations in this report will result in substantial reductions in Federal spending. They also generally improve the value of the compensation system for Service members. Table 1 presents values from a military Leave and Earnings Statement (LES), including estimated changes from the recommendations detailed throughout the remainder of this report. In each LES line item, this Service member would receive the same or additional benefits. A new BAHC offsets expected out-of-pocket costs for a commercial health care plan, including an automatic allotment to pay the health care plan premium. Government contributions on behalf of Service members into the Thrift Savings Plan (TSP) would provide new retirement savings for the entire Force while compensating Service members for a reduced defined benefit (DB) annuity. BAHC and TSP contributions would provide additional Federal tax advantages to Service members. The increase in end-of-month pay shown on the LES would compensate for insurance costs and DB reductions, and Service members would not lose take-home pay as a result of the modernization recommendations in this report.

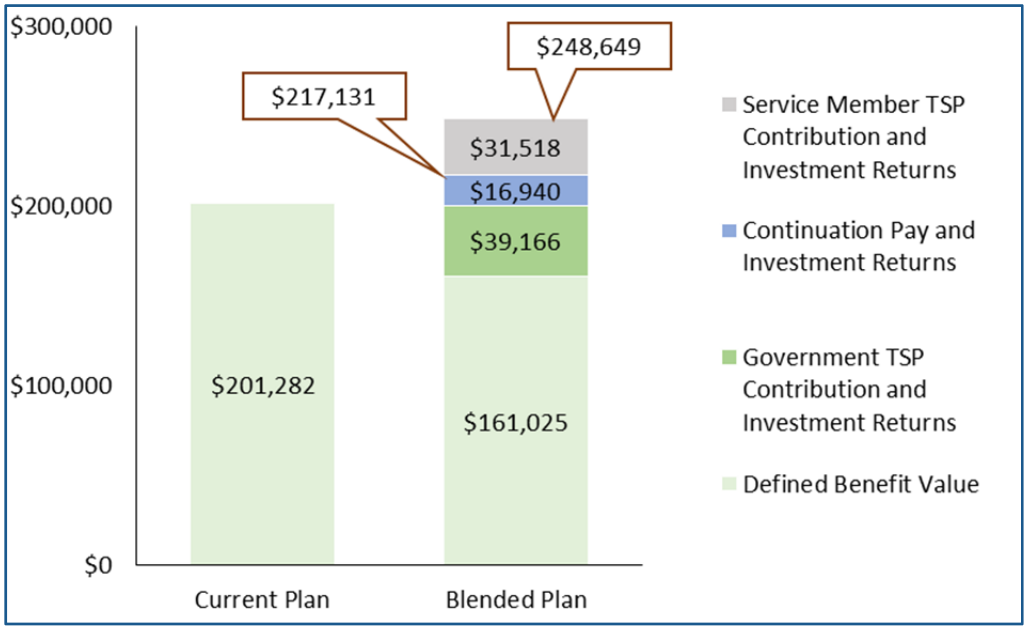
Table 1. Changes to a Leave and Earnings Statement of an Active-Duty E5 with 10 YOS[2]

	CURRENT COMPENSATION SYSTEM	ALTERNATIVE COMPENSATION SYSTEM	CHANGES IN COMPENSATION
ENTITLEMENTS			
Basic Pay	$3,076.20	$3,076.20	$0.00
Basic Allowance for Subsistence	$357.55	$357.55	$0.00
Basic Allowance for Housing	$1,152.00	$1,152.00	$0.00
Basic Allowance for Health Care	$0.00	$305.00	$305.00
Thrift Savings Plan, Government Automatic Contribution	$0.00	$30.76	$30.76
Thrift Savings Plan, Government Matching Contributions	$0.00	$92.29	$92.29
TOTAL ENTITLEMENTS	$4,585.75	$5,013.80	$428.05
DEDUCTIONS			
Standard Deductions	$844.33	$844.33	$0.00
Thrift Savings Plan, Member Contributions	$92.29	$92.29	$0.00
TOTAL DEDUCTIONS	$936.62	$936.62	$0.00
ALLOTMENTS			
TRICARE Dental	$32.89	$32.89	$0.00
TRICARE Choice Health Plan	$0.00	$236.91	$236.91
TOTAL ALLOTMENTS	$32.89	$269.80	$236.91
MONTHLY PAY	$3,616.24	$3,807.38	$191.14

Modernizing the retirement system can also provide additional value for Service members. Take, for example, a blended retirement system that features a modified version of the current DB, a defined contribution (DC) component through TSP, and lump-sum continuation pay awarded at 12 years of service (YOS). The DC component of this blended plan would provide new retirement benefits to the 83 percent of the Force that would otherwise leave service without Government-sponsored retirement savings. It would allow Service members over time to increase retirement savings through compounding investment returns.[3] Service members who contribute to TSP would reduce their taxable income because contributions would be invested as pretax dollars, which would allow Service members to retain more income. The combination of DB and DC assets, plus continuation pay, would be expected to exceed the value of the current DB-only retirement system for those who reach 20 YOS. As shown in Figure 1, the net present value of the current DB annuity for a typical enlisted Service member who retires after 20 YOS would be $201,282. Under a blended retirement system in which the Service member contributes 3 percent of their basic pay to the DC plan, Government-sponsored retirement assets at 20 YOS would total $217,131, an increase of 8 percent. The Service member's own DC contributions would be valued at another $31,518, providing total retirement assets valued at $248,649. The value of Government-sponsored retirement assets for officers would be expected to increase by 10 percent.

[2] Assumes an active-duty E5 who has dependents, has 10 YOS, is stationed at Fort Bragg, and is in a 15 percent Federal tax bracket. Alternative compensation system values are estimated assuming implementation of the Commission's recommendations and assuming that the Service member will contribute 3 percent of basic pay into the Thrift Savings Plan and will participate in the proposed health benefit program (i.e., TRICARE Choice).
[3] See Recommendation 1 of this report for details of TSP.

Figure 1. Retirement Assets of a Retiring Active-Duty E7, Current vs. Blended Retirement Plans[4]

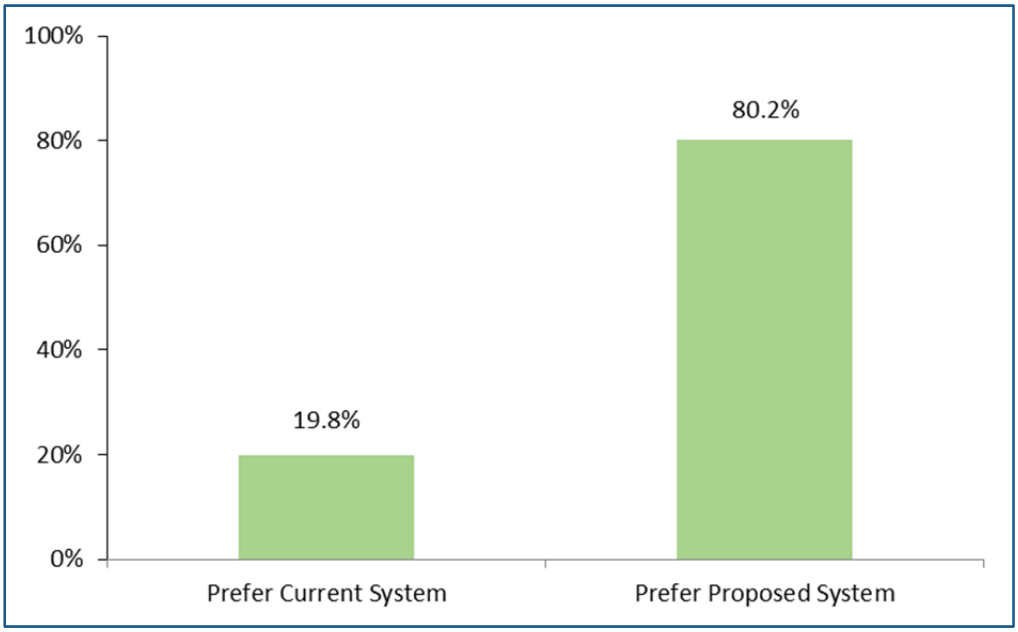


Results from the Commission's survey show that Service members recognize the increased benefit of alternative compensation systems. As shown in Figure 2, active-duty survey respondents indicated that they would prefer the modernized compensation system detailed in this report over the status quo by a margin of 4 to 1.[5] While being more preferable, the proposed compensation system improves fiscal sustainability, providing a win-win solution for Service members and the Services.

[4] The Commission reviewed policies associated with RC members in a nonpay status who drill for points for retirement purposes, particularly those of the Navy (BUPERSINST 1001.39F) because it represents many of these RC members. According to Navy Reserve manpower subject matter experts, most of these Navy RC members reached high-year tenure without accumulating 20 years of qualifying service for retirement purposes. Nonpay drilling allows these members to reach retirement eligibility requirements. Some members voluntarily request to be in a nonpay drilling status to accommodate their individual needs. Others are unable to find a vacant billet for which they would receive both pay and drill points, typically because they were promoted out of a paid billet during a time when promotions were not connected to vacancies at the next pay grade. Navy RC promotion policies have changed to generally prevent promotions independent of paid billets at the next pay grade. The Commission urges the Services to communicate policy concerning nonpay drilling to RC members earlier in their careers and to align RC manpower and personnel levels to further reduce nonpay drilling. Service members would receive CP to promote midcareer retention. This comparison of retirement assets assumes CP is saved and invested for retirement.

[5] The figure represents a close approximation of the preferences of the Commission's recommendations, since the survey did not address all compensation recommendations of the Commission.

Figure 2. Percent of Active-Duty Service Members Who Prefer the Current or Proposed Compensation System



Member Choice, Access, and Quality. A fundamental mismatch has developed between the conditions and requirements of a 21st century workforce and some Uniformed Service compensation programs. The modern civilian workforce prioritizes characteristics such as choice, access, and flexibility over rigid compensation structures. While military life is different from that of civilians, the Services necessarily recruit and retain Service members from broader labor markets. If the Uniformed Services compensation system does not adjust to the preferences of labor market participants, the Services will be at a growing competitive disadvantage for attracting our Nation's best workers.

Substantial changes in demographics and society are not reflected in key aspects of the current compensation system, much of which dates back to 1973 and the birth of the All-Volunteer Force or earlier. Similarly, demographic changes in the Force, such as the increase in women and Service members with children, reflect trends that are not accurately incorporated into the current compensation and benefits package. In the 21st century, prospective recruits and current Service members considering whether to transition to the civilian sector are better educated and more technologically savvy than in previous decades.[6] Some current programs simply comprise piecemeal updates or adjustments to long-standing programs and do not fully reflect the changing preferences of both the Force and society.

The unprecedented operational use of the RC during the last 13 years of war also has implications for the compensation system. In particular, mobilization of the RC highlighted the need for higher levels of medical and dental readiness during peacetime. Recurrent deployments of RC members also showed that processing RC orders could be substantially more efficient. The Commission's recommendations offer

[6] MCRMC, *Report of the Military Compensation and Retirement Modernization Commission: Interim Report*, June 2014, 248-267, http://www.mcrmc.gov/index.php/reports.

additional health and dental care choices to RC members and streamline RC duty statuses. These improvements would smooth the movement of the RC between operational and strategic postures. Nonetheless, DoD should determine the future posture of the RC and ensure compensation resources are aligned to support the National Guard and Reserves. Such alignment would better meet the needs of Service members and positively affect recruitment, retention, and readiness.

Service Flexibility. The Services, as well as Service members, would benefit from additional flexibility in the compensation system. Changing national security requirements will necessarily demand adjustments to manpower requirements. Compensation requirements will vary with changes in the national economy or labor markets. Service personnel managers therefore need a compensation system with which they can easily adjust compensation to obtain the appropriate mix of personnel skills and experience levels. In particular, the Services may benefit from the authority to vary retirement options for different career fields. The retirement system is instrumental in determining the shape of the Services' force profiles.[7] Yet the current one-size-fits-all retirement system does not address fundamental differences in the skill sets, training requirements, and career paths of various professions. For example, doctors, linguists, and cyber personnel have skills that are expensive to acquire and improve over time. The Force may benefit from a flexible retirement system that incentivizes them to remain in service longer than other occupational specialties.

The Services would also benefit from additional flexibility in the management of the Military Health System. A coordinated, strategic framework is required to sustain and, whenever possible, improve upon the tremendous medical skills that were accumulated during the last 13 years of war. New command oversight, coupled with authorities and tools to enhance medical training opportunities during peacetime, would prevent the potential atrophy of operational medical skills and expertise that are critical to DoD's operational mission. In particular, DoD would benefit from the authority to attract additional cases into Military Treatment Facilities related to essential medical capabilities that should be retained within the military's medical force for national security purposes.

Effective Oversight. The Nation requires strong and dedicated oversight of military personnel and readiness programs to maintain the high combat and support capabilities that have developed during 13 years of war. The tools that contributed to the Force's success should be sustained and, whenever possible, improved. Lessons learned during the wars need to be integrated into peacetime training programs and institutionalized throughout the Force. This need for centralized leadership and a focus on combat readiness is especially important in military medicine. Recommendations in this report address additional oversight and readiness tools within DoD.

Two additional improvements, both beyond the scope of this Commission, may serve to further enhance the Nation's capability to provide the best quality medical care for Service members, both on the battlefield and as they transition from DoD to VA care. First, Congressional oversight of DoD and VA medical programs is not unified, which may contribute to ongoing shortfalls in coordination between the two Departments and weaknesses in transitioning Service member care from DoD to the VA.

[7] See Section 3, Recommendation 1 for further explanation.

Recommendations in this report seek to improve the ways in which DoD and VA work together, but coordination would be further improved if Congressional appropriations committees were realigned to provide unified oversight of both medical systems. The House and Senate Appropriations Subcommittee for Military Construction, Veterans Affairs, and related Agencies could expand their jurisdiction to include DoD's military health delivery system. The Subcommittee would have appropriations oversight over the construction of DoD and VA hospitals, clinical operations, information technologies, supply-chain, operations, and related work streams. Doing so would also provide the kind of long-term support and oversight a $100-billion-per-year health care system needs.

The Commission does call for a continuous effort toward increased collaboration between DoD Health Affairs and VA Health Administration to capture synergies of excellence with the goal of seamless transition of Service members and veterans. It is prudent and worthy for the Congress to explore all possibilities and opportunities to improve the DoD and VA health systems including the consideration of creating a single military health care system for all current military and eligible veterans. To determine the structure, authorities, and leadership responsibilities of such a health system was beyond the scope of this Commission and would require systemic changes that may take years to implement effectively.

Fiscal Sustainability and Federal Budget Pressures. Though the fiscal sustainability of Uniformed Services compensation is both relevant and important, the modernization of Service compensation cannot be the cornerstone of attempts to address larger political goals or budgetary concerns. Recent trends placing continued downward pressures on military budgets are expected to continue. National security is a Constitutional priority and fiscal challenges facing the Nation cannot be solved by focusing solely on the Services. Any attempts to use changes in Service members' compensation and benefits to do so would undermine the effectiveness of the All-Volunteer Force.

Maintenance of the All-Volunteer Force requires compensation levels that allow recruitment and retention of high quality personnel in service to our Nation's defense. Though the men and women of the Services have demonstrated time and again a willingness to make substantial sacrifices to serve the Nation, fair and adequate compensation and a good quality of life should not be included among the items Service members forgo. The Commission does not take a position on compensation levels. These items are the appropriate domain of the Congress and the Uniformed Services, so they can preserve the flexibility to build and maintain the Force necessary to meet national security needs. The Commission does conclude that any general reduction in Service member compensation must be part of a larger national discussion regarding budgetary constraints and entitlements, which is beyond the scope of this Commission.

It is possible, however, to modernize some compensation programs to improve their value to Service members while making them more fiscally sustainable. Improvements in the efficiency of some compensation programs would allow for win-win situations that improve responsiveness, quality, and outcomes for Service members and their families, while lowering cost to the American taxpayer. Where such opportunities exist, the Services' compensation system should be improved to implement efficiencies as a means of good stewardship. While maintaining the overall value of the current

benefits package, these recommendations offer efficiencies that reduce Government expenditures by as much as $10 billion per year.

Other Agency Programs. The Commission reviewed a large number of programs affecting Service members across Government agencies, and its recommendations for modernization focus primarily on programs funded and administered by the Uniformed Services. The recommendations in this report account for benefits that Service members receive from other Government agencies; however, this report does not, for example, contain recommendations related to Department of Veterans Affairs disability compensation or programs such as Department of Education Impact Aid. Nevertheless, the targeted modernization of key compensation and benefit programs could improve the experiences of Service members across the board.

Improving choice, access, and quality for Service members and their families should be at the heart of any modernized compensation system. This system should retain the core strengths that have sustained our Nation's All-Volunteer Force for 42 years and through 13 years of war, while definitively modernizing programs and program components that inadequately reflect the conditions and preferences of a 21st century workforce. Doing so would improve the value of compensation programs to Service members and their families. It would also allow the Services to recruit and retain quality personnel in a more competitive employment landscape, and through improvements in efficiency and accountability, it would help ensure continued fiscal sustainability of the compensation system for years to come.

THIS PAGE INTENTIONALLY LEFT BLANK

3. RECOMMENDATIONS

PAY AND RETIREMENT

RECOMMENDATION 1: HELP MORE SERVICE MEMBERS SAVE FOR RETIREMENT EARLIER IN THEIR CAREERS, LEVERAGE THE RETENTION POWER OF TRADITIONAL UNIFORMED SERVICES RETIREMENT, AND GIVE THE SERVICES GREATER FLEXIBILITY TO RETAIN QUALITY PEOPLE IN DEMANDING CAREER FIELDS BY IMPLEMENTING A MODERNIZED RETIREMENT SYSTEM.

Background:
Currently, Service members in the Active Component (AC) may request to retire after 20 years of service (YOS).[1] Beginning the month after retirement, they receive annuity payments on the first day of each month.[2] These annuity payments are generally calculated by multiplying a member's retired pay base by 2.5 percent for each year of creditable service.[3] Before January 1, 2007, the multiplier was capped at 75 percent of a Service member's retired pay base; however, this cap has been lifted for Service members retiring after January 1, 2007.[4]

Service members in the Reserve Component (RC) may also request retired pay after 20 years of creditable service.[5] The formula for calculating their monthly annuity payments is the same as for AC Service members; however, years of service are calculated by dividing the number of Reserve points by 360.[6] There are two major distinctions between RC and AC retirement pay. RC annuity payments do not begin until retirees reach age 60,[7] and only years in which RC Service members accumulate 50 Reserve points are considered "creditable."[8]

[1] Each Uniformed Service has its own authority found respectively at Armed Forces, 10 U.S.C. §§ 3911, 3914 (Army); Armed Forces, 10 U.S.C. §§ 6323, 6330 (Navy); Armed Forces, 10 U.S.C. §§ 8911, 8914 (Air Force); Coast Guard, 14 U.S.C. §§ 291, 355 (Coast Guard); Navigation and Navigable Waters, 33 U.S.C. § 3044 (NOAA Commissioned Officer Corps); The Public Health and Welfare, 42 U.S.C. § 212 (U.S. Public Health Service Commissioned Corps).
[2] Armed Forces, 10 U.S.C. § 1412(b).
[3] Armed Forces, 10 U.S.C. § 1409(b). Service members' retired pay base is dependent upon the date they entered service. 10 U.S.C. § 1406 provides that for a Service member who entered before September 8, 1980, the retired pay base is his or her final month of basic pay. 10 U.S.C. § 1407 provides that for a Service member who entered after September 7, 1980, the retired pay base is the total monthly basic pay for the member's last 36 months divided by 36. Pursuant to 10 U.S.C. § 1409(b)(2), if a Service member elects to receive the 15-year Career Status Bonus, his or her multiplier is reduced by 1 percent for each full year that the member's years of creditable service are fewer than 30.
[4] National Defense Authorization Act for FY 2006, Pub. L. No. 109-364, § 642, 120 Stat. 2083, 2259-2260 (2006).
[5] Armed Forces, 10 U.S.C. § 12731.
[6] 10 U.S.C. § 12733. The years of service to be credited to the Service member are calculated by dividing 360 into the member's total points except that the member is capped to 130 points in a 1-year period. That cap does not apply to points earned for active service.
[7] Armed Forces, 10 U.S.C. § 12731. Under 10 U.S.C. § 12731(f), a Service member in the Reserve Component may begin to receive retired pay before the age of 60. For every 90 days of active service in a designated combat zone, the eligibility age is reduced by 3 months. The eligibility age may not be reduced to younger than age 50.
[8] Armed Forces, 10 U.S.C. § 12732. Points may be earned for various reasons, including membership in the Reserve Component, active service, and drill attendance.

Since 2000, Service members have been authorized to participate in the Thrift Savings Plan (TSP),[9] which is a defined contribution (DC) plan that allows eligible participants to contribute a portion of their pay into a tax-deferred investment account.[10] The TSP was created as part of the reform of the Federal civilian employee retirement plan in 1986.[11] It is maintained by the Federal Retirement Thrift Investment Board, which sets the investment policies for the plan.[12] Contributions to the TSP can be invested through a series of funds with broad market diversification, including short-term U.S. Treasury funds, corporate bond funds, and both domestic and international stock index funds.[13] Over time, funds invested in TSP generally increase in value because of compounding investment returns. According to TSP, investments in corporate bonds and stocks "have higher potential returns than … Government securities," although they "also carry the risk of investment losses."[14] The Services do not contribute to Service members' TSP accounts.[15]

The existing retirement system is effective in providing benefits to Service members who retire after 20 years of service. As such, it plays an important role in readiness and retention of the All-Volunteer Force, especially among members who have served 10 or more years, as discussed below.[16] The Service retirement system as currently constituted, however, provides no benefits for Service members who serve fewer than 20 years, so these members receive no retirement benefit in compensation for their service to the Nation.[17]

The All-Volunteer Force increasingly comprises Service members born after 1980, members of the "millennial" generation. Research has shown members of this generation change jobs frequently and tend to favor flexible retirement options, rather than the defined benefit pension plans preferred by previous generations.[18] Although Service members who separate with fewer than 20 YOS may be eligible for service-related benefits, including education benefits,[19] preferential hiring,[20] and employment

[9] National Defense Authorization Act for FY 2000, Pub. L. No. 106-65, §§ 661-663, 113 Stat. 512, 670-674 (1999) as amended by National Defense Authorization Act for FY 2001, Pub. L. No. 106-398, § 661, 114 Stat. 1654, 1654A–167 (2000).
[10] Government Organization and Employees, 5 U.S.C. §§ 8432(a), 8440(a). Service members may also contribute to a Roth TSP pursuant to Government Organization and Employees, 5 U.S.C. § 8432d.
[11] Federal Employees' Retirement System Act of 1986, Pub. L. No. 99-335, 100 Stat. 514 (1986).
[12] Government Organization and Employees, 5 U.S.C. § 8472. The Board is required, pursuant to 5 U.S.C. § 8438(b)(1), to establish five different index funds: one each for Government Securities, Fixed Income, Common Stock, Small Capitalization Stock, and International Stock. The Board has also created lifecycle funds that automatically allocate funds in a participant's account to meet the needs of a participant's anticipated retirement date.
[13] Thrift Savings Plan, *Summary of the Thrift Savings Plan*, accessed December 12, 2014, http://www.tsp.gov/PDF/formspubs/tspbk08.pdf.
[14] Thrift Savings Plan, *Summary of the Thrift Savings Plan*, 14, accessed December 12, 2014, http://www.tsp.gov/PDF/formspubs/tspbk08.pdf.
[15] 5 U.S.C. § 8440e(e) prohibits contributions from the Services unless there was an agreement reached pursuant to 37 U.S.C. § 211(d).
[16] *See e.g.,* Department of Defense, *Report of the Tenth Quadrennial Review of Military Compensation, Volume II Deferred and Noncash Compensation, July 2008,* 10, accessed December 14, 2014, http://www.defense.gov/news/qrmcreport.pdf. *See also* Baylor University, *Reduced Retirement Benefits: Should I stay or go?*, accessed August 26, 2014, https://bearspace.baylor.edu/J_West/www/retire.pdf. *See also* Figure 1.
[17] Armed Forces, 10 U.S.C. §§ 3911, 3914, 6323, 6330, 8911, 8914. Coast Guard, 14 U.S.C. §§ 291, 355. Navigation and Navigable Waters, 33 U.S.C. § 3044. The Public Health and Welfare, 42 U.S.C. § 212.
[18] Transamerica Center for Retirement Studies, *Millennial Workers: An Emerging Generation of Super Savers, 15th Annual Transamerica Retirement Survey*, 9, accessed November 10, 2014, http://www.transamericacenter.org/docs/default-source/resources/center-research/tcrs2014_sr_millennials.pdf.
[19] Veterans Benefits, 38 U.S.C. §§ 3311-3325.
[20] Employment, 5 U.S.C. § 2108.

assistance,[21] the current retirement system does not provide them with any financial contribution toward their long-term economic security after separation.

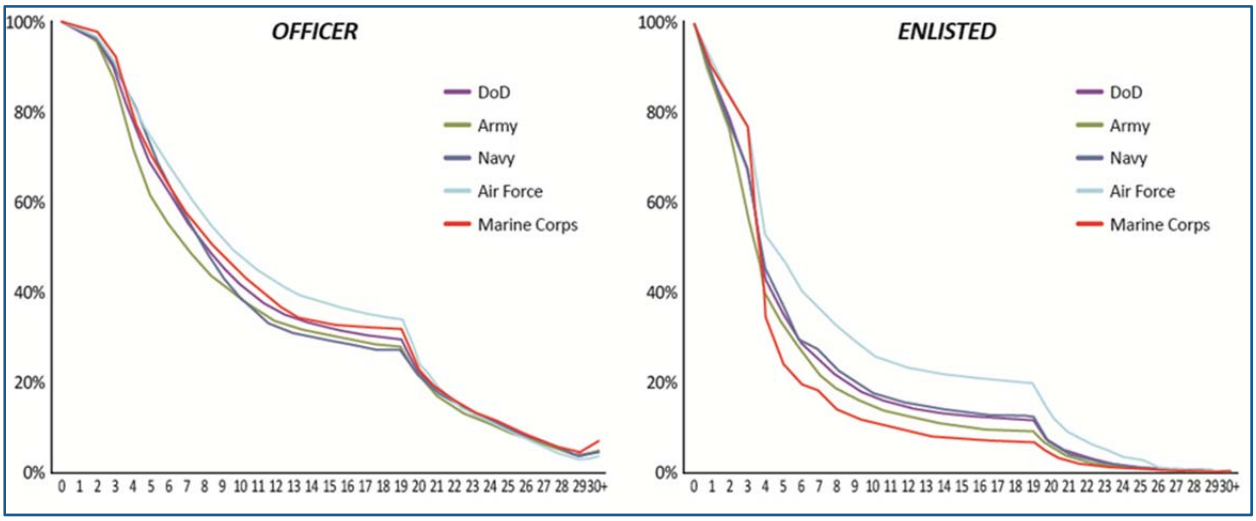
For additional information on Uniformed Services retirement, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 3.4).*

Findings:

Force Profiles

In developing recommendations to modernize Uniformed Services retirement and compensation systems, the Commission's primary goal was to ensure that the Services can maintain the most professional All-Volunteer Force possible, during both peacetime and wartime. An important part of this goal was making certain the Services are able to maintain their desired rank and experience structures. Figure 3 displays the current active-duty force profiles.[22] Representatives of each of the Uniformed Services communicated to the Commission the crucial message that any modernized package of pay and benefits should enable the Services to maintain similar active-duty force profiles.

Figure 3. Continuation Rates for Active-Duty Officers and Enlisted Personnel, FY 2013



The current defined benefit (DB) retirement plan[23] is a key determinant in shaping these force profiles. The active-duty force constitutes a "closed" personnel system in which Service members are generally promoted from a pool of more junior members already in the system.[24] Many personnel, especially enlisted, separate from service

[21] Veterans Assistance, 38 U.S.C. §§ 4100-4114
[22] The force profile shows the number of personnel (in a service or skill) according to their years of service.
[23] In a defined benefit retirement plan, beneficiaries receive specified monthly payments upon retirement. See "Definitions," Internal Revenue Service, accessed December 10, 2014, http://www.irs.gov/Retirement-Plans/Plan-Participant,-Employee/Definitions.
[24] There are some exceptions to this general rule. For example, enlisted personnel who have successfully completed semester hours at accredited colleges or universities may enlist at grades above E1 (*see, e.g.*, Active and Reserve Components Enlistment Program, AR 601-210, 15 (2013)), and medical doctors may enter the military at grades from O2 through O6 (*see* Armed Forces, 10 U.S.C. § 532(b)).

after their first term. This trend leads to steep declines in the percentage of members who remain in service through the end of their first 8 to 10 years. Thereafter, the force profile flattens as Service members begin to feel the "pull" of the current 20-year retirement system.[25] Financial incentives to remain in Service decline substantially after the 20-year vesting point,[26] leading to another drop in retention.

Service members feel the 20-year retirement pull most strongly at about their 10th year of service. This pull generally occurs because Service members place more value on the DB annuity payments as the likelihood they will reach the benefit eligibility threshold increases.[27] On average, younger members value the benefit less because they are less likely to remain in the force for 20 years.[28] The value of the annuity benefit increases as Service members approach eligibility for earning the benefit[29] Ninety percent of enlisted members who remain in service at least 14 years will reach retirement eligibility.[30] Once Service members reach the vesting point, there is a drop in retention as they retire and receive the annuity.[31]

Service Member Choice

Over time, the variety of private-sector benefit plans available to employees has increased substantially.[32] According to the Bureau of Labor Statistics, in March 2014, 74 percent of full-time, private-sector employees had access to one or more retirement plans, and 86 percent had access to medical care benefits.[33] Furthermore, private-sector employers often utilize a variety of contribution benefits packages that allow employees to opt in, including short- and long-term disability plans, supplemental life insurance, and legal services, among others.[34] Private-sector employers also normally provide a menu of health care insurance plans to meet the needs of employees.[35] Data on the use of private health exchanges for U.S. employers show "enrollees chose the health plan they felt offered the best value for themselves and their family, and liked being able to select among multiple carriers."[36]

---

[25] Paul F. Hogan, "Overview of the Current Personnel and Compensation System," in *Filling the Ranks: Transforming the U.S. Military Personnel System*, ed. Cindy Williams (Cambridge: MA: Belfer Center for Science and International Affairs, John F. Kennedy School of Government, Harvard, 2004), 29-53.
[26] According to Merriam-Webster Dictionary, vesting is "the conveying to an employee of the inalienable right to share in a pension fund especially in the event of termination of employment prior to the normal retirement age."
[27] Lazear, E.P. (1990): "Pensions and Deferred Benefits as Strategic Compensation," *Industrial Relations: A Journal of Economy and Society,* 29(2), 264. *See also Tenth Quadrennial Review of Military Compensation, Report of the Tenth Quadrennial Review of Military Compensation, Volume II Deferred and Noncash Compensation, July 2008,* 10, accessed December 14, 2014, *http://www.defense.gov/news/qrmcreport.pdf*. "Reduced Retirement Benefits: Should I stay or go?," Baylor University, accessed August 26, 2014, https://bearspace.baylor.edu/J_West/www/retire.pdf.
[28] Lazear, E.P. (1990): "Pensions and Deferred Benefits as Strategic Compensation," *Industrial Relations: A Journal of Economy and Society*, 29(2), 264.
[29] Ibid.
[30] Department of Defense, *Report of the Tenth Quadrennial Review of Military Compensation, Volume II Deferred and Noncash Compensation, July 2008,* 31, accessed Dec. 10, 2014, http://www.defense.gov/news/qrmcreport.pdf.
[31] Lazear, E.P. (1990): "Pensions and Deferred Benefits as Strategic Compensation," Industrial Relations: A journal of Economy and Society, 29(2), 264.
[32] Jeffrey R. Brown and Scott J. Weisbenner, Building Retirement Security through Defined Contribution Plans, accessed December 9, 2014, https://www.acli.com/Issues/Retirement%20Plans/Documents/Brown%20Weisbenner_FullPaper.pdf.
[33] Bureau of Labor Statistics/U.S. Department of Labor, Employee Benefits in the United States – March 2014, accessed December 9, 2014, http://www.bls.gov/news.release/pdf/ebs2.pdf.
[34] *See* Department of the Treasury, Internal Revenue Service, *Employer's Tax Guide to Fringe Benefits,* Publication 15-B, 1, accessed January 7, 2015, http://www.irs.gov/pub/irs-pdf/p15b.pdf.
[35] Ibid.
[36] "On Private Health Exchanges, Choice Drives Satisfaction," Society for Human Resource Management, accessed December 9, 2014, http://shrm.org/hrdisciplines/benefits/articles/pages/private-health-exchanges.aspx

The Uniformed Services have also begun to recognize the benefits of providing members with more choices. For example, Assignment Incentive Pay (AIP) was created in 2003 "to attract volunteers to fill jobs/billets that have been identified as historically difficult to fill."[37] Under the AIP program, Service members can choose to submit bids representing the additional compensation they would accept for hard-to-fill assignments.[38] By allowing Service members some choice in assignment and related compensation, AIP "has become extremely popular and is the military's preferred way to compensate troops from all of the services for certain unusual and extended assignments."[39] Similarly, DoD's experience with voluntary separation incentive[40] and career status bonuses[41] reveals some Service members prefer lump-sum payments to typical annuities.[42] Continuing to increase flexibility and Service-member choice in the compensation system would enable the Services to more readily adapt to changing views and values of the next generation of recruits.

Defined Benefit Inequity

Observers, including military leaders and past commissions, have commonly criticized the current retirement system for its inequity.[43] Uniformed Services retirement is contingent on 20-year "cliff vesting"—a system in which only those who complete a 20-year career receive benefits.[44] Under the current Uniformed Services retirement system, 83 percent of all enlisted personnel and 51 percent of officers receive no retirement savings for their service.[45] Many comments received by the Commission also spoke to this inequity in the current DB-only retirement plan:

> *There should be Government matching to TSP. Those members who do not serve 20 years have zero support from their employer (DoD) with regard to retirement.*[46]

---

[37] "Assignment Incentive Pay," Navy Personnel Command, accessed December 10, 2014, http://www.public.navy.mil/bupers-npc/career/payandbenefits/pages/aip.aspx.
[38] Assignment Incentive Pay (AIP) Program, Policy Decision Memorandum 003-06, December 7, 2006, accessed January 12, 2015, http://www.public.navy.mil/bupers-npc/career/payandbenefits/documents/TABFAIPPDMOFDEC06.pdf.
[39] "Assignment Incentive Pay (AIP)," Military Compensation, accessed December 10, 2014, http://militarypay.defense.gov/pay/aip.html.
[40] "VSI/SSB Recoupment," Defense Finance and Accounting Service, accessed December 10, 2014, http://www.dfas.mil/retiredmilitary/plan/separation-payments/vsi-ssb-recoupment.html.
[41] "CSB/REDUX," Defense Finance and Accounting Service, accessed December 10, 2014, http://www.dfas.mil/retiredmilitary/plan/estimate/csbredux.html.
[42] Curtis J. Simon, John T. Warner, and Saul Pleeter, "Discounting, Cognition, and Financial Awareness: New Evidence from a Change in the Military Retirement System," *Economic Inquiry*, 53, no. 1, 318-334, accessed December 10, 2014, http://onlinelibrary.wiley.com/doi/10.1111/ecin.12146/pdf.
[43] *See* Department of Defense, *Report of the Tenth Quadrennial Review of Military Compensation, Volume II Deferred and Noncash Compensation, July 2008*, 12-16, http://www.defense.gov/news/qrmcreport.pdf. *See also* Defense Business Board, *Report to the Secretary of Defense: Modernizing the Military Retirement System*, accessed November 10, 2014, http://dbb.defense.gov/Portals/35/Documents/Reports/2011/FY11-5_Modernizing_The_Military_Retirement_System_2011-7.pdf. *See also* University of Pennsylvania, Wharton School of Business, Public Policy Initiative, *An Affordable and Equitable Retirement System for our Veterans*, accessed November 10, 2014, http://publicpolicy.wharton.upenn.edu/live/news/317-an-affordable-and-equitable-retirement-system-for. *See also* David B. Newman, *Mitigating the Inequity of the Military Retirement System by Changing the Rules Governing Individual Retirement Accounts for Service Members*, (Monterey, California: The Naval Postgraduate School, 1997), 31-44.
[44] Patrick Mackin, American Enterprise Institute, *Expanding Access While Saving Money in the Military Retirement System*, 4, accessed December 14, 2014, https://www.aei.org/publication/expanding-access-while-saving-money-in-the-military-retirement-system/.
[45] Department of Defense, *Valuation of the Military Retirement System; September 30, 2012*, 24, accessed December 10, 2014, http://actuary.defense.gov/Portals/15/Documents/MRF_ValRpt2_2012.pdf.
[46] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

> *There should be some type of retirement or IRA for those individuals that leave the military before 20 years.*[47]
>
> *As someone who will very likely retire at or after 20 years, I feel it's important to keep that option for "Career military," but when I was young it seems too little for a large gamble. Think you need matching TSP option to provide some vesting in a retirement option for those that choose to serve less than a 20 year career, since you lose all personal retirement tax benefits with the 20 or nothing option.*[48]

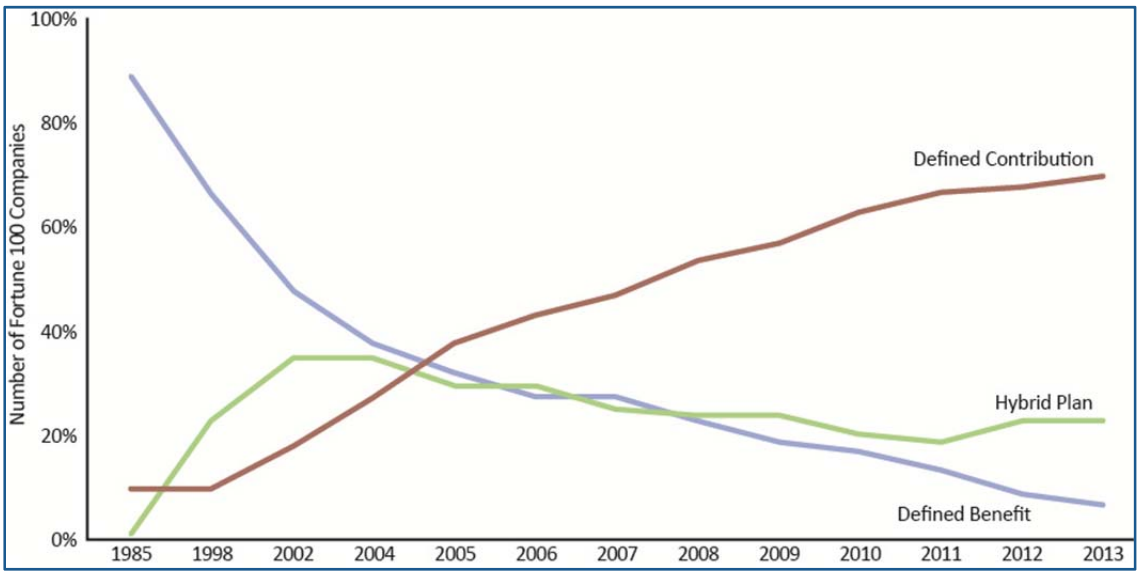
By comparison, the private sector is required by the Employee Retirement Income Security Act (ERISA)[49] to vest its employees in company-provided retirement plans within a much shorter time than the Services' system vests Service members. The timeframe for vesting depends on the type of retirement plan.[50] Pursuant to ERISA, any DB plan must cliff vest by 5 years of employment, or vest gradually during a period of 7 years.[51] A DC plan must cliff vest within 3 years, though graduated vesting may take up to 6 years.[52] As a result of these shorter private-sector vesting times, a much higher percentage of private-sector employees receive some type of retirement benefit, as compared to Service members who can only receive the retirement annuity upon reaching 20 YOS.

As shown in Figure 4, 70 percent of Fortune 100 companies offered DC retirement plans in 2013, and 23 percent offered "blended" plans that combine DC and DB elements.[53] The Society for Human Resource Management reported that 92 percent of all private companies offered a DC plan in 2013, compared to 19 percent that offered only a DB plan.[54] Accordingly, private-sector employees earn retirement savings much earlier in their careers than do Service members, who must currently wait until 20 years into a career to be eligible for any retirement annuity.

---

[47] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[48] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[49] P.L. 93–406, 88 Stat. 829, enacted September 2, 1974, codified in part at 29 U.S.C. ch. 18
[50] *See* Internal Revenue Code, 26 U.S.C. § 411.
[51] Internal Revenue Code, 26 U.S.C. § 411(a)(2)(A).
[52] Internal Revenue Code, 26 U.S.C. § 411(a)(2)(B).
[53] Towers Watson, *Retirement Plans Offered by 2013 Fortune 100*, accessed on November 10, 2014, http://www.towerswatson.com/en-US/Insights/Newsletters/Americas/insider/2013/retirement-plans-offered-by-2013-Fortune-100.
[54] Society of Human Resource Management, *2013 Employee Benefits, An Overview of Employee Benefits Offerings in the U.S.*, accessed October 23, 2014, 19, http://www.shrm.org/research/surveyfindings/articles/documents/13-0245 2013_empbenefits_fnl.pdf.

Figure 4. Fortune 100 Retirement Plans



Depending on the structure and rules of the DC plan, employees could receive higher investment rewards, may have preretirement access to accumulated retirement funds, often receive benefits in lump-sum distributions, could have increased options for inheritance by heirs other than a surviving spouse, and benefit from portability.[55] Portability is a central feature of DC plans, and though it is available in certain DB plans, it is not a feature of the current Uniformed Services' DB plan.[56] The ability to move one's retirement savings throughout a career makes these plans attractive in today's workplace environment with its high rates of job change.[57] Studies show that younger generations prioritize retirement and health saving through workplace benefits[58] and that the number of first-time DC plan enrollees in the general economy is quickly growing as young workers enter the labor force.[59] Approximately 40,000 of these younger workers enrolled in their employer's 401(k) plan for the first time during the first half of 2014—a 55 percent increase from the same 6-month period in 2013.[60] These trends have important implications for the attractiveness of the Uniformed Services retirement system, which is not portable and has a very long vesting period.

Defined Contribution Plan Features

Certain features make some DC plans especially attractive to beneficiaries. Of particular importance to shaping employees' perspective on and interest in participating in DC retirement plans are automatic contributions made by the employer without any participation by the employee, employer matches of

[55] David Rajnes, Employee Benefit Research Institute, *An Evolving Pension System: Trends in Defined Benefit and Defined Contribution Plans, EBRI Issue Report No. 249, September 2002*, 44-45, accessed December 10, 2014, http://www.ebri.org/pdf/briefspdf/0902ib.pdf.
[56] Ibid, 45.
[57] Ibid, 24. EBRI cites DOL data indicating that the average U.S. worker holds about nine jobs by the age of 32.
[58] "Bank of America Merrill Lynch Report Finds Millennials Prioritizing Retirement and Health Savings Through Workplace Benefits," Bank of America, accessed December 11, 2014, http://newsroom.bankofamerica.com/press-releases/global-wealth-and-investment-management/bank-america-merrill-lynch-report-finds-mille.
[59] "*Why Millennials Are Flocking to 401(k)s in Record Numbers*," Money, accessed October 24, 2014, http://time.com/money/3532253/401ks-millennials-saving-increase/.
[60] Ibid.

contributions made by an employee, employee-friendly vesting policies, and automatic enrollment into plans.

Automatic Contribution: Companies with top-rated DC retirement plans, including about a third of the 250 largest U.S. corporations, provide additional contributions to employees' accounts, even when employees choose not to participate.[61] Federal civilian employees receive automatic contributions equal to 1 percent of their pay into their TSP accounts, even if they do not contribute any of their own income.[62] Although such automatic employer contribution programs are attractive benefits for employees, Service members do not currently benefit from automatic or standard contributions.[63]

Matching Funds: "The vast majority of employer-sponsored savings plans include an employer match."[64] These payments match employee contributions based on a portion of each dollar employees invest.[65] In a survey of 476 companies, with 71 percent of the respondents representing large companies (1,000 or more employees), 94 percent reported providing matching contributions in cash versus company stock or a combination of cash and company stock.[66] Cash matching is the most prevalent form of employee 401(k) match offered by employers.[67] Data show participation in a plan is higher when employers provide a matching contribution and the effect is similar across income groups.[68] The data show when employers offer matching contributions, many employees will contribute at least enough to maximize the match.[69] In a joint survey conducted by WorldatWork and the American Benefits Institute, 66 percent of respondents indicated at least half their retirement plan's participants are contributing enough to receive the full employer match.[70] The survey showed 77 percent of the responding organizations' employees contribute more than 5 percent of their salary per paycheck.[71] The Commission received numerous comments expressing the sentiment that "TSP should have employer contributions"[72] for Service members and that the "Military should match a percent of TSP contributions, just as DoD civilian contributions are matched."[73]

Vesting: The amount of time-in-service required before employees are entitled to retain employer contributions to their retirement accounts—known as "vesting"—can affect participant behaviors as well. Industry-wide and organization-specific issues can affect

---

[61] "The Best 401(k)s: Retire at 60 From Conoco With $3.8 million; Facebook Last," Margaret Collins and Carol Hymowitz, Bloomberg, accessed December 11, 2014, http://www.bloomberg.com/news/2014-07-22/conocophillips-best-among-401-k-plans-with-facebook-last.html.
[62] Government Organization and Employees, 5 U.S.C. § 8432(c).
[63] Government Organization and Employees, 5 U.S.C. § 8440e(e).
[64] Brigitte Madrian, National Bureau of Economic Research, *Matching Contributions and Savings Outcomes: A Behavioral Economics Perspective,* 3, accessed December 10, 2014, http://www.nber.org/papers/w18220.
[65] Jamie Cowen, Employee Benefits Research Institute, *Twenty-Five Years After Federal Pension Reform,* 13, accessed December 11, 2014, http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2011_No359_FERS86.pdf.
[66] WorldatWork, Trends in 401(k) Plans and Retirement Rewards, 3, accessed October 22, 2014, http://www.worldatwork.org/waw/adimLink?id=71489.
[67] Ibid.
[68] William F. Bassett, Michael J. Flemming and Anthony P. Rodrigues, *How Workers Use 401K Plans: The Participation, Contribution and Withdrawal Decisions,* National Tax Journal, 51 no. 2 (1998), 276, accessed January 7, 2015, http://www.ntanet.org/NTJ/51/2/ntj-v51n02p263-89-how-workers-use-401.pdf.
[69] Joanne Summer, Society of Human Resource Management, *Finding the Right 401(k) Match*, accessed October 22, 2014, http://www.shrm.org/hrdisciplines/benefits/articles/pages/401k-match-factors.aspx.
[70] WorldatWork, Trends in 401(k) Plans and Retirement Rewards, 2, accessed October 22, 2014, http://www.worldatwork.org/waw/adimLink?id=71489.
[71] Ibid.
[72] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[73] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

the decisions employers make when it comes to 401(k) plan vesting and eligibility. For example, employers in industries with low wages, and therefore low tenure and high employee turnover, such as the restaurant and hospitality industries, might delay employer contributions. If employees in these industries were immediately eligible for plan participation and fully vested upon employment, the plan costs would increase without generating a commensurate benefit to the company, such as employee longevity.[74] For Federal Employee Retirement System employees, there is generally a 3-year vesting period (2 years for most employees in Congressional and certain noncareer positions) before they can keep the agency automatic (1 percent) contributions and associated earnings.[75]

Auto-enrollment: Studies have shown that "by far the most effective method to increase participation in defined contribution saving schemes is automatic enrollment."[76] Many studies have found complexity is a deterrent to participation in savings plans. Automatic enrollment decouples the savings plan participation decision from the contribution rate and asset allocation decision, which are viewed as difficult and lead to procrastination.[77] With automatic enrollment plans, a person is enrolled at a default rate of contribution, and for many, their contributions are invested in a default asset allocation. The effect of automatic enrollment is greatest for groups with the lowest saving rates, generally younger, lower-income workers.[78] Because very few people opt out of savings plan participation when they are automatically enrolled, automatic enrollment promotes long-term savings for retirement.[79] In particular, only 2 to 3 percent of automatically enrolled employees opt out of savings plan participation in a 12-month period.[80] The WorldatWork and American Benefits Institute joint survey showed 56 percent of respondents reported their company offers automatic enrollment in their 401(k) retirement plans.[81] Federal agencies automatically enroll their newly hired or rehired civilian employees in TSP.[82] According to recent data, 96.1 percent of federal employees who are automatically enrolled into TSP remained enrolled.[83] Currently, Service members are exempt from automatic enrollment.[84]

Although defined contribution plans offer Service members greater flexibility and more choices, these benefits are accompanied by increased complexity. To take full advantage of a DC plan, Service members must be informed of the choices available and educated as to the consequences of making each of these choices. Providing such

[74] Joanne Summer, Society of Human Resource Management, *Finding the Right 401(k) Match*, accessed October 22, 2014, http://www.shrm.org/hrdisciplines/benefits/articles/pages/401k-match-factors.aspx.
[75] Government Organization and Employees, 5 U.S.C. § 8432(g).
[76] Brigitte Madrian, "Matching Contributions and Savings Outcomes: A Behavioral Economics Perspective," in *Matching Contributions for Pensions: A Review of International Experience*, eds. Richard Hinz, Robert Holzmann, David Tuesta, Noriyuki Takayama (Washington, DC, The World Bank, 2013), 298-309, accessed January 8, 2014, http://www.nber.org/papers/w18220.pdf (citing research of the effectiveness of automatic enrollment).
[77] Ibid.
[78] Ibid.
[79] Ibid.
[80] James J. Choi, David Laibson, Brigitte C. Madrian, Andrew Metrick, *Defined Contribution Pensions: Plan Rules, Participant Choices, and the Path of Least Resistance*, 11, accessed December 11, 2014, http://www.nber.org/papers/w8655.
[81] WorldatWork, *Trends in 401(k) Plans and Retirement Rewards*, March 2013, 4, accessed December 10, 2014 http://www.worldatwork.org/waw/adimLink?id=71489.
[82] Government Organization and Employees, 5 U.S.C. § 8432(b)(2).
[83] TSP Official, email to MCRMC staff, October, 21, 2014.
[84] Government Organization and Employees, 5 U.S.C. § 8432(b)(2)(D)(ii).

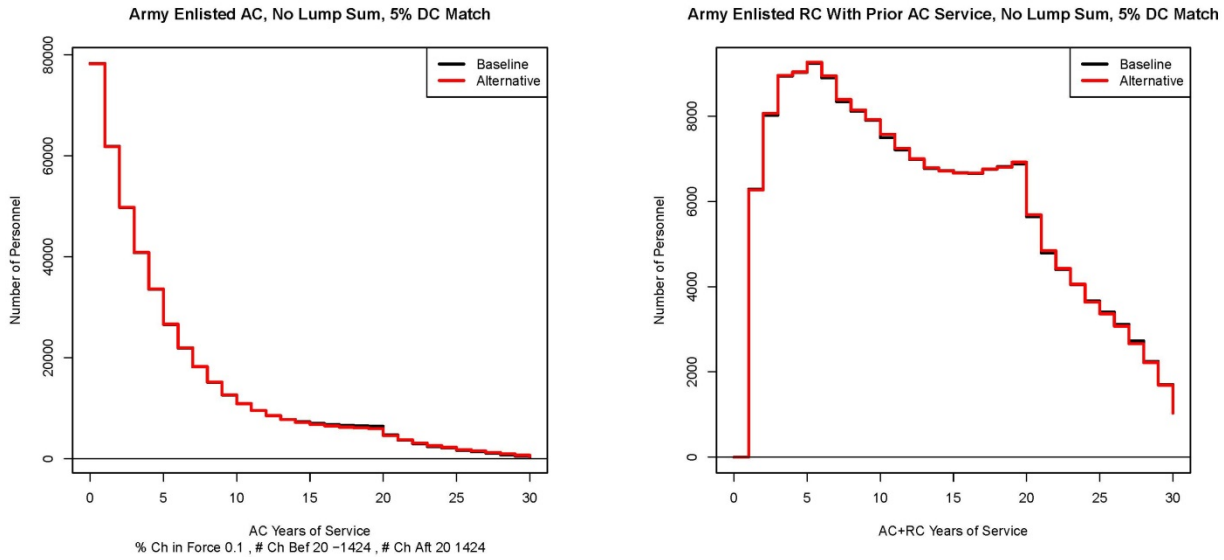
information would require renewed emphasis on financial literacy.[85] A small investment in financial education, however, could have a disproportionately large effect on employee participation in a DC plan and in the plan's effectiveness. A 2008 study indicated that a provision to newly hired employees of relatively simple planning tools designed to aid their understanding of a company's DC plan increased enrollment by 12 to 21 percent.[86] This increase is 2 or 3 times the effect of employer matching, and more cost effective.[87] If Service members are provided the financial education necessary to make informed choices when utilizing a DC plan, they would be more likely to use the plan and more likely to make choices tailored to their individual situations—an important component of a modernized retirement model.

Retention with Defined Contribution

The effectiveness of Uniformed Services compensation can be measured by the achievement of recruiting and retention goals, which in turn ensures the All-Volunteer Force is staffed with sufficient personnel who have the appropriate skill sets.[88] As described above, the current DB retirement plan has a strong effect on maintaining the current force profile, which the Services have stated they want to maintain. The Commission analyzed potential changes or improvements to the current Uniformed Services retirement system, and examined the retention effects of a blended retirement plan for the Services.[89] The conclusion reached was that the current force profile could be maintained with a retirement plan comprised of a majority of the current DB plan, a new DC plan for all Service members, and additional continuation pay to provide midcareer retention incentives.[90] These results are shown in Figure 5, which displays current Active and Reserve Component force profiles (black lines) compared to the projected force profiles (red lines) based on a blended retirement plan. The figures show that retention under the blended retirement system is virtually identical to that of the current DB-only retirement system.

[85] For a thorough discussion of financial literacy, see *The Report of the Military Compensation and Retirement Modernization Commission: Final Report, Recommendation 3*.
[86] Annamaria Lusardi, Punam Keller, Adam Keller, New Ways to Make People Save: A Social Marketing Approach," in *Overcome the Saving Slump: How to Increase the Effectiveness of Financial Education and Savings Programs*, 19-20, accessed December 11, 2014, http://www.nber.org/papers/w14715
[87] *See* Brigitte Madrian, National Bureau of Economic Research, *Matching Contributions and Savings Outcomes: A Behavioral Economics Perspective*, accessed December 10, 2014, http://www.nber.org/papers/w18220.
[88] Karl Gingrich, Brookings, *Making it Personnel: The Need for Military Compensation Reform*, 4, accessed November 10, 2014,
http://www.brookings.edu/~/media/research/files/papers/2012/2/military%20compensation%20gingrich/02_military_compensation_gingrich.pdf
[89] RAND Corporation, *Analysis of Retirement Reform in Support of the Military Compensation and Retirement Modernization Commission Progress Report*, November 2014 (RAND performed this analysis pursuant to a contract with the Commission).
[90] Ibid.

Figure 5. Force Profiles: Current vs. Proposed Retirement Systems[91]



Each figure presents the current force profile (in black). They also present (in red) the force profiles that would result from a blended retirement system that maintains the 20-year vesting of the Services' DB plan with a multiplier of 2.0, a new DC plan for Service members, and continuation pay (i.e., midcareer payments to provide additional retention incentives). The chart on the left shows projections for the AC and the chart on the right shows projections for the RC. These models illustrate there would be no appreciable difference in overall force profile when comparing the current retirement plan to the blended retirement plan.

Based on the features of this blended approach, the DRM projects continuation pay would be required at 12 YOS to maintain the current force profile. Table 2 shows this continuation pay, displayed as multiples of a Service member's monthly basic pay. That is, retaining the Army's current force profile would require paying Army active-duty enlisted personnel continuation pay equal to 2.8 times their monthly basic pay, assuming Service members are auto-enrolled to contribute 3 percent of their basic pay in TSP and that the Services match these contributions. To the extent that the Services need additional retention incentives, they would have the flexibility to increase continuation pay. For each Service, the analysis shows a blended retirement

[91] RAND projected these alternative force profiles with its Dynamic Retention Model (DRM), which is a mathematical model designed to analyze structural changes in the military compensation system. The DRM projects individual decision-making over each Service member's life cycle assuming that members have various preferences for Active and Reserve Component service. The parameters of this model are empirically estimated with data about 25,000 real military careers, spanning 20-21 years, drawn from the Defense Manpower Data Center. The DRM relies upon military pay and compensation information that was drawn from military pay tables, as well as U.S. Census Bureau data to model civilian pay opportunities. The DRM can be used to analyze retention both in steady-state and year-by-year during transitions between compensation systems. More information on the DRM and its underlying methodology and assumptions is available in RAND's report, *Analysis of Retirement Reform in Support of the Military Compensation and Retirement Modernization Commission*. Importantly, DoD also relied upon the DRM for retention analyses in its March 2014 White Paper, *Concepts for Modernizing Military Retirement*. *See* Department of Defense, Concepts For Modernizing Military Retirement, http://rise.naus.org/documents/2014military-retirement-report.pdf.

plan could create a steady-state force level and experience mix equivalent to the current retirement plan.[92]

Table 2. AC and RC Continuation Pay Multipliers by Service

	Enlisted		Officer	
	AC	RC	AC	RC
Army	2.8	0.9	13.0	6.2
Marine Corps	4.2	1.1	11.7	5.8
Navy	4.8	1.2	15.2	6.7
Air Force	2.4	0.8	15.9	6.4

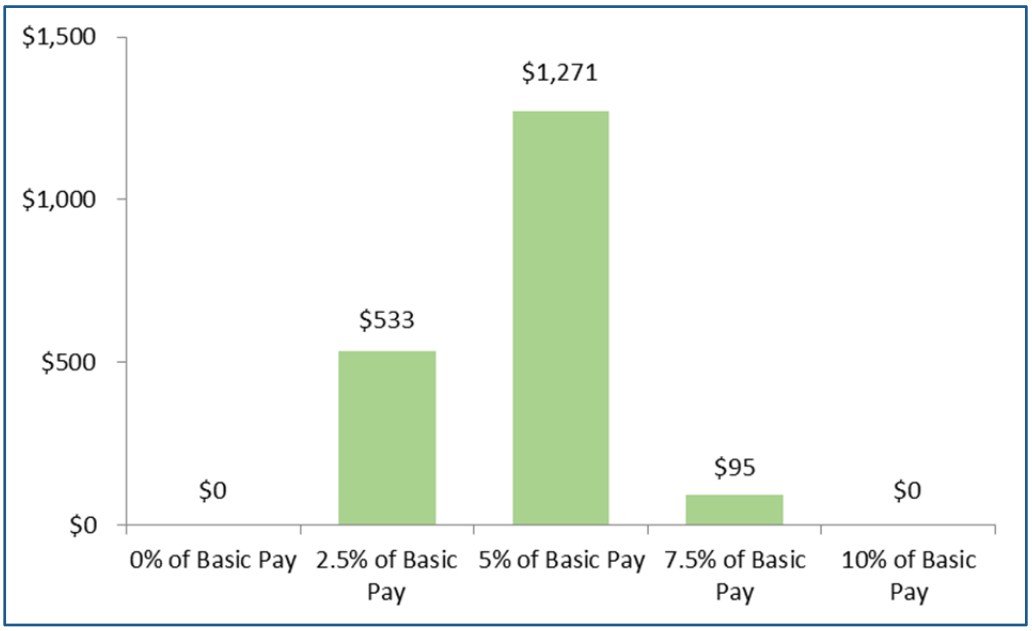
In addition to providing the Services the ability to maintain the current force profiles, continuation pay provides flexibility for Service personnel managers to adjust force profiles if future manpower requirements change. Continuation pay increases the share of Service members' lifetime compensation that is paid as current, rather than deferred, compensation. Studies have repeatedly concluded the current retirement system is heavily weighted toward deferred payments, even though typical Service members are young and have a preference for current compensation, rather than deferred. For example, the President's Commission on Military Compensation (1978) criticized the military retirement system as ineffective because it had little effect on recruiting and early retention, but an extremely strong effect on retention after 10 or 12 YOS.[93] The Defense Advisory Committee on Military Compensation (DACMC) (2006) also critiqued the compensation system, stating too much compensation is deferred. The DACMC concluded that moving some compensation forward to current pay would increase efficiency[94] and substituting current retention pay for deferred retirement pay is preferred by Service members and is less costly to the Government.[95]

Retirement Value with Defined Contribution

The blended retirement system has the potential to provide retirement assets that Service members would value equal to or greater than those of the current DB-only plan. The value of the blended plan can be measured in two ways. First, respondents to the Commission's survey provided their preferences for various potential features of the retirement system. The survey methodology enabled the Commission to quantify the dollar value of those preferences to easily compare among retirement system alternatives (see Section 5 for further explanation of the survey methodology). For example, Figure 6 shows that survey respondents preferred to be auto-enrolled in TSP at 5 percent of their basic pay. Service members could also raise or lower their TSP contributions to adjust their auto-enrollment levels.

[92] RAND Corporation, *Analysis of Retirement Reform in Support of the Military Compensation and Retirement Modernization Commission Progress Report,* November 2014.
[93] Office of the President of The United States, *Report of the President's Commission on Military Compensation, April 1978,* accessed December 19, 2014, http://babel.hathitrust.org/cgi/pt?id=umn.31951d00830253o;view=1up;seq=1
[94] Defense Advisory Committee on Military Compensation, *Completing the Transition to an All-Volunteer Force: Report of the Defense Advisory Committee on Military Compensation,* 23.
[95] Ibid.

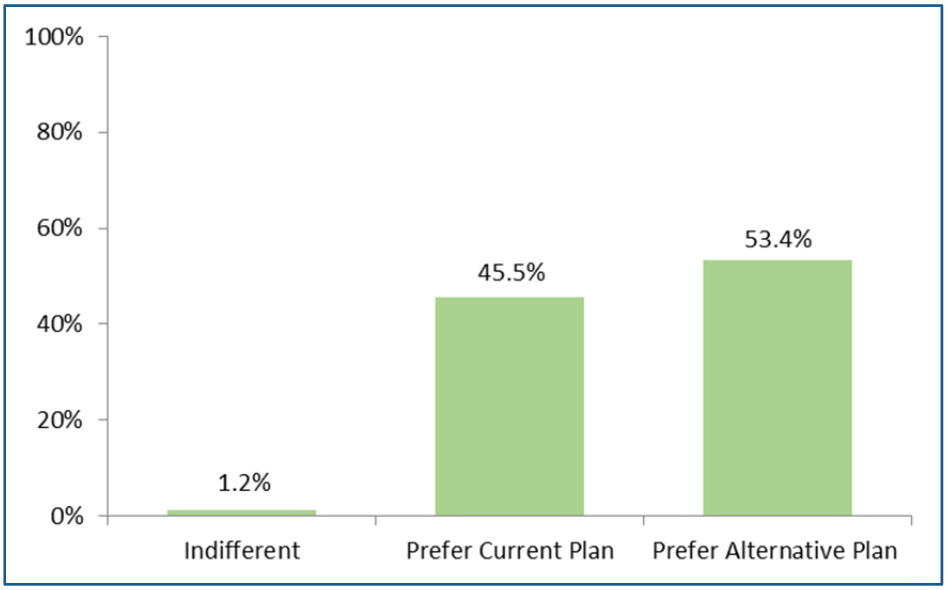
Figure 6. Active-Duty Service Members' Perceived Value: TSP Auto-Enrollment[96]



As shown in Figure 7, the Commission's survey also showed that, compared to the current DB-only plan, 54 percent of active-duty respondents prefer a blended retirement system. The blended retirement system would have a lower DB multiplier, and the survey showed a corresponding decrease in perceived value. Yet survey respondents indicated increased value for automatic enrollment and Government matching of TSP contributions. More recent entrants into service expressed a stronger preference for the blended retirement system, with 60 percent of E1-E4 survey respondents preferring a blended retirement system.

[96] This figure displays the average amount in dollars at which survey respondents valued compensation alternatives. Presentation in dollar values allows the value of compensation features to be directly compared.

Figure 7. Percent of Active-Duty Service Members Who Prefer the Current or Proposed Retirement System[97]



The second way value can be measured is how much a stream of future annuity payments is worth to a Service member at the time of retirement. Research shows that the value a person attaches today to a stream of future payments is typically less than the cumulative amounts eventually paid out.[98] A discount rate is applied to indicate the stream of future payments. This total value is commonly referred to as the payments' "discounted net present value."[99] Figures 8 and 9 illustrate the value of retirement assets for an E7 and an O5 at their 20th year of service under various retirement plans. The first bar shows the net present value of DB payments under the current DB-only plan with a 2.5 percent retirement multiplier. The present value of those DB payments would be $201,282 for enlisted personnel and $711,948 for officers.

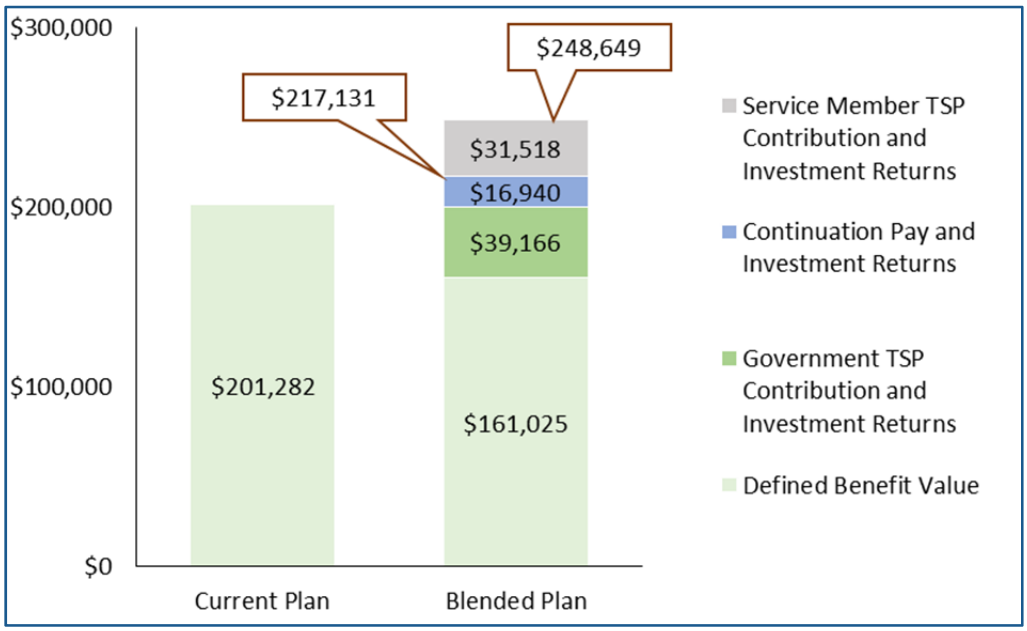
Subsequent bars show the value of retirement assets with a blended retirement system with different levels of Service-member contributions into TSP. The light green portion of each bar represents the net present value of DB payments, assuming a 2.0 percent retirement multiplier. The dark green portion represents the value of Government TSP on behalf of Service members, including associated investment earnings. The blue portion is the value of the continuation pay needed to maintain the force profile, including investment earnings until 20 YOS. The gray-shaded portions on the top represent the Service member's TSP contribution, with associated investment earnings.

The figures show that the blended retirement system, depending on investment behavior, could result in Service members having greater Government-sponsored retirement savings than the current DB-only retirement plan. For example, enlisted

[97] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[98] *See e.g.,* Aswatch Damodaran, *Strategic Risk Taking: A Framework for Risk Management* (New York: Pearson Prentice Hall, 2008), 111.
[99] "Discounted Cash Flow DCF, Net Present Value NPV, Time Value of Money Explained: Definitions, Meaning, and Calculated Examples," Building The Business Case, accessed December 17, 2014, https://www.business-case-analysis.com/discounted-cash-flow.html.

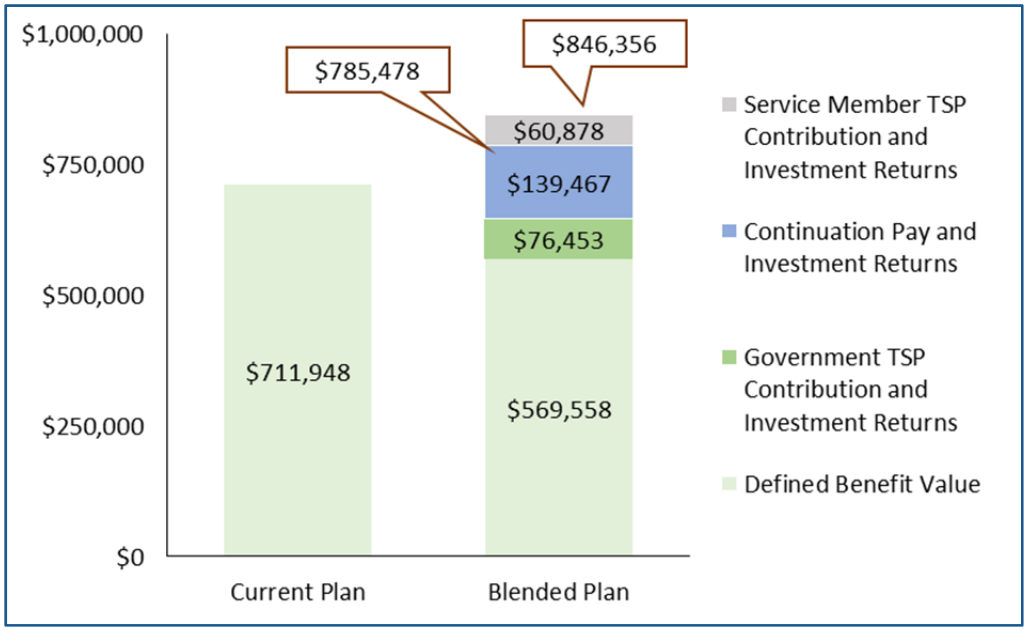
Service members who contribute 3 percent of their basic pay into TSP accounts would be expected to have Government-sponsored assets totaling $217,131 at 20 YOS. This balance exceeds the $201,282 value they would derive from DB-only payments. In addition to Government-sponsored assets, under the blended plan the members would have saved $31,518 of their own funds, enhancing their financial status. Retirement assets under the blended plan are even higher if Service members contribute 5 percent of their basic pay to their TSP accounts, and retirement assets are lower if Service members opt out of DC plan participation.

Figure 8. Retirement Assets of a Retiring Active-Duty E7, Current vs. Blended Retirement Plans[100]



[100] Assumes: (1) An active-duty E7 who retires at age 38 after 20 YOS and who had a standard promotion path; (2) A life expectancy of 85 years; (3) A personal discount rate of 12.7 percent (see RAND report, page XX); (4) An automatic Government contribution of 1 percent of basic pay into the Service member's TSP account; (5) Matching Government contributions of 3 percent of basic pay into the Service member's TSP account; (6) Continuation Pay of 3.37 months of basic pay at 12 YOS that is invested (average of AC Enlisted data in Table 2); (7) Service member contributions of 3 percent of basic pay into the Service member's TSP account; (8) The accumulated value of the TSP contributions is estimated using the historical earnings data from the TSP (2001 – 2014). Assuming an asset distribution similar to the life cycle L2050 plan, the average rate of return is 7.3 percent per year. After adjusting for inflation over those years (averaging approximately 2.35% per year), the real rate of return for the L2050 plan is 4.95 percent per year. Service members would receive CP to promote midcareer retention. This comparison of retirement assets assumes CP is saved and invested for retirement.

Figure 9. Retirement Assets of a Retiring Active-Duty O5, Current vs. Blended Retirement Plans[101]



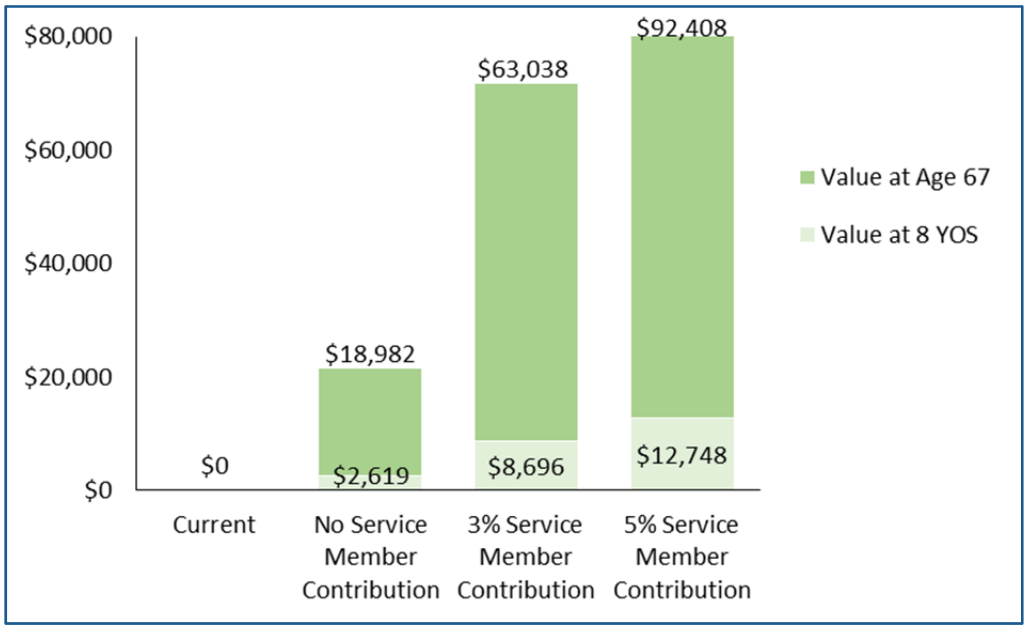
As mentioned above, the Commission's survey indicated that more recent entrants into service prefer a blended retirement system over the current DB-only plan. Because the majority of Service members do not reach 20 YOS and vest for DB payments, a blended retirement system would provide them with Government-sponsored retirement savings that they would not otherwise obtain. Moreover, these new retirement savings could be substantial, even for those who leave before 20 YOS. Figure 10 presents the value of Government contributions into an E5's TSP account at 8 YOS (in light green). If the E5 contributes nothing into TSP, he or she would still have $2,619 of TSP savings at 8 YOS because of automatic Government contributions of 1 percent of basic pay. If the E5 contributes 5 percent of his or her basic pay into TSP, the Government would have contributed $12,748 of TSP savings by 8 YOS. Furthermore, these balances could grow substantially over time because of investment returns. As stated previously, funds invested in TSP generally increase in value because of compounding investment returns, with investments in corporate bonds and stocks having higher potential returns and investment risks.[102] Assuming the E5 left service after 8 years, his or her TSP savings would grow by age 67 to $18,982 if he or

[101] Assumes: (1) An active-duty O5 who retires at age 42 after 20 YOS and who had a standard promotion path; (2) A life expectancy of 85 years; (3) A personal discount rate of 6.4% (see RAND Corporation, *Analysis of Retirement Reform in Support of the Military Compensation and Retirement Modernization Commission Progress Report*, November 2014); (4) An automatic Government contribution of 1 percent of basic pay into the Service member's TSP account; (5) Matching Government contributions of 3 percent of basic pay into the Service member's TSP account; (6) Continuation Pay of 14 months of basic pay at 12 YOS that is invested (average of AC Officer data in Table 2); (7) Service member contributions of 3 percent of basic pay into the Service member's TSP account; (8) The accumulated value of the TSP contributions is estimated using the historical earnings data from the TSP (2001 – 2014). Assuming an asset distribution similar to the life cycle L2050 plan, the average rate of return is 7.3 percent per year. After adjusting for inflation over those years (averaging approximately 2.35% per year), the real rate of return for the L2050 plan is 4.95 percent per year. Service members would receive CP to promote midcareer retention. This comparison of retirement assets assumes CP is saved and invested for retirement.

[102] Thrift Savings Plan, *Summary of the Thrift Savings Plan*, 12, accessed December 12, 2014, http://www.tsp.gov/PDF/formspubs/tspbk08.pdf.

she did not contribute to TSP, or to $92,408 if 5 percent of basic pay was contributed (dark green bar).[103]

Figure 10. Value of Government TSP Contributions for an E5 Who Leaves After 8 Years of Service[104]



Conclusions:
There is substantial Uniformed Services, political, and academic support for a blended retirement system. DoD's March 2014 White Paper, "Concepts for Modernizing Military Retirement," proposed a new DC plan and an adjustment to the DB multiplier to either 2.0 or 1.75 percent.[105] The 10th Quadrennial Review of Military Compensation proposed in 2008 a blended retirement system with both DB and DC elements.[106] The Defense Business Board proposed in 2011 replacing the entire DB plan with a DC plan.[107] The Defense Business Board's all-DC proposal is not advisable because it would make it more difficult for the Services to maintain their desired force profiles, yet the Board's proposal does provide additional support for the implementation of a limited DC plan for all Service members.

The Uniformed Services retirement system should be modified to provide retirement benefits to many more service members and maintain the value of retirement benefits

[103] Withdrawals from TSP before age 59½ may incur tax penalties.
[104] Assumes: (1) An active-duty E5 who leaves service after 8 YOS and who had a standard promotion path; (2) An automatic Government contribution of 1 percent of basic pay into the Service member's TSP account; (3) Matching Government contributions into the Service member's TSP account; (4) Nominal annual investment returns equal to 4.95 percent; and (5) Inflation and Cost-of-Living Adjustments equal to 2.0 percent.
[105] Department of Defense, *Concepts For Modernizing Military Retirement*, http://www.mcrmc.gov/public/docs/report/pr/Concepts_for_Modernizing_Military_Retirement_SBP_FN_15_16_27.pdf.
[106] Department of Defense, *Report of the Tenth Quadrennial Review of Military Compensation, Volume II Deferred and Noncash Compensation, July 2008*, xiii, http://www.defense.gov/news/qrmcreport.pdf.
[107] Defense Business Board, *Modernizing the Military Retirement System: Task Group*, Brief, 4-6, accessed Dec. 11, 2014, http://dbb.defense.gov/Portals/35/Documents/Reports/2011/FY11-5_Modernizing_The_Military_Retirement_System_2011-7.pdf.

for Service members who reach 20 YOS. Such modifications should allow for the Services to maintain the requisite force profile.[108] To accomplish this goal, the Uniformed Services should implement a blended retirement system that offers both DB and DC elements, plus continuation pay to maintain midcareer retention rates. This approach would allow the Uniformed Services to compete more effectively with the private sector for the high quality of personnel they have come to expect as part of the All-Volunteer Force. A blended retirement system would also provide additional options for Service members, as well as provide the Services the tools needed to maintain the balanced forces required to defend our Nation.

The majority of the current DB plan should be maintained because of its strong retention-pull effect on the Services' force profiles. Both Active and Reserve Component Service members should continue to vest for the DB plan after 20 qualifying YOS. DB retirement annuities for both components should be computed as the retired pay base[109] multiplied by 2.0 percent multiplied by YOS. All other statutes pertaining to the existing DB retirement plan should remain in effect, except that Service members whose retirement pay is otherwise grandfathered by existing law must be allowed to opt in to the new blended retirement system.

Implementing a DC plan for all Service members is more equitable than the current DB-only plan. A DC plan would promote savings and financial knowledge throughout the Force, as well as ease Service members' transition to civilian life by giving them experience with the type of retirement system they would likely have with private-sector employers after separation from service. Each Service member should be enrolled automatically in a TSP account, and an amount equal to 1 percent of each Service member's basic pay should be deposited automatically by the Uniformed Services into these accounts as a standard contribution from the Services. Service members should be auto-enrolled upon entry into Service to contribute 3 percent of their basic pay into their TSP accounts. The Uniformed Services should match a Service member's contribution up to 5 percent of basic pay. A period of 2 complete YOS should be required before a Service member can vest in the Uniformed Services' matching contributions, due to the high attrition that occurs during the first 2 YOS (approximately 25 percent for enlisted personnel and 9 percent for officers).[110]

To ensure they are able to maintain their desired force profiles, the Uniformed Services should budget additional funds for continuation pay. A new continuation pay should be authorized and paid at 12 YOS to all Service members who are willing and able to commit to remain in service for an additional 4 years, through 16 YOS. Continuation pay should be a lump-sum payment totaling 2.5 times Service members' monthly basic pay. To ensure funding for continuation pay, it should be authorized separately from other special and incentive pays and be provided for in its own budget line item. The Services should use special and incentive pays currently authorized for additional midcareer retention bonuses as needed, thereby increasing Service flexibility to create specific force profiles by Service and community.

---

[108] By law, existing retirement pay is grandfathered for current retirees and Service members who joined the Uniformed Services prior to legislative enactment of this Recommendation, while also providing the option for these "grandfathered" retirees and Service members to opt in to this new blended retirement plan. See National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 § 674(b)(2) (2013) (as amended by National Defense Authorization Act for Fiscal Year 2014, Pub. L. No. 113-66, § 1095(b), 127 Stat. 672, 879 (2013)).
[109] The retired pay base should be calculated according to Chapter 7 of Title 10.
[110] Defense Manpower Data Center Data Base, accessed December 18, 2013.

This combination of an adjusted DB plan, a new DC plan, and continuation pay, provides the Services with the critical ability to maintain their current force profiles. It also maintains the value of retirement assets for Service members who serve for at least 20 years. To provide additional options to Service members, individuals should be authorized to choose full or partial lump-sum payments of their working-age DB payments, so as to allow them flexibility to receive retirement benefits based on their individual life circumstances. Full monthly retirement annuity payments should resume for all Service members at the full retirement age for Social Security benefits (age 67 for those born after 1959) to ensure Service members have a stable, regular income during normal retirement years. This full annuity should include all cost of living adjustments prior to full retirement age, such that monthly annuity payments are the same as the Service member would have received without the lump-sum payment.

While a blended retirement system would allow the Services to maintain their current force profiles, it may be desirable to alter force profiles in the future. Manpower requirements will vary with changes in the security environment, the economy, and labor markets. Service personnel managers therefore need a compensation system with which they can easily adjust pay and benefits to obtain the appropriate mix of skills and experience levels to maintain a balanced force. The Services would benefit from additional flexibility to address fundamental differences in the skill sets, training requirements, and career paths of various professions, subject to notification to and approval by the Congress. Additional flexibility in the compensation system would help the services compete for high-demand skill sets in the labor market.

Recommendations:

- The Uniformed Services should modernize the current retirement system by adding a DC element to the DB plan. The DC element should incorporate the following attributes:

  - The DC element should reside entirely in TSP.

  - The Uniformed Services should begin a monthly contribution of 1 percent of members' basic pay to Service members' respective TSP accounts upon their Service entry date. The contribution should continue until Service members reach 20 YOS and should not depend upon their participation in TSP.

  - The Uniformed Services should automatically enroll Service members in TSP upon entry into service at an amount equal to 3 percent of their basic pay. Service members should be allowed to raise or lower their TSP contribution amount or to terminate their participation at any time. Service members who terminate their participation will be reenrolled automatically the following January at the 3 percent of basic pay amount. Service members must earn basic pay in a given pay period to make TSP contributions and to receive Government contributions into their TSP accounts.

  - The Uniformed Services should begin matching each Service member's contribution to TSP, up to a maximum of 5 percent of monthly basic pay, after the completion of each member's second year of service. The matching contribution will continue until the Service member reaches 20 YOS and is dependent upon a Service member's monthly participation in the TSP.

  - Service members should be vested in their TSP after 2 complete YOS (the standard 1 percent contribution and matching contribution provided by the Uniformed Services will belong to the Service member upon that date).

- The Uniformed Services should provide continuation pay for all Service members who reach 12 YOS and are willing and able to obligate for 4 additional years.

  - All AC Service members should receive basic continuation pay equal to 2.5 times Service members' monthly basic pay.

  - All RC Service members should receive basic continuation pay equal to 0.5 times Service members' monthly basic pay, as if he/she were an AC Service member.

  - Uniformed Services should budget additional funds for continuation pay, in addition to basic continuation pay, to provide midcareer retention incentives as needed.

  - Basic and additional continuation pay should be paid from an authority to be used only for the purpose of continuation pay. Continuation pay should be budgeted in a new budget line item.

- The Uniformed Services should compute AC Service members' retirement annuity using a 2 percent multiplier times YOS, times the retired pay base. For RC members, the same calculation should be used except YOS should be computed by dividing Reserve points by 360. Both AC and RC members should continue to be eligible for retirement after completing 20 YOS.

- The Uniformed Services should provide AC Service members the choice to receive their retirement annuity in various forms: a monthly payment beginning at their retirement date; a lump sum amount at retirement, combined with a reduced monthly payment until eligibility for full social security payments, at which point the full monthly annuity would begin; or a (larger) lump sum payment with no monthly payment until eligibility for full social security payments, at which point the full monthly annuity would begin.

- The Uniformed Services should provide RC Service members the choice to receive their retirement annuity in various forms: a lump sum amount at retirement, combined with a reduced monthly payment until eligibility for full social security payments, at which point the full monthly annuity would begin; or a (larger) lump sum payment with no monthly payment until eligibility for full social security payments, at which point the full monthly annuity would begin. RC members should receive lump-sum payments upon their retirement from the RC, which will generally be before their retirement annuity begins at age 60.

- The Uniformed Services should allow any AC, RC, or retired member of the Uniformed Services who is grandfathered in the current retirement system the opportunity to opt in to the new retirement system.

- The 75 percent cap on disability retirement when a Service member uses his or her disability rating as the multiplier should be lifted. The multiplier for disability retirement when a Service member uses his or her YOS as the multiplier should be 2.0 times YOS.

- The Secretary of Defense should be given the authority to modify the years of service requirements to qualify for retirement to either fewer or a greater than 20 years of service. The purpose of these modifications is to facilitate management actions to shape the personnel profile or correct manpower shortfalls within an occupational specialty or other grouping of members, as defined by the Secretary. No modification should involuntarily impose retirement program changes on currently serving members. DoD should provide notice to the Congress regarding any proposed modification of the retirement system and be prohibited from implementing a retirement system modification unless a period of one year has elapsed following the day the Congress was provided notice of the proposed modification.

Implementation:

- 5 U.S.C. § 8440e governs the TSP program for members of the Uniformed Services.

  - 5 U.S.C. § 8440e(e) should be repealed to allow for the Services to make contributions to TSP on behalf of the Service member. 37 U.S.C. § 211(d) should also be repealed.

  - 5 U.S.C. § 8440e should be further amended to require the Services to match Service member contributions dollar-for-dollar up to 5 percent of basic pay and to require additional contributions of 1 percent of basic pay beginning at the date of entry regardless of the Service member's participation in TSP. This Code section should also be amended to require the Services to begin matching contributions at YOS 3.

  - 5 U.S.C. § 8440e should be amended to include the TSP Spousal Rights provisions as found in 5 U.S.C. § 8435.

- 5 U.S.C. § 8432 governs contributions into a participant's TSP account

  - 5 U.S.C. § 8432 should be amended to vest Service members in the automatic 1 percent after 2 years of service.

  - 5 U.S.C. § 8432 should be amended to require automatic enrollment of Service members entering service after the effective date or for Service members opting into the new retirement system. This section should also require automatic re-enrollment of Service members each January.

- A new section should be added in Chapter 5, Title 37 of the United States Code to require continuation pay to be paid at a rate of 2.5 months of basic pay at YOS 12 for Active Component Service members and 0.5 months of basic pay at YOS 12 for Reserve Component Service members. This new Code section should authorize the payment of continuation pay only if a Service member elects a 4-year service obligation. This new Code section should reference the repayment provisions of 37 U.S.C. § 373.

- A new section should be added in Chapter 5, Title 37 of the United States Code to authorize the Services to pay discretionary continuation pay equal to13 months of basic pay at YOS 12. As with Basic Continuation Pay, this new Code section should authorize the payment of continuation pay only if a Service member elects a 4-year service obligation. This new Code section should reference the repayment provisions of 37 U.S.C. § 373.

- 10 U.S.C. § 1409 should be amended to reduce the multiplier from 2.5 percent to 2.0 percent for current Service members or retirees who opt in to the new system or enter duty on or after the date of enactment. The opt-in period should begin 180 days after enactment and remain open for 180 days.

- 10 U.S.C. § 12739 should be amended to reduce the multiplier from 2.5 percent to 2.0 percent for those Service members who opt in to the modernized retirement system or enter into duty on or after the date of enactment. The opt-in period should begin 180 days after enactment and remain open for 180-days.

- 10 U.S.C. § 1401 should be amended to reduce the multiplier from 2.5 percent to 2.0 percent for those Service members who opt in to the new system or enter duty on or after the date of enactment. The 75 percent cap should be repealed.

- 33 U.S.C. § 3045 and 42 U.S.C. § 212 should be amended to conform the retirement authorities of NOAA and USPHS, respectively, to the modernized retirement system.

- 37 U.S.C. § 354 should be amended to sunset the authority to pay the Career Status Bonus at the date of enactment, to provide authority for those Service members currently receiving the bonus to continue receiving the bonus, and to allow for those Service members who are receiving the bonus and who opt in to the modernized retirement system to repay the bonus pursuant to 37 U.S.C. § 373.

- A new section should be added in Chapter 71, Title 10 of the United States Code, to authorize the Services to provide a lump sum payout of a Service member's retirement pay that he or she would be entitled to between the date of retirement and the attainment of Social Security age. This new Code section should mandate the Secretary to promulgate regulations addressing the actuarial procedure of determining the amount of the lump sum payment and for collection of SBP premiums if a lump sum is elected. The new section should allow for a 50 percent lump sum/50 percent annuity option. The new section should also allow for the resumption of annuity payments when the retiree reaches Social Security Age. This new section should also exclude Chapter 61 retirees (disability retirees) from eligibility for the lump sum payment.

- A new section should be added in Chapter 71, Title 10 of the United States Code to authorize the Services to provide a lump sum payout of an RC Service member's retirement pay that he or she would be entitled to between the age of 60 and the attainment of Social Security age. This new section would require the payment of the lump sum as of the date of retirement of the Service member, which will generally be before the retirement annuity begins at age 60. This new Code section should mandate the Secretary to promulgate regulations

addressing the actuarial procedure of determining the amount of the lump sum payment and for collection of SBP premiums if a lump sum is elected. The new section should allow for a 50 percent lump sum/50 percent annuity option. The new section should also allow for the resumption of annuity payments when the retiree reaches Social Security age. This new section should also exclude Chapter 61 retirees (disability retirees) from eligibility for the lump sum payment.

- 38 U.S.C. § 5304 should be amended to require a Service member making an election to receive a lump sum to pay back the offset from his or her VA disability compensation.

- 10 U.S.C. § 1463 should be amended to authorize lump sum payments to be paid out of the Military Retirement Fund.

- A new section should be added in Chapter 74, Title 10 of the United States Code to treat the Military Retirement Fund as a qualified trust under Internal Revenue Code § 401(a), so a Service member may roll the lump sum payment to either TSP or another qualified retirement plan.

- A new section should be added in Chapter 71, Title 10 of the United States Code to authorize the Secretary of Defense to change the years of service required of a Service member to be eligible to retire for specific military occupations.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

Recommendation 2: Provide more options for Service members to protect their pay for their survivors by offering new Survivor Benefit Plan coverage without Dependency and Indemnity Compensation offset.

Background:
The Survivor Benefit Plan (SBP) gives retiring Service members the option to provide a lifetime monthly annuity to qualified survivors.[111] SBP provides survivors an annuity equal to 55 percent of the base retirement pay the Service member elects to cover.[112] Service members can elect coverage on any base dollar amount of their retired pay, between $300 and their full retired pay.[113] In return for this survivor annuity, the Service member's retired pay is reduced by 6.5 percent of the base amount elected.[114] The premium for plan participation is deducted from retired pay before taxes.[115] Based on the number and age of participants, investment rates of return, and mortality rate assumptions, these Service member premiums cover approximately two-thirds of the full cost of SBP coverage. DoD subsidizes the remaining amount.[116] In general, SBP payments to the covered survivor are taxable income.[117] Once the member has reached age 70 and has participated in SBP for 360 months, the reductions in the retired pay to cover the retiree's share cease.[118]

Survivors of retirees may also be entitled to Dependency and Indemnity Compensation (DIC) payments from the Department of Veterans Affairs (VA),[119] if the Service member died from: (1) a disease or injury incurred or aggravated in the line of duty while on active duty or active-duty training, (2) an injury incurred or aggravated in the line of duty while on inactive duty for training, or (3) a disability compensable under laws administered by VA.[120] DIC payments are nontaxable.[121]

A survivor is generally restricted by law from receiving the full amounts of both SBP and DIC benefits.[122] SBP benefits are offset by the amount of DIC received, with the total amount paid equal to the greater of the full SBP benefit or the DIC award.[123] DoD proposed eliminating this offset and terminating the SBP subsidy in its March 2014 white paper on retirement options.[124]

---

[111] *See generally* Armed Forces, 10 U.S.C. §§ 1447-1455.
[112] Armed Forces, 10 U.S.C. § 1451(a)(1).
[113] Armed Forces, 10 U.S.C. §§ 1447(6), 1448(a)(3).
[114] Armed Forces, 10 U.S.C. § 1452(a)(1). Premiums for spouse and child, child only, and insurable interests are determined actuarially.
[115] Internal Revenue Code, 26 U.S.C. § 122(a).
[116] The SBP subsidy for FY 2013 was approximately 36 percent of the total cost per participant. Information provided by DoD Office of the Actuary, e-mail to MCRMC, October 7, 2014.
[117] Internal Revenue Code, 26 U.S.C. § 72(n) (provides that if the SBP premiums were excluded from income, then the payments received by the beneficiary are taxed; if not excluded, then SBP payments are not taxed until the beneficiary receives the same amount that was paid in premiums).
[118] Armed Forces, 10 U.S.C. § 1452(j).
[119] Veterans' Benefits, 38 U.S.C. § 1310(a).
[120] Veterans' Benefits, 38 U.S.C. § 1310(a).
[121] Veterans' Benefits, 38 U.S.C. § 5301(a).
[122] Armed Forces, 10 U.S.C. § 1450(c). The Veterans Benefits Act of 2003 eliminated the SBP–DIC offset for surviving spouses who remarry after attaining the age of 57 (see Veterans Benefits Act of 2003, Pub. L. No. 108-183, § 101, 117 Stat. 2651, 2652-2653 (2003) (codified at 38 U.S.C. § 103(d)(2)(B)).
[123] Armed Forces, 10 U.S.C. § 1450(c).
[124] Department of Defense, *Concepts For Modernizing Military Retirement,* 39, http://www.mcrmc.gov/public/docs/report/pr/Concepts_for_Modernizing_Military_Retirement_SBP_FN_15_16_27.pdf.

For additional information on Survivor Benefit Plan and Dependency and Indemnity Compensation, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 3.6)* and *(Section 3.6.1), respectively.*

Findings:
The SBP program has steadily become more attractive as an affordable way to provide lifetime monetary benefits to retirees' survivors. Eighty percent of Service members who retired in 2013 enrolled in SBP, compared to only 58 percent who retired in 1993.[125] This growth is even greater for enlisted personnel, 79 percent of whom enrolled upon retirement in 2013, compared to 52 percent in 1993.[126] The average number of families receiving SBP payments in a year grew by 87.9 percent from 1993 to 2013 (from 172,425 to 323,903).[127] In that same time period, SBP payments to beneficiaries rose 216.7 percent (from $1.2 billion to $3.8 billion).[128] The majority (80 percent) of retiring Service members elect SBP coverage on their full retired pay.[129] This growth is largely due to DoD's subsidy of SBP costs. If the program were not subsidized, Service member costs would total 11.25 percent of the base amount elected based on FY 2013 actuarial figures compared to 6.5 percent currently paid.[130]

Service members broadly participate in SBP, yet the current DIC offset of SBP is unpopular. For example, the Military Officers Association of America reported, "It is apparent that the [SBP–DIC] offset is not only unfair but also unjustly affects so many surviving spouses."[131] Similarly, the American Veterans stated, "The offset of SBP against DIC is inequitable because it penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from government separate from the annuity funded by premiums paid by veterans from retired pay."[132] The Disabled American Veterans also concluded, "Any offset between longevity military retired pay and VA compensation is unjust because no duplication of benefits is involved."[133] In FY 2013, 323,903 survivors received SBP benefits. Of these, 59,302 (20.7 percent) also received DIC payments, making them subject to the SBP-DIC offset.[134] The effect of the offset is somewhat mitigated by the reimbursement of SBP premiums proportional to the DIC offset provided to survivors.

---

[125] Department of Defense, Office of the Actuary, *Statistical Report of the Military Retirement System, Fiscal Year 2013*, 227, accessed December 11, 2014, http://actuary.defense.gov/Portals/15/Documents/statbook13.pdf.
[126] Ibid.
[127] Ibid, 228.
[128] Ibid, 227. Report data and information provided by the Office of the Actuary stated that of the 2013 payments to survivors, totaling $3.82 billion, $1.24 billion (32 percent) were funded from SBP premiums and $1.2 (32 percent) billion (37 percent) from interest earned on past premiums, leaving the remaining $1.38 billion (36 percent) subsidized by DoD through appropriated funding.
[129] DoD, Office of the Actuary, e-mail to MCRMC, September 19, 2014. E-mail correspondence also stated that another 8 percent of Service members selected coverage on 50-100 percent of retired pay, with the remaining 12 percent choosing to cover less than 50 percent of retired pay.
[130] DoD, Office of the Actuary, e-mail to MCRMC, October 8, 2014.
[131] "AMAC Storming the Hill Event 2013," Military Officers Association of America, accessed November 6, 2014, http://www.moaa.org/amacstorming/.
[132] American Veterans, *Resolution 12-13: Survivor Benefit Plan,* accessed October 6, 2014, http://www.amvets.org/pdfs/legislative_pdfs/2012/12-13-survivor-benefit-plan.pdf.
[133] "DAV Releases Mid-Winter Talking Points," Disabled American Veterans, accessed October 6, 2014, http://www.dav.org/learn-more/news/2012/dav-releases-mid-winter-talking-points/.
[134] DoD, Office of the Actuary, e-mail to MCRMC, October 7, 2014.

Below are examples of Service member comments received by the Commission on SBP–DIC offset:

> *SBP and DIC are two separate programs and should not be offset. Retirees can get concurrent receipt [if eligible].*[135]
>
> *[SBP]—hopefully without [DIC] offset—is going to take care of my wife who held things together through my deployments.*[136]
>
> *The SBP–DIC offset takes thousands of dollars out of those families' pockets that really need it. I am asking that the SBP–DIC offset be eliminated. I know this has been an ongoing issue, but it is time to do the right thing.*[137]

The DoD proposal to eliminate SBP–DIC offset would raise the cost of the SBP for all Service members, while reducing their choices. The DoD proposal would provide Service members a choice to elect base coverage of either 25 percent or 50 percent of their retired pay. These options would cost Service members 5 percent and 10 percent of their retired pay, respectively.[138] These options eliminate the current subsidy and would make SBP coverage more expensive for all Service members, including those who never receive DIC. Furthermore, offering only two options reduces Service members' flexibility to tailor SBP coverage to their individual financial situations.

Conclusions:
Survivor benefits could be improved by granting Service members the option of new SBP coverage that is not offset by DIC. Service members should continue to have the option to choose the current, subsidized SBP coverage. Alternatively, they should have an option of fully funded SBP coverage that would not be subject to offset by DIC. The amount paid by Service members should vary according to DoD actuarial calculations of cost, based on number and age of participants, investment rates of return, and mortality rate assumptions. Based on current figures, this new coverage would require an 11.25 percent reduction of the Service members' retired pay base amount selected.[139] Survivors of Service members who elect this new SBP coverage could derive a greater overall benefit by receiving full SBP and DIC payments.

Recommendations:

- The existing SBP program should be maintained for Service members who want to elect subsidized coverage that would remain subject to the SBP–DIC offset.

- A new SBP program should be implemented for which Service members would fully fund SBP costs, but would no longer be subject to offset by DIC payments. With unsubsidized coverage, Service members' retired pay should be reduced by the full cost of the benefit as determined annually by DoD Office of the Actuary. As an example, based on FY 2013 data, the amount would be 11.25 percent of the base amount elected. The base amount should not exceed 100 percent of

[135] MCRMC letter writer, comment form submitted via MCRMC web site, April 4, 2014.
[136] MCRMC letter writer, comment form submitted via MCRMC web site, November 15, 2013.
[137] MCRMC letter writer, comment form submitted via MCRMC web site, November 4, 2013.
[138] Department of Defense, *Concepts For Modernizing Military Retirement*, 14, www.mcrmc.gov/public/docs/report/pr/Concepts_for_Modernizing_Military_Retirement_SBP_FN_15_16_27.pdf.
[139] DoD, Office of the Actuary, e-mail to MCRMC, October 8, 2014.

the member's retired pay consistent with existing statute. Survivors of the Service members who select unsubsidized coverage would receive full SBP and DIC payments without offset. Although this option has a greater out-of-pocket cost to the Service member, it provides a greater overall benefit.

- The Services should provide retiring Service members and their spouses with an individualized, detailed analysis of the costs and benefits of the alternative SBP options, including potential costs and income from the current and new SBP programs.

- Those currently participating in SBP should be provided a one-time opportunity during the SBP open period to opt in to the new program.

Implementation:

- SBP is governed by 10 U.S.C. Chapter 73, Subchapter II. 10 U.S.C. § 1452 should be amended to allow for Service members to elect the new SBP option. Service members who make the election will pay an annually determined premium and not be subject to the DIC offset found in 10 U.S.C. § 1450(c). This section should be further amended to require the Secretary of Defense to promulgate regulations allowing a Service member to elect Spouse and Child Coverage or Child Only Coverage without being subject to the DIC offset found in 10 U.S.C. § 1450(c).

- 10 U.S.C. § 1452 should be amended to require the Services to provide retiring Service members and their spouses with an individualized, detailed analysis of the costs and benefits of the alternative SBP options, including potential costs and income from the current and new SBP programs.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

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

Background:
DoD has established a policy for Service family readiness that sets guidelines for personal financial management (PFM) training.[140] According to this policy, Service members and their families are provided with "tools and information they need to develop individual strategies to achieve financial goals and address financial challenges."[141] The intent of this policy is to incorporate personal and family financial objectives into the "organizational goals related to the recruitment, retention, morale, and operational readiness of the military force."[142] Marine Corps policy states, "instilling financial responsibility and educating Marines and their families about financial matters helps them control their current finances, save for the future, and reduces distractions from mission focus."[143] Similarly, Navy "operational commanders have identified financial decision making and resultant financial problems as having a serious negative impact on the stability of servicemembers and families, as well as a debilitating effect on operational readiness, morale, and retention."[144]

The Services implement PFM training for their members according to their internal policies.[145] The Army, for example, provides mandatory training to junior enlisted personnel prior to their initial permanent change of station move and for personnel who "abused and misused check-cashing privileges."[146] The Navy provides a series of training courses for enlisted personnel, as well as both personal and leadership training for its officers.[147] The Air Force provides training for all personnel upon arrival at their first duty stations and prior to deployments to facilitate preparation for extended absences.[148] Each Service provides financial counseling for Service members and their families.[149] Topics covered by the financial counseling component of PFM training include budgeting, banking, saving, credit and debt management, investing, taxes, insurance, estate planning, and predatory lending practices.[150]

---

[140] Military Family Readiness, DoDI 1342.22 (2012).
[141] Ibid, 15.
[142] Ibid, 2.
[143] Personal Financial Management Education Provided by Non-Federal Entities, MARADMIN 061/13 (2013).
[144] United States Navy Personal Financial Management Education, Training, and Counseling Program, OPNAVINST 1740.5B CH-2, 1-2 (2010).
[145] Army Community Service, Army Regulation 608-1 (2013). Personal Financial Management Education Provided by Non-Federal Entities, MARADMIN 061/13 (2013). United States Navy Personal Financial Management Education, Training, and Counseling Program, OPNAVINST 1740.5B CH-2 (2010). Airman and Family Readiness Centers, Air Force Instruction 36-3009 (2014).
[146] Army Community Service, Army Regulation 608-1, 23 (2013).
[147] United States Navy Personal Financial Management Education, Training, and Counseling Program, OPNAVINST 1740.5B CH-2, Enclosure 5 (2010).
[148] Airman and Family Readiness Centers, Air Force Instruction 36-3009, 16 (2014).
[149] Army Community Service, Army Regulation 608-1 (2013). Personal Financial Management Education Provided by Non-Federal Entities, MARADMIN 061/13 (2013). United States Navy Personal Financial Management Education, Training, and Counseling Program, OPNAVINST 1740.5B CH-2 (2010). Airman and Family Readiness Centers, Air Force Instruction 36-3009, 16 (2014).
[150] Military Family Readiness, DoDI 1342.22, 16 (2012).

For additional information on financial literacy in the Military Services, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 3.9).*

Findings:
Existing financial literacy programs do not adequately educate Service members and their families on financial matters. According to the 2013 Blue Star Families Annual Lifestyle Survey, only 12 percent of Service member respondents indicated they were receiving financial education from Service member training.[151] Furthermore, 90 percent indicated they would like to receive more preventive financial education, and 82 percent indicated their spouse should be included in financial readiness courses.[152]

Academic research showed a correlation between Service member financial readiness training and improved financial readiness among Service members.[153] A 2012 study by the Financial Industry Regulatory Authority (FINRA) concluded that Service respondents, though performing well in many areas, often engage in expensive credit card and nonbanking practices.[154] Specifically, Service personnel regularly make minimum payments, pay late fees, or pay over-the-limit charges on credit cards. They also commonly borrow from nonbank financial institutions (e.g., pawn shops). Service member comments, such as the following, also indicate a desire for additional training.

> *I wish there was more mandatory education on retirement savings, in either the TSP or IRAs. Most enlisted personnel, including higher ranks do not understand how they work or the benefits associated with them.[155]*

> *The key to successful retirement is educating people financially and in the art of living well but inexpensively.[156]*

This shortfall in financial literacy training has been a long-standing issue. "In May 2003, DoD formally launched a financial readiness campaign to address Service members' poor financial habits and increase financial management awareness, savings, and protection against predatory practices."[157] DoD's balanced scorecard, developed in FY 2003, included indicators of personal finances for which evaluation was based on junior enlisted personnel's self-reported financial condition and ability to make timely payments of bills.[158] DoD has formed partnerships with nonprofit organizations and Government agencies to provide Service members with financial

---

[151] Blue Star Families, 2013 Military Family Lifestyle Survey, Comprehensive Report, 34, accessed Dec. 10, 2014, http://www.mcrmc.gov/public/docs/report/pr/BlueStarFamilies_2013MilitaryFamilyLifestyleSurvey_Comprehensive_Report_May2013_p34_FinLit_FN_12-13-24.pdf.
[152] Ibid.
[153] William Skimmyhorn, Office of Economic and Manpower Analysis, Department of Social Sciences, United States Military Academy, *Assessing Financial Education: Evidence from a Personal Financial Management Course,* accessed December 11, 2014, http://www.globalfinlitsummit.com/wp-content/uploads/2013/11/Assessing-Financial-Education-Skimmyhorn.pdf.
[154] FINRA Investor Education Foundation, *Financial Capability in the United States: 2012 Report of Military Findings*, 14, http://www.usfinancialcapability.org/downloads/NFCS_2012_Report_Military_Findings.pdf.
[155] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[156] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[157] Government Accountability Office, *Military Bankruptcies,* GAO 04-465R, 2, accessed December 11, http://www.gpo.gov/fdsys/pkg/GAOREPORTS-GAO-04-465R/content-detail.html.
[158] Ibid, 7.

assistance programs."[159] These partners encourage general financial fitness and well-being."[160]

Weaknesses in financial literacy are adversely affecting Service members and their families. A bad credit report, a debt-collection action, or other financial problem can be devastating for a Service member's career and can affect the mission readiness of a unit, which often cannot use a Service member who has lost a security clearance due to financial problems.[161] In FY 2013, financial issues were the fourth highest-ranking reason for losing security clearances, costing 1,129 military Service members their security clearance.[162]

Costs associated with increasing financial literacy training would be offset, at least partially, by associated savings. DoD estimated it would save between $13 million and $137 million annually by providing Service members and their families more protection against high-cost debt, consequently reducing the number of troops involuntarily separated because of financial problems.[163] According to these estimates, between 4,703 and 7,957 military personnel would otherwise be involuntarily separated because of financial distress. The cost of separating one Service member can be as much as $57,333.[164] Loss of experienced mid-grade noncommissioned officers (NCOs) may be even costlier because such losses directly degrade mission effectiveness.[165] Financial concerns detract from mission focus and often require attention from Commanding Officers and senior NCOs to resolve outstanding debts and other credit issues.[166]

Conclusions:
Service members' financial literacy should be improved for the benefit of Service members, their families, force readiness, and DoD cost-effectiveness. Implementing a comprehensive PFM training program would help educate Service members and provide them with enhanced tools to better protect their finances. Current training programs could be better tailored to the behaviors of today's Service members. Financial education should be provided to Service members to develop a culture of personal financial responsibility. Training should contain real-world, practical lessons packaged to engage the youngest cohort of Service members. Technology-based instruction should be enhanced with in-person coaching as necessary.[167] A more

---

[159] Government Accountability Office, *Servicemembers Civil Relief Act: Information on Mortgage Protections and Related Education Efforts,* GAO-14-221, 16, http://www.gao.gov/assets/670/660398.pdf.
[160] Ibid, 17.
[161] Government Accountability Office, *Personnel Security Clearances: Additional Guidance and Oversight Needed at DHS and DOD to Ensure Consistent Application of Revocation Process,* GAO-14-640, 18, accessed December 11, 2014, http://www.gao.gov/products/GAO-14-640.
[162] Ibid.
[163] 79 Fed. Reg. 58601 (September 29, 2014), *See also* "Shielding troops from high interest rates may help DoD," *Military Times,* accessed October 8, 2014, http://www.militarytimes.com/article/20141008/NEWS/310080053/Shielding-troops-from-high-interest-rates-may-help-DoD.
[164] 79 Fed. Reg. 58601 (September 29, 2014), accessed December 11, 2014, http://www.gao.gov/assets/320/315051.pdf, estimating each separation costs the Department $52,800 in 2009 dollars). The cost of $57,333 is calculated in 2013 dollars (through December 2013), using the U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index, All Urban Consumers (CPI–U).
[165] Department of Defense, *Report: Enhancement of Protections on Consumer Credit for Members of the Armed Forces and Their Dependents*, 5, accessed December 11, 2014, http://www.consumerfed.org/pdfs/140429_DoD_report.pdf.
[166] Ibid.
[167] Consumer Financial Protection Bureau, *Office of Service Member Affairs Financial Fitness Forum, Building Bridges between the Financial Services Industry and the Department of Defense,* accessed December 11, 2014 http://files.consumerfinance.gov/f/201209_cfpb_Financial-Fitness-Whitepaper.pdf.

robust PFM education program could save DoD millions of dollars per year by reducing the number of troops involuntarily separated due to financial problems. PFM training would become even more important with adoption of the Commission's recommendations on items such as the Thrift Savings Plan (TSP), continuation pay, and retirement options (see Recommendation 1).

Educating Service members on health care benefits would also prepare them for the increased choice and personal control that Recommendation 6 in this Report would provide Service members. Many members enter the Service shortly after high school or college and therefore have not likely purchased or selected through an employer various health benefits. Accordingly, Service members should receive mandatory health benefits seminars when they register one or more dependents, and when they are nearing retirement from the Service. After completing the course, Service members should better understand how health insurance works, how plan types are structured and the differences among them, how to complete enrollment forms, and how to manage the Basic Allowance for Health Care (see Recommendation 6). Such a course would also guide Service members as they proceed through their Service careers and ultimately reenter the civilian sector.

Recommendations:

- DoD should increase the frequency and strengthen the content of financial literacy training. At a minimum, training and counseling should be provided during initial training, upon arrival at the first duty station (upon arrival at each duty station for E4/O3 and below), at the vesting point for the TSP program, on dates of promotion (up to pay grades E5 and O4), for major life events (e.g., marriage, divorce, birth of first child, disabling sickness or condition), during leadership and pre- and postdeployment training, at transition points (e.g., AC to RC, separation, and retirement), and upon request of the individual.

- DoD should enhance the content of financial literacy training. One-time training should be offered to educate the entire force on implications of this Commission's recommendations. Also, training on health care insurance options and other recommendations from this Commission should be added to existing curriculum.

- DoD should hire professional training firms to provide financial literacy training. DoD should consider if these professional trainers should be certified financial advisors. Outsourcing training requirements may require additional funding, but would ensure this critical topic is not assigned as a secondary responsibility. Improving financial literacy would also reduce long-term personnel costs, which could defray additional training costs.

- Messaging from the Secretary of Defense; Deputy Secretary of Defense; Chairman, Joints Chiefs of Staff; and Service Chiefs should reinforce the importance of financial literacy from both readiness and quality of life perspectives, and emphasize the popularity of similar programs in other countries. The Deputy Secretary of Defense should also be assigned responsibility for ensuring financial literacy training in his or her role as DoD's Chief Management Officer. For example, the Australian Defence Force created a similar literacy program in 2006, and 95 percent of participants indicated the

sessions they attended met their needs.[168] Support and messaging from senior leaders was instrumental in the success of the Australian financial literacy program.

- DoD should require Defense Manpower Data Center (DMDC) to survey the force on the status of financial literacy and preparedness and use the results as a benchmark from which to evaluate and update the training and education as needed. Results of the initial survey and follow-on surveys should be provided to the Congress.

- DoD should strengthen partnerships with other federal and nonprofit organizations (e.g., President's Advisory Council on Financial Capability for Young Americans, the Financial Literacy Education Council, and individual Service emergency relief organizations).

- DoD should provide an online budget planner with archival history capability for each Service member. As changes in pay occur (e.g., promotion, arrival at duty station with different BAH rate, dependent status), the budget planner should update automatically and prompt the Service member to complete it.

- The Leave and Earnings Statement (LES) should be restructured to reflect changes to compensation made as a result of this Commissions' recommendations, to include TSP balances (current value and projected value at 20-year point), and also to provide a more accurate accounting by displaying the value of benefits paid by the Government for the Service member (similar to a Federal civilian employee's LES).

Implementation:

- 10 U.S.C. § 992 provides the statutory authority for consumer education programs throughout DoD and should be amended to reflect the program changes described in the recommendation. This section should be amended to provide for changes to the frequency of financial literacy training. The language should, at a minimum, indicate that training will be provided:

  - during initial training;

  - upon arrival at the first duty station;

  - upon arrival at each subsequent duty station for each Service member ranked E4/O3 and below;

  - on date of promotion (up to pay grades E5 and O4);

  - at the vesting point for the TSP program;

  - major life events (e.g., marriage, divorce, birth of first child, and disabling sickness or condition);

  - during leadership training;

[168] Air Commodore Robert Brown, briefing with MCRMC, February 19, 2014.

- during pre- and postdeployment training;

- at transition points (e.g., Active Component to Reserve Component, separation, and retirement); and

- upon the request of the individual.

This section should also mandate the Secretary to implement regulations addressing other triggering events when financial literacy training will be mandatory.

- 10 U.S.C. § 992 should be further amended to expand the definition of "financial services." This new definition should include health insurance options, budget management, TSP matching, retirement lump-sum options (including rollover options and tax consequences), SBP options, and any other topics the Secretary determines are needed to educate Service members.

- 10 U.S.C. § 992 should be further amended to require DMDC to regularly survey the force on the status of financial literacy and preparedness in its "Status of Force" survey. Legislation should mandate that the Services use the results from this survey as a benchmark to evaluate financial training and to update financial training as necessary. The legislation should mandate that DoD report the results of the initial survey and any follow-on surveys to the Congress.

- Additional legislation should require current Service members to receive education on the implications of the Commission's recommendations within 6 months of enactment.

- A Sense of Congress provision should be enacted to encourage DoD to strengthen partnerships with other federal agencies and nonprofit organizations to improve the financial literacy and preparedness of members of the Armed Forces, as well as to encourage the Chairman of the Joints Chiefs of Staff and the Service Chiefs to provide support for the new financial literacy training program.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed. Such as:

  - Volume 8, Chapter 9 of the DoD Financial Management Regulation (FMR) provides the elements required on a Service member's LES. Chapter 9 should be amended to reflect the Service member's Basic Allowance for Health Care, TSP balance, and a more accurate accounting of benefits paid by the Government for the Service member.

  - Chapter 9 of the DoD FMR should be further amended to require DoD to provide an online budget planner for Service members that is updated regularly at promotion points and changes in dependency status.

Recommendation 4: Increase efficiency within the Reserve Component by consolidating 30 Reserve Component duty statuses into 6 broader statuses.

Background:
Although Active Component members have a single duty status—active duty—Reserve Component (RC) members serve under a variety of duty statuses. "Duty status reflects a reservist's availability to perform a specific mission, function, or job, and is linked to appropriated funds and legal authorities."[169] Titles 10, 32, and 14 of the U.S. Code provide the authorities for the statuses, as well as various DoD policies (see Table 3). The status under which an RC member serves differs depending on a variety of factors: whether the status is active duty, full-time National Guard duty, or inactive duty; whether the duty is voluntary or involuntary; and whether the RC member's mission is training, support, or operations.[170] Statuses may differ based on the type of appropriation that funds the status, (i.e., Military Personnel, Reserve Personnel, or National Guard Personnel appropriation).[171] Statutory limitations for overall RC end strength and the number of RC members who may be used for a specific purpose may require a change in status during an RC member's period of duty.[172] In the current system, each time the purpose or the source of appropriation for an RC member's orders changes, existing orders must be cancelled and new orders must be issued.[173] Table 3 displays the three RC authorities and various statuses that may be used to call an RC member to duty.[174]

Table 3. Current Reserve Component Statutory Authorities and Duty Statuses

Title 10 United States Code		
Full mobilization	Disciplinary action	Aid for state governments
Partial mobilization	Annual active duty (up to 30 days)	Enforce federal authority
Presidential reserve call-up	Additional training and operational support	National Guard called to federal service
Major disaster/emergency response	Medical evaluation and treatment	Additional training periods
Preplanned combatant command	Medical care (duty < 30 days)	Additional flight training periods
Captive status	Retiree recall	Readiness management periods
Unsatisfactory participation (45 days)	Muster duty	Funeral honors duty
Unsatisfactory participation (24 months)	Duty at the National Guard Bureau	
Title 32 United States Code—National Guard		
Required training and other duty	Additional training periods	Readiness management periods
Additional training and other duty	Additional flight training periods	Funeral honors duty
Title 14 United States Code—U.S. Coast Guard		
Emergency augmentation		

[169] Michelle Dolfini-Reed and Darlene E. Stafford, *Identifying Duty Status Reforms Needed to Support an Operational Reserve*, CRM D0021656.A2, (Alexandria, VA: CNA, 2010), 1.
[170] Department of Defense, Office of the Undersecretary of Defense for Personnel and Readiness, *The Report of the Eleventh Quadrennial Review of Military Compensation,* 133, accessed December 15, 2014, http://militarypay.defense.gov/reports/qrmc/11th_QRMC_Supporting_Research_Papers_(932pp)_Linked.pdf.
[171] Ibid.
[172] Ibid.
[173] Michelle Dolfini-Reed and Darlene E. Stafford, *Identifying Duty Status Reforms Needed to Support an Operational Reserve,* CRM D0021656.A2, (Alexandria, VA: CNA, 2010), 24-25.
[174] Department of Defense, Office of the Undersecretary of Defense for Personnel and Readiness, *The Report of the Eleventh Quadrennial Review of Military Compensation,* 134, accessed December 15, 2014, http://militarypay.defense.gov/reports/qrmc/11th_QRMC_Supporting_Research_Papers_(932pp)_Linked.pdf.

Findings:
The numerous criteria for determining RC statuses can make it difficult for operational commanders to call RC members to duty.[175] Indeed, the current RC status system "is complex, aligns poorly to current training and mission support requirements, fosters inconsistencies in compensation and complicates rather than supports effective budgeting."[176] Additionally, the RC status system causes members to experience disruptions in pay and benefits as they transition among different duty statuses.[177] For example, they may have gaps in health care coverage when there are gaps in orders. These disruptions discourage volunteerism and impede an ideal continuum of service.[178] Military Services sometimes use "the RC duty statuses in ways that are inconsistent with their intended purposes."[179]

The challenges of this complex RC status system have been exacerbated by how the RC has been employed during the past 13 years of war. The current duty status system was developed to support a "strategic Reserve," in which RC members mainly participated in inactive duty and annual training.[180] "Operational missions were limited."[181] Since 2001, however, RC members have served more frequently on active duty and have had to transition numerous times between active and inactive-duty statuses.[182] Duty statuses have not evolved to keep pace with how RC members are being employed. Instead, they have expanded in piecemeal fashion as the use of the RC has changed and grown.[183] As a result, both Service members and the Services are adversely affected by the complexity of the status system and the consequential issues that arise.

Simplifying RC statuses has broad support. In general, the Reserve Component is supportive of a more streamlined, consolidated RC duty status system.[184] The Commission on the National Guard and Reserves (2008),[185] the Eleventh Quadrennial Review of Military Compensation (2011),[186] the Reserve Forces Policy Board (2013),[187] the National Commission on the Structure of the Air Force (2014),[188] and the House

---

[175] Commission on the National Guard and Reserves, *Transforming the National Guard and Reserves into a 21st-Century Operational Force,* 2008, 160.
[176] Office of the Assistant Secretary of Defense for Reserve Affairs, *Review of Reserve Component Contributions to National Defense*, December 2002, 77.
[177] Michelle Dolfini-Reed and Darlene E. Stafford, *Identifying Duty Status Reforms Needed to Support an Operational Reserve*, CRM D0021656.A2, (Alexandria, VA: CNA, 2010), 15.
[178] Michelle Dolfini-Reed and Darlene E. Stafford, Identifying Duty Status Reforms Needed to Support an Operational Reserve, CRM D0021656.A2, (Alexandria, VA: CNA, 2010), 15, 25. Commission on the National Guard and Reserves, *Transforming the National Guard and Reserves into a 21st-Century Operational Force,* 2008, 160.
[179] Michelle Dolfini-Reed and Darlene E. Stafford, Identifying Duty Status Reforms Needed to Support an Operational Reserve, CRM D0021656.A2, (Alexandria, VA: CNA, 2010), 25.
[180] Ibid, 24-25.
[181] Ibid, 25.
[182] Ibid, 24-25.
[183] Department of Defense, Office of the Undersecretary of Defense for Personnel and Readiness, *The Report of the Eleventh Quadrennial Review of Military Compensation*, 133, accessed December 15, 2014, http://militarypay.defense.gov/reports/qrmc/11th_QRMC_Supporting_Research_Papers_(932pp)_Linked.pdf.
[184] MCRMC staff meetings with officials from the Navy Reserve (July 8, 2014), the Marine Corps Reserve (June 23, 2014), the Army Reserve (September 18, 2014) and Air Force Reserve (September 18, 2014).
[185] Commission on the National Guard and Reserves, *Transforming the National Guard and Reserves into a 21st-Century Operational Force,* 2008, 156.
[186] Department of Defense, Office of the Undersecretary of Defense for Personnel and Readiness, *The Report of the Eleventh Quadrennial Review of Military Compensation*, 146, accessed December 15, 2014, http://militarypay.defense.gov/reports/qrmc/11th_QRMC_Supporting_Research_Papers_(932pp)_Linked.pdf.
[187] Department of Defense, Office of the Secretary of Defense Reserve Forces Policy Board, *Report of the Reserve Forces Policy Board on Reserve Component Duty Status Reform: Info Memo*, 2013, 1.
[188] National Commission on the Structure of the Air Force, *Report to the President and Congress of the United States*, 2014, 50.

Report on the FY 2015 National Defense Authorization Bill (House Report 113-443)[189] all recommended the number of RC duty statuses be reduced.

Conclusions:
The Services and Service members would benefit from a streamlined, consolidated Reserve Component status system. Streamlining the RC statuses reduces challenges associated with the current system. Without such changes, RC members may be discouraged from volunteering for active duty and commanders would continue to have problems calling RC personnel to duty when they are needed to support operational missions, impeding the effectiveness of those missions. Simplifying RC statuses supports both operational and training missions, better enables the purpose of RC duties to be tracked to justify budget requests, and facilitates a seamless process for RC members.

Recommendations:

- The Congress should replace the 30 current Reserve Component duty statuses with six broader statuses (see Table 4). This new RC status structure should principally focus on Active Duty, Inactive Duty, and full-time National Guard Duty as the three primary statuses.

- The Congress should stipulate that, in this new system, orders should be issued only when an authority changes. When a duty status, purpose, or funding source changes, orders need only be amended, accordingly. This change would allow uninterrupted RC service.

Table 4. Streamlined Reserve Component Duty Statuses

Title 10, United States Code – Armed Forces		
New Status	**Current Statuses to be Consolidated into New Statues**	
Active Duty	Full mobilization Partial mobilization Presidential reserve call-up Major disaster/emergency response Preplanned combatant command mission call-up Captive status Unsatisfactory participation (45 days) Unsatisfactory participation (24 months)	Disciplinary action Annual active duty (up to 30 days) Additional training and operational support Duty at the National Guard Bureau Medical evaluation and treatment Medical care (duty < 30 days) Retiree recall
Inactive Reserve Service	Muster duty Additional training periods Additional flight training periods	Readiness management periods Funeral honors duty
Federal Service (Presidential call-up)	Aid for state governments Enforce federal authority	National Guard called to federal service
Title 32, United States Code – National Guard		
Full-Time National Guard	Required training and other duty Additional training and other duty	
Inactive National Guard	Additional training periods Additional flight training periods	Readiness management periods Funeral honors duty
Title 14, United States Code – Coast Guard		
Active Duty	Emergency augmentation	

[189] National Defense Authorization Act for Fiscal Year 2015 (House Report 113-446), Report of the Committee on Armed Services House of Representatives on H.R. 4435, 142-143, 2014.

Implementation:

- Chapter 1209, Title 10 of the United States Code should be amended by adding three new sections for the Reserve Component of the Armed Forces to consolidate current statuses into Active Duty, Inactive Reserve Service (i.e., Inactive Duty Training), or Federal Service (Presidential Call-Up).

- 32 U.S.C. § 502 should be amended to consolidate current statuses into either Full-Time National Guard Duty or Inactive National Guard Service.

- 14 U.S.C. § 712 should be amended to reflect the consolidation of statuses.

- The Active Duty authority statutes in Titles 10, 14, and 32 of the United States Code should be amended to contain language that stipulates changes to duty statuses, purpose, or funding require amendments to existing orders, rather than issuance of new orders. This revised language should also stipulate no break in service should be recorded if orders are changed and the break in service was 24 hours or fewer.

- The following statutes that currently authorize calling up Reserve Component members should be amended or repealed to reflect the duty status consolidation:[190]

Table 5. Current Reserve Component Duty Statuses to be Amended/Repealed

	Legal Authority	Purpose of Duty	Applies To	Type of Duty	
Training	10 U.S.C. 10147	Annual Training/Drill Requirement	Reserve Only	AD/IDT	Involuntary
	10 U.S.C. 12301(b)	Annual Training	Reserve & National Guard	AD	Involuntary
	10 U.S.C. 12301(d)	Additional/Other Training Duty	Reserve & National Guard	AD	Voluntary
	32 U.S.C. 502(a)	Annual Training/Drill Requirement	National Guard Only	FTNGD/ID	Involuntary
	32 U.S.C. 502(f)(1)(A)	Additional Training Duty Additional/Other	National Guard Only	T FTNGD	Involuntary
	32 U.S.C. 502(f)(1)(B)	Training Duty	National Guard Only	FTNGD	Voluntary
Support	10 U.S.C. 12301(d)	AGR Duty/Operational Support/Additional	Reserve & National Guard	AD	Voluntary
	10 U.S.C. 12304b	Duty	Reserve & National Guard	AD	Involuntary
	32 U.S.C. 502(f)(1)(B)	Preplanned/Preprogrammed CCDR Support	National Guard Only	FTNGD	Voluntary
	32 U.S.C. 502(f)(1)(A)	AGR Duty/Operational Support/Additional Duty Other Duty	National Guard Only	FTNGD	Involuntary
Mobilization	10 U.S.C. 12301(a)	Full Mobilization	Reserve & National Guard	AD	Involuntary
	10 U.S.C. 12302	Partial Mobilization	Reserve & National Guard	AD	Involuntary
	10 U.S.C. 12304	Presidential Reserve Call-up	Reserve & National Guard	AD	Involuntary
	10 U.S.C. 12304a	Emergencies and Natural Disasters	Reserve Only	AD	Involuntary
	14 U.S.C. 712	Emergencies and Natural Disasters	USCGR Only	AD	Involuntary

[190] Uniform Reserve training, and retirement categories for the Reserve Components, DoD Instruction 1215.06, Appendix to Enclosure 4, 22, 2014.

	Legal Authority	Purpose of Duty	Applies To	Type of Duty	
	10 U.S.C. 12503	Funeral Honors	Reserve & National Guard	ID	Voluntary
	32 U.S.C. 115	Funeral Honors	National Guard Only	ID	Voluntary
	10 U.S.C. 12319	Muster Duty	Reserve & National Guard	ID	Involuntary
	10 U.S.C. 12301(h)	Medical Care	Reserve & National Guard	AD	Voluntary
	10 U.S.C. 12322	Medical Evaluation and Treatment	Reserve & National Guard	AD	Voluntary
	10 U.S.C. 688	Retiree Recall	Reserve & National Guard	AD	Involuntary
	10 U.S.C. 802(d)	Disciplinary	Reserve & National Guard	AD	Involuntary
Other	10 U.S.C. 10148	Unsatisfactory Participation (up to 45 days)	Reserve & National Guard	AD	Involuntary
	10 U.S.C. 12301(g)	Captive Status	Reserve & National Guard	AD	Involuntary
	10 U.S.C. 12303	Unsatisfactory Participation (up to 24	Reserve & National Guard	AD	Involuntary
	10 U.S.C. 12402	months)	National Guard Only	AD	Voluntary
	10 U.S.C. 331	Duty at National Guard Bureau	National Guard Only	FS	Involuntary
	10 U.S.C. 332	Insurrection	National Guard Only	FS	Involuntary
	10 U.S.C. 12406	Insurrection	National Guard Only	FS	Involuntary
		Insurrection			

AD - Active Duty • CCDR - Combatant Command • ID - Inactive Duty • IDT - Inactive Duty Training
FTNGD - Full Time National Guard Duty • FS - Federal Service • PRC – Presidential Reserve Call-up

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

Health Benefits

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

Background:
Joint military readiness is a critical function of modern military warfare, and the failure to be ready is a threat to deployed forces and to our national security. As evidenced by the draw-down of military forces following Operation DESERT STORM, which includes the end of the Cold War, and leading into the period before September 11, 2001, military readiness suffers during peacetime. In the years since September 11, 2001, DoD has learned hard lessons in combat and in joint operations. Losing or forgetting these hard-won lessons, as the Nation contends with fiscal challenges and declining budgets, is a substantial and ill-afforded risk. With the drawdown of combat forces in Southwest Asia, and the deployment of smaller specialized forces to deal with terror threats, biological outbreaks, and humanitarian support missions, losing any joint capability will degrade the effectiveness of future military operations.

An essential component of joint military readiness is the capability of the force to provide health and combat-casualty care for Service members in operational environments. Joint capabilities include the evacuation of casualties, both ground and air, and the support logistics necessary to maintain a forward medical presence, as well as the clinical requirements of combat casualty care. The Military Health System (MHS) is responsible for maintaining a healthy military force that is ready for deployments, as well as a cadre of health care providers who are trained to provide quality medical care both during contingency operations and for returning wounded Service members.[191] The ability of the MHS to provide operational health care is measured by the readiness of its medical personnel and related capabilities.

To train medical personnel, the MHS relies heavily on Military Treatment Facilities (MTFs) located on or near major military installations as training platforms to maintain the clinical skills of military medical personnel. There are 56 military hospitals and medical centers and 360 outpatient facilities worldwide.[192] Medical personnel assigned to MTFs deliver health care to active-duty Service members, as well as to active-duty family members, retirees, and other eligible beneficiaries, on a

[191] *See generally* Armed Forces, 10 U.S.C. ch. 55. *See also* Assistant Secretary of Defense for Health Affairs, DoDD 5136.01, 9-10 (2013). "Defense Health Agency," Military Health System and Defense Health Agency, accessed November 29, 2014, http://health.mil/About-MHS/Organizational-Overview/Defense-Health-Agency. "Global Preparedness and Response," Military Health System and Defense Health Agency, accessed November 29, 2014, http://health.mil/Military-Health-Topics/Health-Readiness/Global-and-Domestic-Health-Preparedness-and-Response.
[192] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, accessed December 15, 2014, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf.

space-available basis.[193] In locations where local agreements exist, MTFs also provide care to patients of the Department of Veterans Affairs (VA) or civilians. For example, the San Antonio Military Medical Center is a regional Level-I[194] trauma center that provides medical care to "military members and other statutorily defined beneficiaries,"[195] as well as "non-DoD eligible Life and Limb Threatening emergencies under [certain] criteria."[196]

Military medical personnel may also receive proficiency training in certain civilian institutions. For example, the Army Trauma Training Center partners with Jackson Memorial Hospital Ryder Trauma Center in Miami, Florida, to "ensure clinical readiness for lifesaving Army and Army Reserve forward surgical teams"[197] through a 17-day training rotation.[198] The Navy Trauma Training Center partners with Los Angeles County, California, and University of Southern California to provide didactic and clinical trauma exposure.[199] Air Force Centers for Sustainment of Trauma and Readiness Skills (C-STARS) provide advanced sustainment training at specific civilian Level-I trauma centers[200] currently located in Baltimore, Maryland;[201] Cincinnati, Ohio;[202] and St. Louis, Missouri.[203] The Air Force also maintains the Sustainment of Trauma and Resuscitation Skills Program, in which Air Force medical personnel assigned to certain MTFs are regularly immersed in on-going clinical rotations at local civilian Level-I trauma centers.[204] Military medical personnel also work to maintain

---

[193] *See, e.g.,* Armed Forces, 10 U.S.C. §§ 1074, 1074h, 1077. *See generally* Armed Forces, 10 U.S.C. ch. 55. Additional information and discussion on beneficiary eligibility requirements can be found at http://www.tricare.mil (https://www.tricare.mil/Plans/Eligibility.aspx), the official website of the Defense Health Agency (DHA) a component of the Military Health System.

[194] Trauma centers receive a designation from state and local authorities, between 1 and 5, based on their capabilities Ratings may be verified by the American College of Surgeons. Level-1 trauma centers are those with the most capabilities. *See* "Trauma Center Levels Explained," American Trauma Society, accessed January 10, 2015, http://www.amtrauma.org/?page=TraumaLevels.

[195] Memorandum of Understanding Between Bexar County Hospital District, San Antonio Military Medical Center, Trauma Services Cooperative Agreement, signed 2014.

[196] Memorandum of Understanding Between Bexar County Hospital District, San Antonio Military Medical Center, Trauma Services Cooperative Agreement, signed 2014. *See also* Secretary of the Army Memo to Assistant Secretary of the Army (Manpower and Reserve Affairs), *Delegation of Authority - Secretarial Designee Program*, paragraph 6.c. and sub paragraphs, April 18, 2013. Memorandum of Understanding Between Bexar County Hospital District, San Antonio Military Medical Center, Trauma Services Cooperative Agreement, signed 2014, para 3.01 (c). *See generally* Health Care Eligibility Under the Secretarial Designee Program and Related Special Authorities, DoDI 6025.23 (2011).

[197] "The U.S. Army Trauma Training Center – Training Soldiers to Heal Troops and Save Lives in Battle," PR Newswire, accessed November 29, 2014, http://www.prnewswire.com/news-releases/the-us-army-trauma-training-center---training-soldiers-to-heal-troops-and-save-lives-in-battle-74798712.html. Army doctrine defines a forward surgical team as "a 20-Soldier team which provides far forward surgical intervention to render nontransportable patients sufficiently stable to allow for medical evacuation to a Role 3 combat support hospital." *See* Casualty Care, Army Training Publication 4-02.5, 3-23 (2013).

[198] The Academy of Health Sciences, *U.S. Army Medical Department Center and School Course Catalog 2014*, 49, accessed December 15, 2014, http://www.cs.amedd.army.mil/filedownload.aspx?docid=940c7c87-febd-43fd-981e-77a3115f8202.

[199] "Navy Trauma Training Center (NTTC)," Navy Medicine Operational Training Center – Pensacola, accessed November 29, 2014, http://www.med.navy.mil/sites/nmotc/nemti/nttc/Pages/default.aspx.

[200] Medical Readiness Program Management, AFI 41-106 (22 April 2014), para 5.4.8.

[201] "C-STARS (Center for the Sustainment of Trauma and Readiness Skills)," University of Maryland School of Medicine, Program in Trauma, accessed November 29, 2014, http://medschool.umaryland.edu/trauma/CSTARS.asp.

[202] "C-STARS," University of Cincinnati Health, accessed November 29, 2014, http://uchealth.com/education/c-stars/.

[203] "USAF Trauma Training Programs at SLU Hospital," Saint Louis University Hospital, accessed on November 29, 2014, http://www.sluhospital.com/en-US/ourServices/medicalServices/Pages/USAFTraumaTrainingPrograms.aspx.

[204] Medical Readiness Program Management, AFI 41-106, para 5.3.2. (2014). *For example*, partnership between Nellis AFB and University Medical Center, Nevada (MCRMC site visit, 3 Oct 2014); more information, see Lt. Gen. (Dr.) Charles B. Green, *"The Air Force Medical Service: What is Next?" U.S. Medicine, This Year in Federal Medicine – Outlook 2011*, accessed November 29, 2014, http://www.usmedicine.com/this-year-in-federal-medicine---outlook-2011/the-air-force-medical-service-what-is-next/.

critical skills through DoD and VA joint ventures and other resource-sharing agreements.[205]

Findings:

Joint Medical Operations and Oversight

Service members have benefitted substantially from the joint nature of operations and the improvements from the rapid institutionalization of lessons learned during the recent wars. For example, the military medical force was highly successful at treating combat casualties during the recent wars. Case fatality rates in theater hospitals were approximately 10 percent in Operation ENDURING FREEDOM (OEF) and Operation IRAQI FREEDOM (OIF), down from 30 percent during WWII and 24 percent during the Vietnam and the 1991 Persian Gulf conflicts.[206] It is critical to sustain, and whenever possible, improve upon, these joint capabilities. Each Military Service, however, develops its medical resources to support its own Service-specific mission.[207] Although the MHS is an interrelated system that coordinates medical services, capabilities, and specialties among the Service components, it is not a joint command charged with integrating these capabilities and maintaining proficiency.

For example, several changes in medical logistics saved lives during OEF and OIF. Approximately 10,000 Service members wounded in action were medically evacuated out of theater.[208] En route care and Air Force Critical Care Air Transport Teams revolutionized combat care for critically ill Service members.[209] This global medical capability is considered one of the most important contributions to survival in OEF and OIF.[210] Forward deployment of blood products to mitigate hemorrhage in the prehospital environment, deployment of forward resuscitative surgical-system teams in close proximity to the point of engagement, and split-based operations of forward surgical teams also contributed to survival.[211] Although there has been substantial advances in combat medical care, there remains no central oversight of the medical evacuation mission, the training requirements necessary to maintain the newly developed capabilities during peacetime, or the research and development necessary to expand forward surgical capabilities.

---

[205] *See generally*: Veterans Benefits, 38 U.S.C. § 8111. DoD and Department of Veterans Affairs Health Care Resource Sharing Program, DoDI 6010.23 (2013). VA-DOD Direct Sharing Agreements, VHA Handbook 1660.04.Memorandum of Understanding Between the Department of Veterans Affairs and the Department of Defense – Health Care Resources Sharing Guidelines, accessed January 10, 2015, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1776. For further discussion of DoD and VA resource sharing, see Recommendation 8 in this report.

[206] Nicholas R. Langan, Matthew Eckerts, and Matthew J. Martin, "Changes in Patterns of In-Hospital Deaths Following Implementation of Damage Control Resuscitation Practices in US Forward Military Treatment Facilities," *JAMA Surgery,* 149, no. 9 (September 2014): E5, http://archsurg.jamanetwork.com/article.aspx?articleid=1888411.

[207] *See, e.g.,* Army Health System, FM-4-02 (August 2013), ch. 1, Army Health System Overview.

[208] Congressional Research Service, American War and Military Operations Casualties: Lists and Statistics, February 26, 2010, 13 &16, accessed December 23, 2014, https://www.fas.org/sgp/crs/natsec/RL32492.pdf.

[209] U.S. Air Force, Wilford Hall Ambulatory Surgical Center, Lackland AFB, Texas, *Critical Care Air Transport Team Fact Sheet,* accessed December 15, 2014, http://www.whasc.af.mil/shared/media/document/AFD-120810-038.pdf.

[210] Jay A. Johannigman, "Maintaining the Continuum of En Route Care," *Critical Care Medicine*, 2008, 36 (Suppl. 7):S377-S382.

[211] *See, e.g.,* John B. Holcomb et al., "U.S. Army Two-Surgeon Teams Operating in Remote Afghanistan—An Evaluation of Split-Based Forward Surgical Team Operations," *The Journal of Trauma,* 66, 5 Suppl, (2008): S37-47. Lorne H. Blackbourne et al., "U.S. Army Split Forward Surgical Team Management of Mass Casualty Events in Afghanistan: Surgeon Performed Triage Results in Excellent Outcomes," *American Journal of Disaster Medicine,* 4, no. 6, (2009): 321-329.

The military also adopted several improvements in joint medical training that improved battlefield survivability during OEF and OIF. The Combat Life Saver (CLS) program, which extended medical training to all Service members, including members of the Reserve Component, was instrumental in providing immediate medical care to wounded Service members.[212] CLS was developed as part of the Tactical Combat Casualty Care (TCCC) course,[213] which was funded by the U.S. Special Operations Command.[214] CLS and TCCC provide a comprehensive set of battlefield trauma care strategies customized for use in combat.[215]

CLS and TCCC have been noted in multiple published reports for successfully saving lives on the battlefield during the last decade of war.[216] Availability of TCCC skills is considered a dominant factor in reducing preventable deaths and in achieving a casualty case fatality rate of 10 percent.[217] Similarly, tourniquet use on the battlefield has become widespread,[218] saving an estimated 1,000–2,000 lives because they were used rapidly and effectively for life threatening extremity hemorrhage.[219] Yet, none of the military Services had tourniquet policies or programs in place before the beginning of hostilities in Afghanistan in 2001.[220] Without continuous and focused joint integration, the medical capabilities now resident with the total force may degrade or atrophy and ongoing improvements in joint capabilities may be limited.

Joint battlefield data management provides another example of a capability developed during the wars that may atrophy during peacetime. Based on a casualty card collection program developed by the 75th Ranger Regiment,[221] a prehospital Joint Theater Trauma Registry also reduced mortality rates. The registry, now known as Department of Defense Trauma Registry (DoDTR), was implemented in 2005 to evaluate tactical combat casualty care treatment strategies, as well as modifications to

---

[212] Defense Health Board, *Tactical Combat Casualty Course and minimizing Preventable fatalities in Combat Memorandum, August 6, 2009*, accessed January 10, 2015, http://www.health.mil/~/media/MHS/Report%20Files/200905.ashx. Defense Medical Readiness Training Institute, *TCCC Skills Sets by Provider Level,* http://www.dmrti.army.mil/TCCC%20Skill%20Sets%20by%20Provider%20Level%20120917.pdf.

[213] Defense Medical Readiness Training Institute, *TCCC Skills Sets by Provider Level*, http://www.dmrti.army.mil/TCCC%20Skill%20Sets%20by%20Provider%20Level%20120917.pdf.

[214] Frank K. Butler, John Hagmann, and George Butler, "Tactical Combat Casualty Care in Special Operations," *Military Medicine,* 161, suppl. 3 (1996), 1-15, http://www.dmrti.army.mil/TCCC%20Skill%20Sets%20by%20Provider%20Level%20120917.pdf.

[215] Frank K. Butler, John Hagmann, and George Butler, "Tactical Combat Casualty Care in Special Operations," *Military Medicine*, 161, suppl. 3 (1996), 1-15, http://www.dmrti.army.mil/TCCC%20Skill%20Sets%20by%20Provider%20Level%20120917.pdf. Defense Medical Readiness Training Institute, TCCC Skills Sets by Provider Level, http://www.dmrti.army.mil/TCCC%20Skill%20Sets%20by%20Provider%20Level%20120917.pdf.

[216] *See* Lorne H. Blackbourne et al., "Military Medical Revolution: Prehospital Combat Casualty Care," *Journal of Trauma Acute Care Surgery,* 73, no. 6, suppl. 5 (2012), (discussing multiple sources that address battlefield casualties during OEF and OIF), http://journals.lww.com/jtrauma/Fulltext/2012/12005/Military_medical_revolution___Prehospital_combat.2.aspx#.

[217] "Tactical Combat Casualty Course and Minimizing Preventable Fatalities in Combat," Defense Health Board Memorandum, August 6, 2009, accessed November 29, 2014, http://www.health.mil/~/media/MHS/Report%20Files/200905.ashx.

[218] Lorne H. Blackbourne et al., "Military Medical Revolution: Prehospital Combat Casualty Care," *Journal of Trauma Acute Care Surgery,* 73, no. 6, suppl. 5 (2012), S373, http://journals.lww.com/jtrauma/Fulltext/2012/12005/Military_medical_revolution___Prehospital_combat.2.aspx#.

[219] Lorne H. Blackbourne et al., "Military Medical Revolution: Prehospital Combat Casualty Care," *Journal of Trauma Acute Care Surgery,* 73, no. 6, suppl. 5 (2012), http://journals.lww.com/jtrauma/Fulltext/2012/12005/Military_medical_revolution___Prehospital_combat.2.aspx#.

[220] Ibid, S372.

[221] Russ S. Kotwal, Harold R. Montgomery, and Kathy K. Mechler, "A Prehospital Trauma Registry for Tactical Combat Casualty Care," *U.S. Army Medical Department Journal,* 2011.

unit medical and nonmedical personnel, training, and equipment requirements.[222] The joint DoDTR captures injury demographics, anatomic and physiologic parameters, and trauma care and outcomes across the continuum of combat casualty care,[223] providing critical information used to affect improvements in clinical care, drive medically related doctrine and policy, and support the creation of new knowledge through research.[224] Though these advances in data collection have made it possible to significantly increase necessary medical training to the entire force and save lives, such levels of integration and research are difficult to maintain during peacetime.

Great advances have also been made in the care of returning wounded warriors, such as prostheses research, development, and fielding. These improvements include silicone liners that allow better fitting, energy-storing prostheses that allow for higher-intensity activity, and motorized prostheses that allow for more normal walking gaits.[225] The Center for the Intrepid at Fort Sam Houston, Texas, developed custom-fit, energy-storing orthotics that offload weight to the leg and relieve pain, improving functional performance.[226] The advances in prosthetics and orthotics, improved pain control, and aggressive rehabilitation have allowed a return-to-duty rate of approximately 20 percent for soldiers who have had a lower limb amputation[227] and limb salvage.[228] During long periods of peacetime, advances in wounded warrior care are no longer the focus. National treasures such as the Center for the Intrepid will require continued joint coordination within the military and a strong relationship with military allies and civilian institutions to continue the progress made during the last decade.

Despite these critical examples of wartime medical capabilities, military medical requirements neither have a high level joint focus nor are they jointly developed. The requirement for military medical personnel and capabilities is determined by each Service in response to DoD planning scenarios.[229] Each Military Service independently completes this process annually. This process then produces requirements estimates using separate models and planning assumptions for the provided defense scenarios.[230] Consequently, the Services take different approaches to equipping and

---

[222] *See* United States Army, Institute of Surgical Research, *Department of Defense Joint Trauma Registry (DODTR) Mission*, accessed December 23, 2014, http://www.usaisr.amedd.army.mil/joint_trauma_system.html.
[223] "Joint Trauma System," U.S. Army Institute of Surgical Research, accessed November 29, 2014, http://www.usaisr.amedd.army.mil/joint_trauma_system.html.
[224] United States Central Command, *CENTCOM Joint Theater Trauma System (JTTS) Clinical Practice Guidelines (CPGs) Development, Approval, Implementation and Monitoring Process,* accessed December 15, 2014, http://www.usaisr.amedd.army.mil/assets/cpgs/02_centcom_jtts_cpg_process_2_apr_12.pdf .
[225] Lorne H. Blackbourne et al., "Military Medical Revolution: Military Trauma System," *Journal of Trauma Acute Care Surgery,* 73, no. 6, suppl. 5 (2012): S392, accessed January 10, 2015, http://journals.lww.com/jtrauma/Fulltext/2012/12005/Military_medical_revolution___Military_trauma.4.aspx.
[226] Commission's visit to the Center for the Intrepid, January 6, 2014. Joseph R. Hsu et al., "Return To Duty After Integrated Orthotic And Rehabilitation Initiative," Skeletal Trauma Research Consortium (STReC).
[227] Daniel J. Stinner et al., "Return to Duty Rate of Amputee Soldiers in the Current Conflicts in Afghanistan and Iraq," *Journal of Trauma,* 68, No. 6, (2010), http://opmarketing.com/storage/Research%20EncyclOPedia/Military/OEF%20OIF%20return%20to%20duty%20rates_J%20Trauma.pdf.
[228] Jessica D. Cross et al., "Return to Duty Following Type III Open Tibia Fracture," *Journal of Orthopaedic Trauma,* 2012, 26:43Y47, abstract accessed December 14, 2014, http://www.ncbi.nlm.nih.gov/pubmed/21885998.
[229] John E. Whitley, Brandon Gould, Nancy Huff, and Linda Wu, Institute for Defense Anlayses, *Medical Total Force Management*, accessed December 19, 2014, https://www.ida.org/~/media/Corporate/Files/Publications/IDA_Documents/CARD/P-5047.ashx.
[230] Department of Defense, *Military Health System Modernization Study, v.28*, October 2014. John E. Whitley, Brandon Gould, Nancy Huff, and Linda Wu, Institute for Defense Anlayses, *Medical Total Force Management*, accessed December 19, 2014, https://www.ida.org/~/media/Corporate/Files/Publications/IDA_Documents/CARD/P-5047.ashx.

training personnel to meet medical readiness missions.[231] Independent of the Services, the Joint Force Surgeon works with combatant command surgeons to assess health care needs for contingency operations.[232] Together they make recommendations to the joint force commander regarding health service support and force health protection requirements for contingency operations.[233] There is no joint doctrine among the Services regarding definitional aspects of medical readiness manpower requirements, even though independently developing medical requirements are unlikely to result in medical capabilities that are fully integrated. Conversely, jointly developing requirements from the beginning would be more efficient and provide an integrated medical force that is better prepared for joint operations at the beginning of the next conflict.

The Service Surgeons General stated they neither had a common definition of clinical medical readiness, nor associated skills maintenance standards.[234] For example, DoD recently completed the first phase of a *MHS Modernization Study*, which analyzed skill maintenance by measuring workload volume using the physician work Relative Value Unit (RVUs).[235] RVUs provide a measurement that accounts for the time, technical skill and effort, mental effort and judgment, and stress to provide a service, resulting in a measure of workload weighted by the intensity of the procedure.[236] RVUs do not directly measure the suitability of medical cases for maintaining the military readiness of the medical force. Similarly, the MHS monitors 18 Healthcare Effectiveness Data and Information Set (HEDIS) measures in MTFs related to health and safety issues.[237] HEDIS, used by more than 90 percent of health plans in the country to measure quality, consists of 81 measures across five domains.[238] While HEDIS measures allow for accreditations and comparisons across health plans and facilities, they do not measure clinical proficiency or military medical readiness. The Surgeons General of the Services stated that DoD had not agreed upon better measurements than RVUs and HEDIS to measure skill maintenance.[239] Yet there is a clear need for better skills measurement.

The MHS could also benefit from more consistent coordination with the civilian medical sector. The Services each have training programs with civilian trauma facilities; however, these programs differ substantially in scope and duration. For example, there are only isolated instances in which enlisted medics receive skill maintenance training in civilian facilities. The Captain James A. Lovell Federal Health Care Center has an agreement with Cook County Health and Hospital System (CCHHS), Chicago, Illinois, to allow for 2-month training rotations of Navy hospital

---

[231] Department of Defense, *Military Health System Modernization Study, v.28*, October 2014.
[232] Department of Defense, *Health Service Support*, Joint Publication 4-02, accessed January 10, 2015, http://www.dtic.mil/doctrine/new_pubs/jp4_02.pdf
[233] Ibid.
[234] Service Surgeons General, meeting with MCRMC Commissioners, June 12, 2014.
[235] Department of Defense, *Military Health System Modernization Study, v.28*, October 2014.
[236] National Health Policy Forum, The George Washington University, *The Basics – Relative Value Units (RVUs)*, accessed December 15, 2014, http://www.nhpf.org/library/the-basics/Basics_RVUs_02-12-09.pdf.
[237] Department of Defense, *Military Health System Review-Final Report, Appendix 4. Quality of Care, Table 4.4-3 percent of Eligible Patients Receiving Select Care Measures, External Comparison: MHS vs. HEDIS (2010-2013),* accessed December 15, 2014, http://www.defense.gov/pubs/140930_MHS_Review_Final_Report_Appendices.pdf.
[238] *See* "Measuring Performance," NCQA, accessed December, 16, 2014, http://www.ncqa.org/HEDISQualityMeasurement.aspx.
[239] The Navy Surgeon General also commented that the RVU does not account for the fact that the military medical force must be ready to deploy for contingency operations and provide medical services necessary to maintain the medical readiness of the force, which takes away from beneficiary care. Navy Surgeon General, briefing with MCRMC Commissioners, June 12, 2014.

corpsmen, as well as nurses and surgeons, through the CCHHS Trauma Department.[240] Similarly, the Sacred Heart Health System in Pensacola, Florida expressed a desire to expand military training opportunities, including developing a completely new career track for a medical assistant that is geared toward the medical skill necessary to support the basic Navy hospital corpsman.[241] Central joint oversight and standardization of agreements between civilian institutions and the military could help expand civilian training opportunities for military medical staff, which in turn would assist in sustaining medical readiness.

Training During Peacetime

Attracting a different mix of medical cases into MTFs could better support combat-care training and medical readiness. Research reveals a long history of the military medical community needing to refocus its capabilities at the start of wars, after concentrating during peacetime on beneficiary health care.[242] A recent DoD study stated, "In order to meet its deployment mission, our uniformed medical personnel must practice and hone their skills in garrison. Therefore, our study assessed the ability of the MHS to sustain the medical readiness skills of the uniformed medical force."[243] The study further stated, "Our fundamental approach was to focus on medical readiness as the principle mission of our treatment facilities."[244]

Beneficiary care may not sufficiently provide ideal training opportunities to maintain and sustain the military medical capabilities developed during the last 13 years of war. For example, prevalent injuries and wounds during operations in Afghanistan and Iraq were a result of penetrating or blast trauma.[245] As a result, there has been a preponderance of extremity, vascular, genital, visual, skeletal, and traumatic brain injuries. Yet surgeons were not adequately prepared to treat these injuries. A survey of general surgeons from all military Services who deployed between 2002 and 2012 found that 80 percent of respondents desired additional training on particular surgical disciplines or injury types prior to deployment. The most commonly requested types of training were extremity vascular repairs, neurosurgery, orthopedics, and abdominal vascular repairs.[246] Surgeons overwhelmingly cited vascular surgeries as the most difficult cases, followed by neurosurgical procedures, burns, and thoracic cases.[247] Surgeons reported they had difficulty with these procedures because they had not

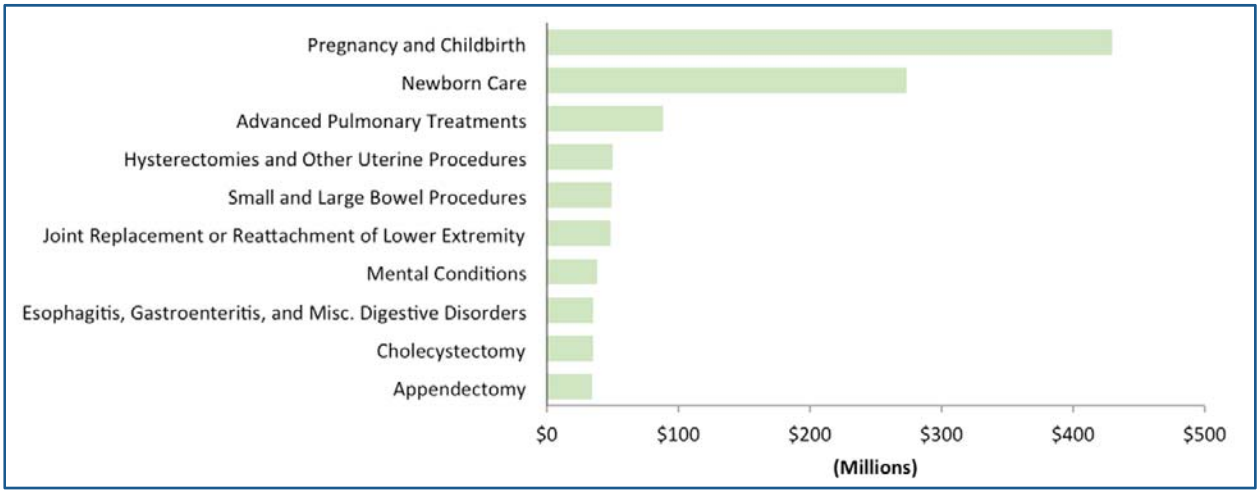
---

[240] Memorandum of Understanding For Navy Active Duty Staff between The Captain James A Lovell Federal Health Care Center and The Cook County Health and Hospital System.
[241] Susan Davis, CEO Sacred Heart Health System, and Henry Stovall, President, Sacred Heart Hospital Pensacola, meeting with MCRMC Commissioners, May 21, 2014.
[242] Bernard Rostker details this historic pattern in early U.S. wars in Bernard Rostker, *Providing for the Casualties of War: The American Experience Through World War II*, (Washington, DC: RAND, 2013). National Defense Research Institute, Government Accountability Office, *Medical Readiness: Efforts Are Underway for DOD Training in Civilian Trauma Centers,* (GAO/NSIAD-98-75) April 1998, accessed December 16, 2014, http://www.gao.gov/assets/160/156122.pdf.
[243] Department of Defense, *Military Health System Modernization Study,* v. 28, October 2014.
[244] Ibid.
[245] CNA Analysis Solutions, *The Quality-Volume Relationship: Comparing Civilian and MHS Practice,* November 2014, DIM-2014-009221-Final.
[246] Note that respondents included general surgeons and associated surgical subspecialties who deployed in general surgery billets. Joshua A. Tyler et al., "Combat Readiness for the Modern Military Surgeon: Data from a Decade of Combat Operations," *Journal of Trauma and Acute Care Surgery*, 73, no. 2 (2012): S64-S70, http://www.ncbi.nlm.nih.gov/pubmed/22847097. CNA Analysis Solutions, *The Quality-Volume Relationship: Comparing Civilian and MHS Practice,* November 2014, DIM-2014-009221-Final.
[247] Ibid.

performed them in nondeployed clinical settings, and because there had been a substantial time lapse since they had last treated these types of injuries.[248]

The increased cohesion of medical teams in military hospitals and clinics is an important requirement for battlefield medical readiness; nevertheless, the medical care provided in typical military hospital and clinic settings is seldom directly applicable to combat-care injuries. Figure 11 provides a breakdown of prevalent inpatient procedures in military hospitals, the most predominant of which relate to pregnancy, childbirth, and newborn care. Although these procedures can provide valuable workload to support the general skill of providers and health care teams, they do not represent the ideal case load required to maintain the clinical skills directly related to medical readiness.

Figure 11. Top 10 Inpatient Procedures in Military Treatment Facilities, FY 2013[249]



Relying on existing MTF medical cases as a training platform for combat care can result in a misalignment of military medical personnel compared to the medical requirements necessary to support the operational missions.[250] At the start of the wars in Afghanistan and Iraq, the military medical force was understaffed for surgeons, anesthesiologists, and other specialties critical to combat casualty care,[251] and overstaffed in specialties that generally provide peacetime health care.[252] Some military medical professionals have concluded that the expectation to deliver ongoing, high quality, beneficiary health care, while preparing for the possibility of war, creates

[248] Ibid.
[249] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress, February 21, 2014*, 78, accessed December 15, 2014, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf. Note: The DoD has deliberately decreased inpatient mental health beds.
[250] John E. Whitley, Brandon Gould, Nancy Huff, and Linda Wu, Institute for Defense Anlayses, *Medical Total Force Management*, accessed December 18, 2014, https://www.ida.org/~/media/Corporate/Files/Publications/IDA_Documents/CARD/P-5047.ashx.
[251] Department of Defense, *DoD Force Health Protection and Readiness—A Summary of the Medical Readiness Review, 2004-2007*, June 2008. The report identified that in 2004, the military medical force contained 359 more pediatricians and 179 more obstetricians than was required for military missions and was understaffed for its military mission by 59 anesthesiologists and 242 general surgeons.
[252] Ibid.

competing interests and directs resources and training away from maintaining battlefield skills.[253]

This misalignment of military medical staffing has led the Services to develop a medical personnel substitution policy.[254] This policy was first established for the Army in 1980 to simultaneously support military operations and manage the demands for all military health system beneficiaries.[255] Under this policy, for example, a requirement for general surgeons to staff a combat casualty care hospital might be filled, in part, by obstetricians (up to a 35 percent level of replacement).[256] In practice, not all substituted medical personnel are deployed to support combat operations, resulting in a wide range of deployment rates between medical specialties.[257] This situation caused many physicians with high-demand specialties for combat-casualty care to have deployment rates near the levels of the highest deploying combat forces.[258] High deployment rates among medical personnel are particularly burdensome because deployed doctors may not have access to the number and range of cases necessary to maintain their certifications. A RAND analysis found that shifting manpower requirements to match those specialties that are demanded in deployed settings "could improve situations at MTFs, since there would be more health care professionals available for deployment in high demand positions."[259] RAND also noted, "it could create challenges if there is not enough volume at the MTFs for the extra health care professionals to be productive and maintain their skills."[260] Creating mechanisms to change the case mix in MTFs could afford military medical personnel training opportunities that are more closely aligned to the combat care mission, improving medical readiness.

MHS Workload

MTFs would benefit from additional workload. As mentioned above, DoD recently completed the first phase of its *MHS Modernization Study*, which compared the volume of health care performed by physicians in military hospitals and clinics to that of civilian physicians.[261] The study presented data on military physician work RVU volume compared to civilian physician work RVU volume. For example, the study shows that military medical personnel in San Diego, California perform as many general surgery procedures as 5 percent of civilian surgeons; the other 95 percent of

---

[253] Robert L Mabry, LTC MC USA, and Robert DeLorenzo, COL MC USA, "Challenges to Improving Combat Casualty Survival on the Battlefield," *Military Medicine*, 179.5 (May 2014): 480.
[254] *See, e.g.,* Personnel Procurement: Army Medical Department Professional Filler System, Army Regulation 601-142, April 9, 2007.
[255] *See* RAND, Arroyo Center and RAND Health, *Improving the Deployment of Army Health Care Professionals – An Evaluation of PROFIS*, accessed December 19, 2014, http://www.rand.org/content/dam/rand/pubs/technical_reports/TR1200/TR1227/RAND_TR1227.pdf.
[256] *See, e.g.,* Personnel Procurement: Army Medical Department Professional Filler System, Army Regulation 601-142, April 9, 2007.
[257] RAND, Arroyo Center and RAND Health, *Improving the Deployment of Army Health Care Professionals – An Evaluation of PROFIS*, accessed December 19, 2014, http://www.rand.org/content/dam/rand/pubs/technical_reports/TR1200/TR1227/RAND_TR1227.pdf.
[258] John E. Whitley, Brandon Gould, Nancy Huff, and Linda Wu, Institute for Defense Anlayses, *Medical Total Force Management,* accessed December 19, 2014, https://www.ida.org/~/media/Corporate/Files/Publications/IDA_Documents/CARD/P-5047.ashx.
[259] RAND, Arroyo Center and RAND Health, *Improving the Deployment of Army Health Care Professionals – An Evaluation of PROFIS*, accessed December 19, 2014, http://www.rand.org/content/dam/rand/pubs/technical_reports/TR1200/TR1227/RAND_TR1227.pdf.
[260] Ibid.
[261] Department of Defense, *Military Health System Modernization Study, v. 28*, October 2014. Note: The RVU measure does not account for training a physician may have received while deployed or while providing health care at a civilian medical facility.

civilian surgeons do more procedures each year and in San Antonio military orthopedic surgeons perform as many procedures as 7 percent of civilian orthopedic surgeons.[262] The study used this RVU data as a proxy for clinical currency or proficiency and, as such, presented the data as a tool to advocate for the repurposing of MTFs and the reallocation of the medical force to MTFs with access to a greater volume of patients.

Because RVUs, as mentioned above, are not an ideal metric to measure clinical proficiency or the readiness of the medical force, the Commission tested the *MHS Modernization Study* findings by examining military hospital workload across a range of alternative health care measures.[263] The research relied upon academic literature that suggests the volume of complex surgical cases performed should be measured for individual providers (to measure individual proficiency) and for the hospital as a whole (to measure the proficiency of the entire hospital team supporting the individual surgeon).[264] For example, evidence-based standards for coronary artery bypass grafting (CABG) suggest a hospital should do at least 250 CABGs per year to get the best outcomes.[265] In FY 2013 only 338 CABGs were performed within the direct care system of military hospitals. The Eisenhower Army Medical Center performed 64 procedures, the most for any single facility.[266] The Commission found similar results in other orthopedic procedures and cardiothoracic surgical procedures.[267] The Commission also found that 82 percent of intensive care unit admissions occurred in MTFs with total admissions below the level at which academic literature suggests the best outcomes can be expected.[268]

This analysis supports those of the *MHS Modernization Study* related to low workload in military hospitals. These workload issues could be addressed by attracting additional cases into MTFs, especially those cases that provide good training opportunities for the combat care mission. The *MHS Modernization Study* concluded that 16 of the 41 military inpatient hospitals in the United States required changes to their capability.[269] DoD determined eight of these military hospitals should transition out of inpatient care delivery and be repurposed as outpatient facilities or birthing centers.[270] Final determination on the other eight facilities was delayed for a year.[271] Closing underutilized facilities does not address the necessary mix of complex cases required to maintain the readiness of the medical force.

---

[262] Department of Defense, *Military Health System Modernization Study, v.28*, 35, October 2014. The Commission calculated the percentages from the MHS Modernization Study's chart illustrating median percentages for given procedures in selected MTFs.
[263] CNA Analysis Solutions, The Quality-Volume Relationship: Comparing Civilian and MHS Practice, November 2014, DIM-2014-009221-Final. (Research and analysis performed for MCRMC.)
[264] Ibid, iii.
[265] Ibid, 20.
[266] Ibid, 21.
[267] Ibid, 23-24, 27.
[268] Ibid, 26.
[269] Under Secretary of Defense (Personnel and Readiness), *Enhancing Military Health System Performance*, memorandum for members of the Military Health System Executive Review, March 6, 2014. Facilities that required changes to their capability were identified based on multiple criteria, including the ability to recapture health care from the private network, the availability of local civilian health care providers, and cost-effectiveness to maintain services at the military facility.
[270] Under Secretary of Defense (Personnel and Readiness), Enhancing Military Health System Performance, memorandum for members of the Military Health System Executive Review, March 6, 2014.
[271] Department of Defense, *Military Health System Modernization Study, v.28*, October 2014.

New Tools To Maintain Medical Readiness

The issues related to workload levels and the mix of medical cases represent challenges to maintaining the readiness of the medical force, yet DoD has limited means of effecting meaningful change in the amount of medical workload, the mix of complex medical cases, or the access to trauma-care cases. An assumption used by the *MHS Modernization Study* was that the MHS can recapture health care currently being provided to eligible beneficiaries in local civilian hospitals or clinics.[272] Both the Army and Navy Surgeons General told the Commission current catchment areas around MTFs limit their ability to attract eligible beneficiaries who would like to receive care in MTFs.[273] Figure 11 indicates that the current beneficiary workload may not generate the case mix needed to ideally support training for combat care. In some locations the eligible beneficiary population does not require the right type of or complexity of surgical or trauma care for maintaining the readiness of the military medical force.[274] Recapturing beneficiary workload has resulted in reassignment of some beneficiaries from civilian to military primary care managers, limiting their choice of health care providers and disrupting their current health care delivery.[275]

There are several new tools that could attract more complex medical cases into the MHS to aid in the management of MTF workload and case mix, which in turn would contribute to the readiness of the medical force. For example, alternative prices could be established for certain procedures that would provide the necessary access to complex medical cases and contribute directly to maintaining the readiness of the medical force.[276] Establishing commercial reimbursement rates and associated billing systems,[277] improving authorities, and allowing greater access to veterans and civilians with relevant complex medical cases and trauma that contribute to essential medical capabilities all would provide military hospitals and clinics more opportunities for training the military medical force.[278] Also, providing additional incentives for eligible MHS beneficiaries to use military hospitals and clinics would increase utilization of these facilities and provide additional opportunities to maintain clinical proficiency. Recommendation 6 details means of accomplishing these goals.

The military has opportunities to sustain or improve the readiness of the medical force through partnerships with civilian trauma care facilities. These partnerships were originally developed in response to the lack of trauma training available to the medical force within the MTFs. The Government Accountability Office (GAO) found that the military Services were unprepared for trauma care during the Gulf War.[279] According

---

[272] Ibid.
[273] Navy and Army Surgeon General, meeting with MCRMC Commissioners, June 12, 2014.
[274] Ibid.
[275] *See, e.g.*, Madigan Army Medical Center, *April Community Update*, 2014. Note: a change from a civilian PCM to a Military PCM means to change from a civilian medical practice to a military facility, the actual health care provider within the military facility can be civilian or military.
[276] *See* Amanda E. Lechner, Rebecca Gourevitch, and Paul B. Ginsburg, Center for Studying Health System Change, The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer, Research Brief Number 30, accessed December 23, 2014, http://www.hschange.org/CONTENT/1397/.
[277] General Dynamics was awarded a $63 million contract to modernize the military billing and collection system. The Armed Forces Billing and Collection Utilization Solution (ABACUS) will provide software-as-a-service to automate, consolidate, and centralize billing and collections across 136 medical treatment facilities. "News and Events," General Dynamics Information Technology, accessed November 29, 2014, http://www.gdit.com/News-And-Events/2014/General-Dynamics-Awarded-63-Million-to-Modernize-Military-Health-Billing-and-Collections-System/.
[278] One barrier to providing health care to alternative populations at military hospitals and clinics is that many of the facilities are located on secure military installations with restricted access.
[279] Government Accountability Office, *Operation Desert Storm: Problems With Air Force Medical Readiness*, GAO/NSIAD-94-58, accessed January 10, 2015, http://www.gao.gov/assets/220/218960.pdf. *Operation Desert Storm:*

to GAO, the Gulf War highlighted that military medical forces were "unprepared to provide combat casualty care" and it brought into question the DoD's "ability to meet its wartime medical mission."[280] GAO attributed this lack of readiness to the types of training medical forces receive. "Since most military treatment facilities provide health care to active-duty personnel and their beneficiaries and do not receive trauma patients, military medical personnel cannot maintain combat trauma skills during peacetime by working in these facilities."[281] Ultimately, the Congress directed DoD to enter into partnerships at civilian facilities to improve predeployment training in combat casualty care.[282]

Subsequent to this directive, each of the Services established trauma training programs that partner with nationally renowned level-1 civilian trauma centers.[283] These programs are highly regarded for the training resource they afford the military, as well as access to civilian medical research infrastructure and the capability to maintain a group of highly skilled military trauma care providers.[284] They are also beneficial to the civilian trauma centers because military providers augment their labor force, the partnership provides for the introduction of cutting-edge ideas and practices from the battlefield, and the civilian providers have an opportunity to participate in DoD-sponsored research.[285] A study comparing military personnel at the Baltimore Shock Trauma Center (STC) with personnel at the theater hospital in Balad, Iraq found that, despite an important difference in patients and settings, "the operations performed and outcomes were similar."[286] The authors concluded, "Because a higher volume of trauma patient admission correlates with improved outcomes, the large-volume, high acuity exposure and training obtained by the C-STARS rotators at STC would suggest an advanced level skill set before deployment."[287]

Research on brigade support medical companies that were augmented with forward surgical teams found all interviewed physicians and physician assistants who attended predeployment trauma training courses or programs at the Services' trauma training centers associated with civilian level-1 trauma centers perceived them extremely valuable.[288] Those who did not attend such training believed it would have greatly improved their ability to treat trauma and mass casualties.[289] The Air Force Deputy Surgeon General stated as current military operations diminish, a priority is to invest more in civilian partnerships to ensure military physicians continue to be exposed to cases that are operationally relevant.[290] Although this realistic trauma

---

Improvements Required in the Navy's Wartime Medical Program GAO/NSIAD-93-189, accessed January 10, 2015, http://www.gao.gov/assets/220/218210.pdf. *Operation Desert Storm: Full Army Medical Capability Not Achieved*, GAO/NSIAD-92-175, accessed January 10, 2015, http://www.gao.gov/assets/220/218309.pdf.

[280] Government Accountability Office, *Medical Readiness: Efforts Are Underway for DOD Training in Civilian Trauma Centers,* GAO/NSIAD-98-75, 12, accessed January 10, 2015, http://www.gao.gov/assets/160/156122.pdf.

[281] Ibid.

[282] National Defense Authorization Act for FY 1996, Pub. L. No. 106-104, § 744, 110 Stat. 386 (1996).

[283] Chad M. Thorson, MD, et al., "Military Trauma Training at Civilian Centers: A Decade of Advancements," *Journal of Trauma and Acute Care Surgery*, 73, no. 6 (2012): S483-S489.

[284] Ibid.

[285] Ibid.

[286] Maureen McCunn, MD et al., "Trauma Readiness Training for Military Deployment: A Comparison between a U.S. Trauma Center and an Air Force Theater Hospital in Balad, Iraq," *Military Medicine*, 176, no. 7 (July 2011): 772.

[287] Ibid.

[288] Emil Lesho, COL MC USA, "Prospective Data, Experience, and Lessons Learned at a Surgically Augmented Brigade Medical Company (Level II+) During the 2007 Iraq Surge," *Military Medicine*, 176, no. 7 (July 2011): 763-768.

[289] Ibid.

[290] Air Force Deputy Surgeon General, meeting with MCRMC Commissioners, June 12, 2014.

training in a live setting provides beneficial experience, some question whether these training platforms will continue after current contingency operations conclude.[291]

Flow of Health Care Funding

MHS is currently funded from a variety of sources, including Defense Health Program appropriations (operations and maintenance, procurement, and research and development),[292] the Services' military personnel appropriations,[293] Defense-wide military construction appropriations,[294] and payments from the Medicare-Eligible Retiree Health Care Fund (MERHCF).[295] These funds cover medical readiness costs, including delivering care to active-duty Service members and training for military medical personnel, and the costs of delivering care to beneficiaries. The budgeting process, as currently designed, does not allow for distinction between these two expenditures.[296] This flow of funding can have a negative effect on the MHS. As GAO has written, "choices about the method of budget reporting represent much more than technical decisions about how to measure cost, rather they reflect fundamental choices about the controls and incentives to be provided by the decision-making process."[297]

Conclusions:

The critical nature of joint readiness, including the essential medical readiness examples above, make it clear that four-star leadership is needed to sustain dedicated focus on the joint readiness of the force. Ensuring that the hard-fought progress achieved during the past decade in the delivery of combat casualty care on the battlefield, the global capability for evacuating casualties and providing critical care while in transit, and the research that has led to advances in wound care and hemorrhage control, requires strong oversight at the highest level. The Commission thoroughly evaluated the merits of a four-star joint medical command. In fact, 15 out of 18 studies between 1948 and 2011 recommended the establishment of a unified, joint, or central authority over military medicine. Yet, medicine is only one component of joint military readiness. The essential nature of military medicine by itself warrants four-star oversight, and the Commission concludes the best course of action is to create a four-star Joint Readiness Command to manage the readiness, as well as the interoperability, efficiency, and "jointness" of the entire military force, including medical readiness.

---

[291] *See* Chad M. Thorson, MD, et al., "Military Trauma Training at Civilian Centers: A Decade of Advancements," *Journal of Trauma and Acute Care Surgery*, 73, no. 6 (2012): S483-S489.
[292] *See, e.g.,* Defense Health Program, *Fiscal Year (FY) 2015 Budget Estimates: Operation and Maintenance Procurement Research, Development, Test and Evaluation,* accessed December 19, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/budget_justification/pdfs/09_Defense_Health_Program/DHP_PB15_Vol_I-II.pdf.
[293] *See, e.g.,* Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress,* accessed December 15, 2014, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf.
[294] *See, e.g.,* Department of Defense, *Fiscal Year (FY) 2015 Budget Estimates: Military Construction Family Housing Defense-Wide,* accessed December 19, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/budget_justification/pdfs/07_Military_Construction/Military_Construction_Defense-Wide.pdf.
[295] *See, e.g.,* Department of Defense, Office of the Actuary, *Valuation of the Medicare-Eligible Retiree Health Care Fund,* accessed December 19, 2014, http://actuary.defense.gov/Portals/15/Documents/FY_2012_MERHCF_ Val_report.pdf.
[296] Government Accountability Office, *Accrual Budgeting: Experiences of Other Nations and Implications for the United States, Report to the Honorable Benjamin L. Cardin, House of Representatives,* GAO/AIMD-00-57, accessed December 19, 2014, http://www.gao.gov/assets/160/156759.pdf.
[297] Ibid.

Joint Readiness Command

A four-star command is essential for the proper oversight of joint readiness that extends beyond medical readiness. For example, despite repeated inquiries, the Commission was unable to obtain a definitive answer as to whether the Reserve Component (RC) would remain operational or revert to a strategic posture. This question has broad implications for the maintenance of the All-Volunteer Force, as well as the proper design of the military compensation system. A four-star commander with responsibility for joint readiness would have the stature and resources necessary to thoroughly analyze the best posture of the RC, recommend strategic guidance for maintenance of the All-Volunteer Force, and provide input to the Secretary of Defense and the Chairman of the Joint Chiefs of Staff needed to best align compensation programs with maintaining a balanced force.

In addition, a four-star commander is needed to ensure the flexibility inherent in the recommendations in this report are best used to maintain the readiness of the entire force and, as argued in this recommendation, specifically the readiness of the medical force. This report provides new tools with which DoD can adjust workload in MTFs to provide the best available training opportunities to maintain the clinic proficiency of medical personnel. Because these adjustments may require additional funding to attract workload, there would be a natural tension between maintaining readiness and budget pressures. A four-star commander is needed to effectively advocate for readiness funding and actively participate in the planning, programming, budget, and execution (PPBE) process, especially in the current period of declining military budgets.

A four-star command is also consistent with both the Commission's Congressional mandate and Presidential principles. The Commission's establishing statute mandates that its recommendations must "ensure the long-term viability of the All-Volunteer Force by sustaining the required human resources of that force during all levels of conflict and economic conditions."[298] Strong leadership at the most senior levels, including oversight of the readiness of critical medical personnel, is required to achieve this mandate. Similarly, a four-star commander best fulfills the President's principles that seek to sustain "our Nation's ability to sustain an All-Volunteer Force," to ensure "responsive and prudent management" of the Force, and to "actively retain the most experienced and qualified service members and align compensation and benefits to achieve this end."[299]

The President, the Congress, and DoD should therefore create a new four-star general/flag officer billet to lead a Joint Readiness Command (JRC) that manages the readiness of military personnel. The JRC should focus on the military personnel aspects of DoD's ability to train, mobilize and deploy an integrated and ready active and RC force to support assigned missions. The JRC would include readiness issues across combat domains, including, of particular concern to the Commission, the area of military medical readiness.

[298] National Defense Authorization Act for FY 2013, Pub. L. No. 112-239, § 671(a)(1), 126 Stat. 1632, 1787 (2013) (amended by National Defense Authorization Act for FY 2014, Pub. L. 113-66, § 1095(b), 127 Stat. 672, 879 (2013)).
[299] President Barack Obama, *Principles for Modernizing Compensation and Retirement Systems,* accessed December 15, 2014, http://www.mcrmc.gov/public/docs/statutory/Principles.pdf.

Joint Staff Readiness Directorate
To further ensure the appropriate focus on medical readiness throughout the requirements determination and budget processes, medical readiness issues should be elevated within the Joint Staff. A Joint Staff Medical Readiness Directorate (J10) should be established and directed by a three-star general/flag medical officer. The J10 should coordinate with the JRC on medical readiness issues. The current Joint Force Surgeon (J4) office should be transitioned to the new J10, which has responsibility to include establishing a Joint Medical Readiness Oversight Council (JMROC). The JMROC should comprise the J10, the medical section of the JRC, the Service Surgeons General, the Medical Officer of the Marine Corps, and, as needed, the Combatant Command Surgeons. The JMROC should also include advisory representatives from Offices of the Undersecretaries of Defense for Personnel and Readiness, Acquisition, Technology and Logistics, and Comptroller; the Assistant Secretary of Defense for Health Affairs; and the Directors, Cost Assessment and Program Evaluation; Defense Health Agency (DHA); and such others as the J10 director may deem appropriate. The J10 director should advocate for medical readiness matters in the PPBE process, including providing staff representatives to PPBE issue teams and the three-star programmers meeting on all medical issues in the PPBE process. The J10 director should also provide advice to the Chairman and Vice Chairman on all medical issues in the PPBE process.

Reorienting MTF Capabilities
MTFs, with their current workload and case mix, are not ideal platforms for training military medical personnel for the readiness mission. The predominance of care provided at MTFs does not provide direct training opportunities for those medical specialties most needed in wartime situations. Military medical personnel are misaligned with wartime requirements; deployment rates of medical specialties are highly inconsistent; and medical readiness funding is comingled with beneficiary care costs. Overall workload in MTFs is below commercial standards, particularly in operational specialties. DoD has very limited means of effecting change in the underlying causes for MTFs not being ideal training platforms. It can only change workload in MTFs by "recapturing" beneficiary care, which restricts beneficiaries' health care choices and does not resolve case mix challenges. Although this report suggests new tools to make MTFs better training platforms, DoD has no centralized oversight of battlefield health care or the medical readiness mission to ensure those tools are implemented and used to best support combat casualty care.

To ensure the Nation is not left unprepared at the start of the next war, the military medical lessons learned during war must be preserved and improved upon whenever possible. The military medical force should be provided every opportunity to access the best possible training environments. Accordingly, DoD needs to implement a new strategic framework to maintain medical readiness, new tools with which to achieve this readiness, and new oversight to ensure Service members receive the best care possible during the next conflict.

DoD should clearly identify Essential Medical Capabilities (EMCs)[300] the military needs for its operational mission, taking into account the experiences during the last

[300] Essential Medical Capability (EMC) refers to a limited number of critical medical capabilities that must be retained within the military for national security purposes. These capabilities are vital to effective and timely health care during contingency operations. EMCs should include clinical and logistical capabilities related to combat casualty care;

13 years of war. EMCs should include Specialized Military Conditions (SMCs)[301] not primarily performed in theater but commonly associated with military operations. EMCs should be maintained as a core capability of military medicine. To maintain these EMCs, DoD should establish clinical proficiency standards for military medical personnel and facilities that are based on widely accepted metrics of the medical profession, taking into account military readiness requirements. DoD should also be given new authorities to make certain it meets these proficiency standards, including:

- Allowing beneficiaries to choose from a selection of commercial insurance plans offered through a DoD heath benefit program. This approach, which Recommendation 6 outlines in greater detail, would improve the health benefit for military beneficiaries. It would also create new tools with which DoD could attract patients into military hospitals, especially those with complex medical cases that are important for medical readiness training that will advance the medical readiness mission.

- Annually adjusting copayments for EMC-related care delivered in MTFs so DoD beneficiaries have financial incentives to receive MTF care.

- Providing care to VA patients and civilians[302] who have cases consistent with DoD's EMCs.

- Annually adjusting procedure reimbursement rates at MTFs. Reimbursement rates charged by MTFs should be based, in part, on the need to attract sufficient EMC-related workload and case mix to maintain MTFs as appropriate readiness training platforms. Such tools require strong oversight to guard against budget cutting and ensure they are used to maintain readiness of the medical force and the health of the MHS as a training platform.

- MTF catchment areas[303] should be eliminated. By doing so, eligible beneficiaries who currently live outside of catchment areas would be able to seek health care at military hospital and clinics. Not only would this change provide additional choices to beneficiaries, it could provide additional workload to better support MTFs in achieving their readiness mission. Recommendation 6 outlines the basis for eliminating these catchment areas.

---

medical response to and treatment of injuries sustained from chemical, biological, radiological, nuclear, and explosives incidents; diagnosis and treatment of infectious diseases; aerospace medicine; and undersea medicine. EMCs also include a limited number of "Specialized Military Conditions" (SMCs) not primarily performed in theater but commonly associated with military operations.

[301] Care provided for Specialized Military Conditions (SMC) refers to the diagnosis, treatment, and rehabilitation of certain conditions incurred as a direct result of military activity, i.e., amputations, certain musculoskeletal trauma, burns, traumatic brain injuries, and post-traumatic stress disorder. SMCs are unusual medical conditions that are particularly associated with military action during major operations and training exercises and are not typically common among the civilian population. SMCs evolve to reflect emerging medical conditions that result from changes in warfighting and advancements in commercial-sector medical treatments.

[302] Health care provided to civilians should be limited to EMC-related health care. For example: Burn patients at the San Antonio Military Medical Center, Traumatic brain injury rehabilitation at any of the National Intrepid Centers of Excellence, or rehabilitation at the Center for the Intrepid for amputations, burns, or functional limb loss.

[303] National Defense, 32 CFR 728.2. A specified geographic area surrounding each Uniformed Services Medical Treatment Facility (USMTF) or designated Uniformed Services Treatment Facility (USTF). In the United States, catchment areas are defined by zip codes and are based on an area of approximately 40 miles in radius for inpatient care and 20 miles in radius for ambulatory care.

- Standardizing and increasing the number of local agreements to take advantage of the opportunities to provide the medical force more trauma-care training at civilian facilities. If operational medical requirements exceed the training capacity of the MTF system, DoD should have the authority to make training in civilian facilities a more prominent program and to seek ways to allow more medical forces to participate. To the extent possible, DoD should be able to standardize agreements with civilian hospitals to facilitate training by medical personnel across the Services. Agreements also need to be structured so that military medical personnel can be mobilized without introducing risk to the civilian facilities.

- Segregating funding for beneficiary care from the cost of medical readiness in the DoD budget. As Recommendation 6 outlines in detail, beneficiary costs can be segregated by funding them through insurance premiums and a new Basic Allowance for Health Care. By doing so, additional readiness funds necessary to cover MTF costs would be budgeted separately, improving transparency, oversight, and allocation to the readiness mission. Improving transparency in medical readiness funding also helps ensure ongoing focus on medical research contributing to battlefield and expeditionary medicine.

The *MHS Modernization Study* concluded that many MTFs without sufficient workload should discontinue their inpatient services.[304] Although it may be appropriate to close inpatient services at some MTFs, doing so is not the only solution to workload and case mix shortfalls. In fact, closing or reducing services at MTFs may exacerbate workload issues at other facilities. Reducing the capability at too many MTFs has the potential to adversely affect the ability of the MHS to maintain sufficient capacity for wounded warrior care. Facility reduction may represent long-term risk to military medicine, and does not address the underlying problem. The military medical force requires access to the desired volume and mix of complex medical cases and trauma to maintain medical force readiness.

Recommendations:

- The Secretary of Defense, together with the Chairman of the Joint Chiefs of Staff, should seek to improve the oversight of joint medical readiness through the creation of newly established Joint Readiness Command led by a four-star general/flag officer, as well as transitioning the Joint Force Surgeon (J4) office to the J10 Medical Readiness Directorate in the Joint Staff.

    - The JRC should be a functional unified command led by a four-star military officer with broad responsibilities for readiness across DoD. Much of the required structure for this new command can be harvested from the Joint Staff which has grown in recent years to provide oversight of many of the functions that would be the responsibility of this new command. The JRC should include a subordinate joint medical function whose primary responsibilities include advising the JRC commander on the readiness status of the medical force, determining joint medical doctrine and

[304] Department of Defense, *Military Health System Modernization Study, v.28*, October 2014.

requirements,[305] and advising joint sourcing of medical assets with Joint Staff J3 and J10.

- The J10 Medical Readiness Directorate should be led by a three-star military medical officer whose primary responsibilities include advising the Chairman of the Joint Chiefs of Staff on medical readiness issues, advising the Joint Requirements Oversight Council, validating joint medical readiness requirements, chairing the JMROC, and participating in the PPBE process.

- The Congress should establish the statutory requirement for DoD to maintain EMCs to promote and maintain certain medical capabilities within the military. Figure 12 shows components of EMCs, and Table 6 outlines roles and responsibilities regarding EMCs.

Figure 12. Components of Essential Medical Capabilities

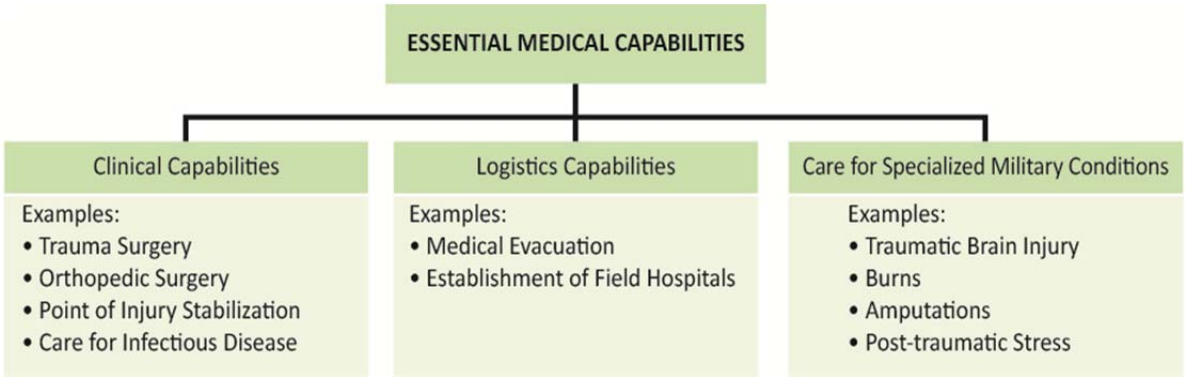


Table 6. Roles and Responsibilities Regarding Essential Medical Capabilities

Congress	1) Establish the statutory requirement for DoD to maintain EMCs 2) Establish requirement for Secretary of Defense to report annually to the Congress on EMCs 3) Establish requirement for Comptroller General to review annually DoD's adherence to EMC requirements
Secretary of Defense	1) Approve the capabilities designated as EMCs and establish policies and standards to maintain them 2) Report annually to the Congress on EMCs and associated metrics

[305] Services determine their own medical readiness requirements; the JMC would complete joint medical requirements analysis in support of joint combatant command operations.

Joint Readiness Command (with regard to military medical readiness)	1) Establish joint readiness requirements consistent with EMCs 2) Identify EMCs in collaboration with the Under Secretary of Defense for Personnel and Readiness, the Joint Staff, and the Military Services. 3) Monitor and report on Service adherence to EMC policies, standards, and medical manning requirements and fill rates for each EMC 4) Participate in PPBE process to recommend allocation of medical readiness funding from Service O&M Readiness accounts to fulfill EMCs 5) Recommend and coordinate usage of tools designed to assist in maintenance of EMCs, including providing recommendations to Defense Health Agency (DHA) and the Office of Personnel Management for annual negotiations with health insurance carriers (see Recommendation 6) 6) Monitor and recommend allocation of medical personnel to locations to ensure maintenance of EMCs
J10/Joint Readiness Directorate	1) Advise the Chairman on medical readiness issues 2) Advise Joint Requirements Oversight Council (JROC) on medical readiness issues 3) Chair the Joint Medical Readiness Oversight Council (JMROC) 4) Participate in PPBE process on medical readiness issues
Services	1) Develop Service-specific medical readiness requirements 2) Submit to JRC the core manning requirements that directly fulfill each EMC, by medical specialty. 3) Maintain at all times the medical specialties required for EMCs, without substitution 4) Regulate medical manning requirements and fill rates that fulfill each EMC 5) Manage preservation of core skills that are required for each EMC 6) Adhere to EMC policies and standards

- EMCs should be defined as a limited number of critical medical capabilities that must be retained within the military for national security purposes. These capabilities are vital to effective and timely health care during contingency operations. EMCs should include clinical and logistics capabilities necessary to accomplish operational requirements such as combat casualty care; medical response to and treatment of injuries sustained from chemical, biological, radiological, nuclear, and explosives incidents; diagnosis and treatment of infectious diseases; aerospace medicine; and undersea medicine. EMCs also include a limited number of SMCs not primarily performed in theater but commonly associated with military operations (e.g., therapy for post-traumatic stress disorder).[306] EMCs should not include medical missions or specialties not commonly associated with operational military medicine or SMCs. The Congress should require the Secretary of Defense and GAO to report annually on EMCs and their associated readiness metrics.

  - The Secretary of Defense should approve the capabilities designated as EMCs and establish policies to maintain them, including standards for the

[306] Care provided for Specialized Military Conditions (SMC) refers to the diagnosis, treatment, and rehabilitation of certain conditions incurred as a direct result of military activity, i.e., amputations, certain musculoskeletal trauma, burns, traumatic brain injuries, and post-traumatic stress disorder. SMCs are unusual medical conditions that are particularly associated with military action during major operations and training exercises and are not typically common among the civilian population. SMCs should evolve to reflect emerging medical conditions that result from changes in warfighting and advancements in commercial-sector medical treatments.

mix and volume of medical cases based on widely accepted metrics of the medical profession and the unique readiness requirements of the military.

- The JRC should measure adherence to the Secretary's EMC policies and standards using information pertaining to personnel, training, and MTFs provided by the Services. The JRC should participate in the PPBE process to advise on appropriate funding levels for military medical readiness and the allocation of such funds to best maintain EMCs. Upon identifying a shortfall in maintaining EMC standards, the JRC should recommend employing the following tools based on local market conditions, some of which relate to the commercial insurance benefit described in Recommendation 6:

    - Adjustments to procedure prices for EMC-related cases that MTFs charge to insurance carriers.

    - Adjustments to beneficiary copayments to incentivize use of the MTFs. The JRC should coordinate with the DHA on DoD's annual recommendations to the Office of Personnel Management (OPM) and the insurance carriers, as required with implementation of Recommendation 6 of this report.

    - Authority to allow veterans and civilians with cases that are needed for EMC skill maintenance to be treated in MTFs.[307]

    - Permanent Change of Station assignments of the medical force to civilian hospitals or VA facilities to offer alternative venues for skill maintenance.

- The Services should develop the means for adhering to EMC policies and clinical skill maintenance standards.

    - The Services should closely manage the preservation of core skills that are directly required for each EMC approved by the Secretary of Defense.

    - The Services should carefully regulate the manning requirements and personnel fill rates, by medical specialty, that directly fulfill each EMC.

    - Services should not substitute medical specialties required for EMCs.

    - The Services should submit to the JRC a description of these core skills and the actions taken to achieve the Secretary's skill maintenance standards. The Services should submit to the JRC these medical personnel requirements and fill rates.

[307] The Code of the Federal Regulations specifies the priority level assigned to categories of DoD beneficiaries with space-available access to MTFs. Veterans and civilians should be added at a level below the existing priority groups, and EMC-related medical cases should be included as a factor in the prioritization. Veterans and civilians seeking medical treatment of the same type as DoD beneficiaries should not displace DoD beneficiaries in the existing priority groups.

- The Congress should adjust the flow of funding to better align DoD medical programs with their purpose and operations.

  - Funding for active-duty family, retiree, and Reserve Component health care should be contained in Services' Military Personnel (MILPERS) budget accounts.

  - The MERHCF should be expanded to cover the health care and pharmacy programs for non-Medicare-eligible retirees. Non-Medicare-eligible retiree health care should be accrual funded, similar to how Medicare-eligible retiree health care is today.

  - To finance the new health care program for active-duty families, RC members and families, and non-Medicare-eligible retirees (see Recommendation 6), funds should be transferred as follows:

    - For active-duty families and RC members and families, funds should be transferred from the MILPERS accounts to the Employee Health Benefits Fund managed by OPM.

    - For non-Medicare-eligible retirees, funds should be transferred from the MERHCF to the Employee Health Benefits Fund managed by OPM.

  - To finance the existing pharmacy and dental programs for families and RC members and families and pharmacy, dental, and health care for active-duty Service members, a new trust fund should be created and managed by DoD for health care expenditures appropriated in the current year.

  - The MTFs should be funded through a revolving fund using the reimbursements they receive for care delivered.

  - In the case of MTF operations that are deemed required for EMC skill maintenance, costs that exceed the revenue generated from the delivery of care should be paid by the Services' Operations and Maintenance (O&M) accounts. This amount would be a necessary cost of readiness of the medical force.

  - The Congress should eliminate the Defense Health Program budget account because health care should be funded from MILPERS accounts for transfer to the trust funds referenced above and readiness costs should be resourced from Services' O&M accounts.

- Catchment areas around MTFs should be rescinded, allowing MTFs to attract cases unrestricted by geographic vicinity.

Implementation:

- 10 U.S.C. Chapter 6 governs the Combatant Commands of the military. Chapter 6 should be amended by adding a new section that establishes a Joint Readiness Command (JRC).

- 10 U.S.C. § 155 governs the Joint Staff. This section should be amended to add a new provision that establishes a new directorate (J10) responsible for medical readiness.

- A new chapter, Chapter 174, Sustainment of Essential Medical Capabilities, should be created in Title 10 of the United States Code. The chapter should: establish a general definition of essential medical capabilities (EMCs); require the Secretary of Defense to establish EMCs in consultation with the JRC and to develop policies to maintain EMCs; require the Services to maintain EMCs and the JRC to track the Services' capabilities relating to EMCs; and require annual reporting to the Congress by both DoD and the Government Accountability Office on DoD's progress establishing EMCs and meeting goals relating to EMCs.

- Chapter 101, Title 10, U.S. Code governs general military training. Chapter 101 should be amended to add a new section, authorizing the Secretary of Defense and each Secretary concerned to permit military medical personnel to train in VA or civilian facilities.

- 5 CFR 199.17 should be amended to include veterans and civilians with EMC-related cases at a priority level below the existing beneficiary groups and to include EMC-related medical cases as a factor in the prioritization. The section should also be amended to eliminate geographic "catchment areas" for MTFs.

- Any other regulations (including the Code of Federal Regulations, if applicable) instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

Recommendation 6: Increase access, choice, and value of health care for active-duty family members, Reserve Component members, and retirees by allowing beneficiaries to choose from a selection of commercial insurance plans offered through a Department of Defense health benefit program.

Background:
The Department of Defense's TRICARE program provides health care benefits for Active Component (AC) Service members, Reserve Component (RC) members, retirees, their dependents, survivors, and some former spouses at Military Treatment Facilities (MTFs) or through a network of civilian health care providers.[308] TRICARE comprises three main plans:[309] TRICARE Prime, which is structured as a health maintenance organization (HMO);[310] TRICARE Standard, which is a nonnetwork, fee-for-service (FFS)[311] plan;[312] and TRICARE Extra, which is also an FFS plan, but with a preferred provider organization (PPO).[313] Members of the National Guard and Reserve can purchase TRICARE Reserve Select, which is a premium-based health plan.[314]

---

[308] *See generally* Armed, Forces, 10 U.S.C. ch. 55. *See also* Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2013 Report to Congress,* 5, accessed June 20, 2014, http://tricare.mil/tma/dhcape/program/downloads/TRICARE2013%2002_28_13%20v2.pdf. Members of the Uniformed Services and their dependents also are eligible for TRICARE. See MCRMC, *Report of the Military Compensation and Retirement Modernization Commission: Interim Report*, June 2014, 116-117, http://www.mcrmc.gov/index.php/reports. The individuals listed are considered eligible "beneficiaries" for the TRICARE program. Additional information and discussion on eligibility requirements can be found at www.tricare.mil (https://www.tricare.mil/Plans/Eligibility.aspx), the official website of the Defense Health Agency (DHA), a component of the Military Health System.

[309] The President's Budget for FY 2015 included a proposal to consolidate TRICARE Prime, Standard, and Extra options into one plan. For a description of the PB 2015 health care proposals, see Office of the Undersecretary of Defense (Comptroller), *United States Department of Defense, Fiscal Year 2015 Budget Request Overview (March 2014)*, 5-10–5-14, accessed April 14, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/fy2015_Budget_Request_Overview_Book.pdf.

[310] National Defense, 32 CFR 199.17(a)(6)(ii)(A). *See also* Department of Defense, *TRICARE Choices at a Glance*, 3, accessed June 20, 2014, http://www.tricare.mil/~/media/Files/TRICARE/Publications/BrochuresFlyers/Choices_Glance_BR.pdf. A Health Maintenance Organization (HMO) is "A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness." "Health Maintenance Organization (HMO)," Healthcare.gov, accessed October 24, 2014, https://www.healthcare.gov/glossary/health-maintenance-organization-HMO/.

[311] Fee-for-Service is "a method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits." "Fee-for-Service," Healthcare.gov, accessed October 24, 2014, https://www.healthcare.gov/glossary/fee-for-service/.

[312] National Defense, 32 CFR 199.17(a)(6)(ii)(C). National Defense, 32 CFR 199.17(f). Department of Defense, *Evaluation of the TRICARE Program Fiscal Year 2014 Report to Congress*, 5, accessed June 20, 2014, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20%28FY%202014%29%201.pdf.

[313] National Defense, 32 CFR 199.17(a)(6)(ii)(B). "TRICARE Standard and Extra," Defense Health Agency, accessed June 20, 2014, http://www.tricare.mil/Plans/HealthPlans/TSE.aspx. A Preferred Provider Organization is "A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost." "Preferred Provider Organization," Healthcare.gov, accessed October, 24, 2014, https://www.healthcare.gov/glossary/preferred-provider-organization-PPO/.

[314] National Defense, 32 CFR 199.24(a)(1). Department of Defense, *TRICARE Choices at a Glance*, 4, accessed June 20, 2014, http://www.tricare.mil/~/media/Files/TRICARE/Publications/BrochuresFlyers/Choices_Glance_BR.pdf.

In TRICARE Prime, beneficiaries must enroll with a primary-care manager (PCM) in an MTF or with a civilian provider.[315] Care is predominantly accessed by first visiting the PCM, who refers patients for additional required care to other providers.[316] TRICARE Prime involves no costs for AC family members.[317] The annual enrollment fees for non-Medicare-eligible retirees in fiscal year 2015 are $277.92 for a single person and $555.84 for a family.[318] Retirees enrolled in Prime pay $12 copayments for outpatient visits unless they go to nonnetwork providers, in which case copayments carry a point-of-service charge.[319] In 2012, there were approximately 5.5 million beneficiaries enrolled in TRICARE Prime.[320]

Beneficiaries are not required to enroll in TRICARE Standard and Extra, but those who choose to use the two programs have an annual deductible for outpatient services.[321] They can see any provider without referral.[322] Annual deductibles vary from $50 to $300, depending on status (AC, RC, or retired) and pay grade.[323] Beneficiaries pay a share of procedure costs, but annual out-of-pocket (OOP) expenses are limited to a $1,000 catastrophic cap for AC and RC families per year, and a $3,000 catastrophic cap for all others, including retirees, per year.[324] TRICARE Reserve Select has a similar payment structure, except participants also pay monthly premiums of $50.75 for an individual or $205.62 for a family, as of January 1, 2015.[325] An estimated one million beneficiaries used TRICARE Standard and Extra at least once in 2012.[326] More than 240,000 RC members purchased TRICARE Reserve Select in 2012.[327]

---

[315] National Defense, 32 CFR 199.17(n)(1); Assistant Secretary of Defense (Health Affairs) memorandum, *TRICARE Policy for Access to Care, February 23, 2011*, accessed November 6, 2014, http://www.health.mil/~/media/MHS/Policy%20Files/Import/11-005.ashx.
[316] "Book Appointments," Defense Health Agency, accessed December 19, 2014, http://www.tricare.mil/FindDoctor/Appointments.aspx.
[317] Department of Defense, *TRICARE Choices at a Glance*, 3, accessed June 20, 2014, http://www.tricare.mil/~/media/Files/TRICARE/Publications/BrochuresFlyers/Choices_Glance_BR.pdf.
[318] "Prime Enrollment Fees," Defense Health Agency, accessed October 24, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/PrimeOptions/EnrollmentFees.aspx.
[319] "Prime Network Copayments," Defense Health Agency, accessed October 24, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/PrimeOptions/Copayments.aspx. When Prime beneficiaries go to nonnetwork providers, they pay point-of-service fees instead of regular copayments. The cost for outpatient visits and hospitalization under this scenario is 50 percent of the TRICARE allowable charge. "Point of Service Option," Defense Health Agency, accessed November 5, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/PrimeOptions/POS.aspx.
[320] "Approaches to Reducing Federal Spending on Military Health Care," Congressional Budget Office, January 2014, 7, accessed November 18, 2014, https://www.cbo.gov/publication/44993.
[321] National Defense, 32 CFR 199.17(m). Department of Defense, *TRICARE Standard Fact Sheet*, accessed June 20, 2014, http://www.tricare.mil/~/media/Files/TRICARE/Publications/FactSheets/TSE_FS.pdf.
[322] "TRICARE Standard and Extra," Defense Health Agency, accessed October 24, 2014, http://tricare.mil/Plans/HealthPlans/TSE.aspx.
[323] "TRICARE Standard and Extra Costs," Defense Health Agency, accessed October 24, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/TSE.aspx.
[324] "Catastrophic Cap," Defense Health Agency, accessed December 18, 2014, http://www.tricare.mil/Costs/CatCap.aspx
[325] "TRICARE Reserve Select Costs," Defense Health Agency, accessed October 24, 2014, http://tricare.mil/Costs/HealthPlanCosts/TRS.aspx.
[326] "Approaches to Reducing Federal Spending on Military Health Care," Congressional Budget Office, January 2014, 7, accessed November 18, 2014, https://www.cbo.gov/publication/44993. Note that TRICARE Standard and Extra do not require enrollment and retirees often use Standard and Extra to supplement civilian health insurance, making it difficult to measure accurately the number of beneficiaries that rely on the program for their health coverage. Estimates of Standard and Extra users typically measure the number of beneficiaries who have used medical services under Standard or Extra at least once in the year under consideration.
[327] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2013 Report to Congress*, 96, accessed December 18, 2014, http://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

The findings and recommendations below address the ways beneficiaries access health care, the choices they have regarding their care, and the value of this benefit. Under the Commission's recommended changes, AC members, because of readiness requirements, would still use their respective unit-level medical capability and, as necessary, MTFs as their primary access points for medical care. When referred to the private sector, AC members would have access to an unlimited network of providers at no cost to the member. DoD beneficiaries would continue to have access to care in MTFs.[328]

This recommendation would provide new financial tools, such as lower copayments and reduced reimbursement rates for certain procedures at MTFs, which could attract workload and particular complex cases to MTFs. This additional workload would provide training opportunities for military medical personnel to maintain critical combat care skills and remain ready for operational missions. These tools require strong, centralized oversight to be used efficiently and effectively to support joint medical readiness. Such oversight, along with associated definitions and skill maintenance standards, are discussed in detail in Recommendation 5 of this Report, which should be considered an integral part of this recommendation.

For additional information on TRICARE programs, please see the Health Benefits: Department of Defense sections of the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(sec. 4.1).*

Findings:
Since its creation, TRICARE has deteriorated relative to the goals of this Commission. The quality of TRICARE benefits as experienced by Service members and their families has decreased, and fiscal sustainability of the program has declined. For example, and as explained below, TRICARE costs for beneficiaries have not kept pace with inflation, increasing budgetary pressures within DoD. In response, DoD has revised TRICARE contracts to restrict benefits coverage, including the recent reduction in TRICARE Prime service areas; and TRICARE contractors have negotiated provider reimbursement rates below Medicare levels that have restricted access to care. Alternative means of providing health care to TRICARE beneficiaries could restore both quality and fiscal sustainability.

Access to Care

According to beneficiaries, timely and convenient access to care is a critical element of a high quality, properly functioning health care benefit, yet many TRICARE users expressed frustration with this element.[329] Typical of this concern was the comment of one survey respondent who wrote, "I have an assigned primary care provider, but never see them due to lack of available appointments. I usually see a different provider each time I make an appointment. There is no continuity of care."[330] Gaining access to medical services is largely dependent on the number of providers available to beneficiaries and the process and time required for beneficiaries to see those

[328] These findings and recommendations do indirectly affect the funding mechanism for MTFs, which is described in Recommendation 5. These funding changes, however, will not materially affect patient care or experiences within MTFs.
[329] See for example: Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[330] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

providers. The Commission found areas for improvement with respect to both variables.

Cumbersome Referral and Authorization Process. The process enabling TRICARE Prime beneficiaries to gain access to care is often lengthy and frustrating. The Commission heard many complaints regarding the process by which beneficiaries make appointments with providers, including specialty providers that require prior authorization. One aspect of this process that often exasperates TRICARE Prime users is the amount of time that passes before they can see a specialty provider. According to DoD guidelines for scheduling appointments, beneficiaries seeking urgent care should be seen within 24 hours.[331] The goal for routine care is 7 calendar days, and wellness or nonurgent specialty care is 28 calendar days.[332]

The Commission found, however, that getting access to specialty care under TRICARE Prime can, in reality, take much longer and is often a complicated process. To receive access to TRICARE Prime services, beneficiaries must first see their primary care managers, who give referrals for additional care as needed.[333] Beneficiaries are referred for treatment in MTFs first, which have priority for providing both inpatient and specialty care for all TRICARE Prime enrollees.[334] If care is unavailable in an MTF, then referrals are given for treatment by civilian providers in the TRICARE network.[335]

In all cases, if an appointment cannot be provided within the prescribed timelines either in an MTF or the TRICARE network, the beneficiary would be offered the opportunity to seek the required care outside the TRICARE network.[336] Beneficiaries are referred to non-TRICARE network civilian providers "only when it is clearly in the best interest of the Government and the beneficiary, either clinically or financially."[337] If beneficiaries receive care without a referral, other than in an emergency situation, they may be subject to paying point-of-service OOP fees.[338] It can actually take as long as 35 days to receive specialty care based on DoD standards: 7 days for the first appointment for the primary care manager plus an additional 28 days for the specialty appointment.

There is considerable dissatisfaction with this situation. A survey respondent wrote, "It takes 30-60 days to have an appointment to see my primary care physician. That is unacceptable."[339] Another stated, "Access time to care is poor. [I] would rather pay for civilian service at times. [With the current system] I have to wait months to find out if

---

[331] National Defense, 32 CFR 199.17(p)(5)(ii).
[332] National Defense, 32 CFR 199.17(p)(5)(ii).
[333] National Defense, 32 CFR 199.17(n)(1). Assistant Secretary of Defense (Health Affairs), *TRICARE Policy for Access to Care*, *February 23, 2011*, accessed November 6, 2014, http://www.health.mil/~/media/MHS/Policy%20Files/Import/11-005.ashx. "Book Appointments," Defense Health Agency, accessed October 23, 2014, http://www.tricare.mil/FindDoctor/Appointments.aspx.
[334] Assistant Secretary of Defense (Health Affairs), *TRICARE Policy for Access to Care*, *February 23, 2011*, 3, accessed November 6, 2014, http://www.health.mil/~/media/MHS/Policy%20Files/Import/11-005.ashx.
[335] When care is unavailable in an MTF, this usually means the care is not provided within the MTF or the care is not available within the time frame of the established standards for access to care. Assistant Secretary of Defense (Health Affairs), *TRICARE Policy for Access to Care*, *February 23, 2011*, 3, accessed November 6, 2014, http://www.health.mil/~/media/MHS/Policy%20Files/Import/11-005.ashx.
[336] Assistant Secretary of Defense (Health Affairs), *TRICARE Policy for Access to Care, February 23, 2011*, 3, accessed November 6, 2014, http://www.health.mil/~/media/MHS/Policy%20Files/Import/11-005.ashx.
[337] Ibid.
[338] "Book Appointments," Defense Health Agency, accessed October 23, 2014, http://tricare.mil/FindDoctor/Appointments.aspx. "Point-of-Service Option," Defense Health Agency, accessed October 23, 2014 http://tricare.mil/Costs/HealthPlanCosts/PrimeOptions/POS.aspx.
[339] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

something is wrong then it is too late to [the] correct issue."[340] Another survey respondent explained, "It takes a month for my wife to get an appointment. This is totally unsatisfactory. Part of the reason I joined the Army was for the health care for my family."[341]

Numerous organizations have argued on behalf of Service members and their families for improved access standards and simplified referral processes. For example, the National Association for Children's Behavioral Health (NACBH) provided the Commission a written example of the problems beneficiaries experience when attempting to gain access to mental health providers in the TRICARE system:

> *"It is not unusual for a family member to be given a list of names and phone numbers for 30 to 100 community therapists, only to find that those providers are not currently accepting TRICARE patients, or that the first available appointment is too far in the future. In one instance, a mental health professional at the MTF called over 100 listed mental health providers and found only three who would accept new TRICARE referrals. Commonly, family members report that they give up after the tenth or eleventh call."*[342]

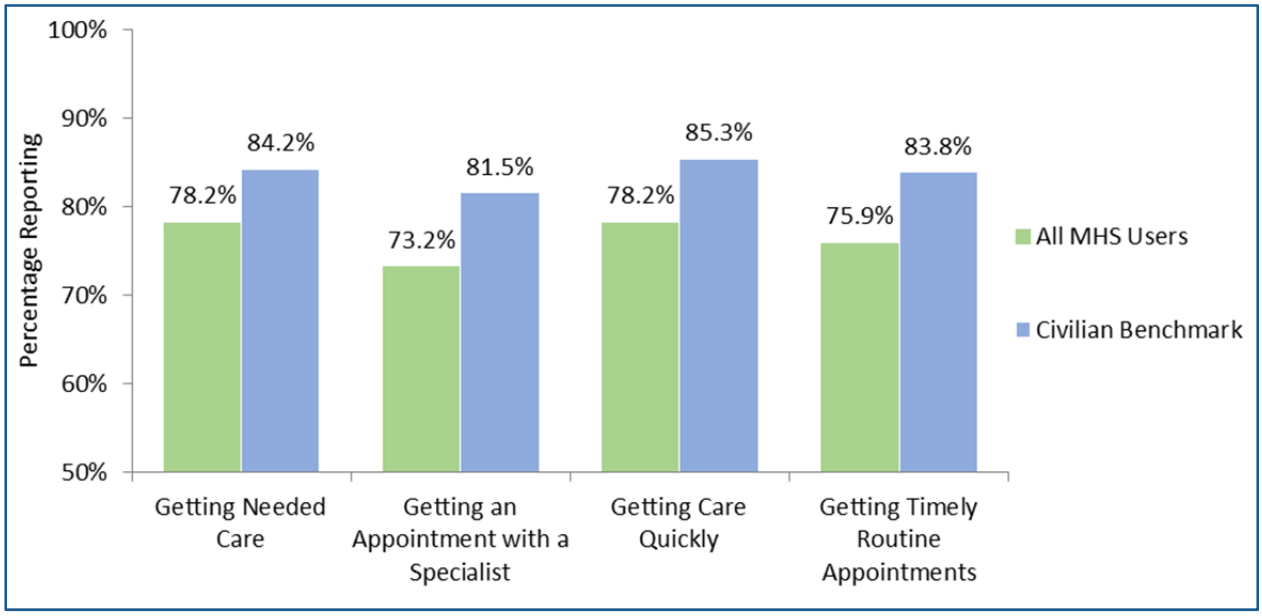
The Military Officers Association of America recently advocated for better access to care by "improving appointing systems, ensuring compliance with access timeliness standards by offering civilian appointments when military appointments are unavailable, and reducing/eliminating pre-authorization requirements that impede timely care delivery."[343] In the words of the National Military Family Association, "The current TRICARE Prime referral and authorization process can be cumbersome and sometimes prevents timely access to specialty care."[344] DoD survey data on access to care provides further evidence of the frustration conveyed by these groups. Figure 13 shows that civilians generally experience greater ease and timeliness in obtaining health care services than beneficiaries in TRICARE.[345] For example, as DoD reported,

---

[340] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[341] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[342] National Association for Children's Behavioral Health, letter to MCRMC, 2, July 31, 2014.
[343] "TRICARE Prime and TRICARE Standard Improvements," Military Officers Association of America, accessed November 8, 2014, http://www.moaa.org/Main_Menu/Take_Action/Top_Issues/Serving_in_Uniform/TRICARE_Prime_and_TRICARE_Standard_Improvements.html.
[344] National Military Family Association, *Statement of the National Military Family Association before the Subcommittee on Military Personnel, Armed Services Committee, U.S. Senate, March 26, 2014*, 9, http://www.armed-services.senate.gov/imo/media/doc/Moakler_03-26-14.pdf.
[345] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, 38, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf. DoD conducts the Health Care Survey of DoD Beneficiaries (HCSDB) to assess customer satisfaction of TRICARE beneficiaries. The HCSDB questions are closely worded to, and results compared with, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys sponsored by the Agency for Healthcare Research and Quality. CAHPS surveys are nationally recognized resources for comparing health care experiences in the civilian sector. In the report, *Evaluation of the TRICARE Program*, DoD adjusts the CAHPS civilian benchmark data to account for demographic differences among the civilian and military populations. "Health Care Survey of DoD Beneficiaries (HCSDB) Overview," Defense Health Agency, accessed 23 October 2014, http://www.tricare.mil/survey/hcsurvey/. Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, 99-100, accessed November 10, 2014, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf.

85.3 percent of civilian survey respondents said they received care quickly, as opposed to 78.2 percent of DoD health care users.[346]

Figure 13. Comparison of Access to Care for DoD and Civilian Health Care Users, FY 2013[347]



Beneficiaries' preferences regarding access to care are evident in the Commission's survey results. The survey included questions about the perceived value of several quality attributes pertaining to the health care benefit. Although choice was the most valued attribute (as will be discussed in more detail below), access measures such as flexible appointment scheduling, the ability to remain with the same provider, and the size of the network of available providers were all rated very highly by survey respondents. For retiree survey respondents, improving the flexibility of appointment scheduling was perceived higher than the value of a 30 percent grocery discount at commissaries.[348]

[346] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, 38, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf. In the report, *Evaluation of the TRICARE Program*, DoD reports a "civilian benchmark" that adjusts CAHPS data to account for demographic differences among the civilian and military populations. The CAHPS and HCSDB surveys ask respondents about their access to care using composite measures of frequency. See Agency for Healthcare Research and Quality, *CAHPS Health Plan Surveys; Version: Adult Commercial Survey 5.0*, accessed December 6, 2014, https://cahps.ahrq.gov/surveys-guidance/survey5.0-docs/2151a_engadultcom_50.pdf and "TRICARE Adult Beneficiary Reports Help Index," Department of Defense, accessed December 6, 2014, http://www.tricare.mil/survey/hcsurvey/2014/bene/fy2014/html/help.htm#composite.

[347] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, 38, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf. In the report, *Evaluation of the TRICARE Program*, DoD reports a "civilian benchmark" that adjusts CAHPS data to account for demographic differences among the civilian and military populations.

[348] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.

DoD recently reviewed access to care under the Military Health System (MHS). DoD reported a range of 7 to 23 days in wait times to see specialty providers in MTFs;[349] however, DoD concluded there was a "notable difference between data that reflect compliance with access standards and the reported satisfaction of patients with their ability to receive timely care in MTFs."[350] The Commission's review of beneficiary comments and satisfaction surveys confirms there is widespread discontent for access to care within the MHS.

DoD also acknowledged that results across the system varied and insufficient data from the purchased care network impeded the analysis.[351] The number of days Prime beneficiaries wait to gain access to specialists in the purchased-care network is not available, but whether or not these beneficiaries' referrals result in an appointment within 28 days is known.[352] DoD reports the percentage of referrals that met the 28-day access standard for specialty appointments ranged from 53 percent to 84 percent in the purchased care network depending on the location.[353] In other words, in some locations approximately half of the referrals to the purchased care network resulted in beneficiaries waiting more than 28 days to see a specialist; and even in locations with the highest reported access to care, 16 percent of referrals still do not get appointments within the 28-day standard.

Gaining access to medical care in the civilian sector through various commercial insurance plans can be a simpler, quicker endeavor than under TRICARE. For example, a 2014 study surveyed about 1,400 physician offices to determine the average delays for physician appointments in 15 metropolitan areas and five specialties.[354] The study found, "The average cumulative wait time to see a physician for all five specialties surveyed in 2014 in all 15 markets was 18.5 days."[355]

---

[349] Department of Defense, *Final Report to the Secretary of Defense: Military Health System Review*, August 2014, 47, accessed November 7, 2014, http://www.defense.gov/pubs/140930_MHS_Review_Final_Report_Main_Body.pdf. The DoD reported a precise range of 6.5 to 22.8 days, which is rounded here.

[350] Department of Defense, *Final Report to the Secretary of Defense: Military Health System Review*, August 2014, 4, accessed November 7, 2014, http://www.defense.gov/pubs/140930_MHS_Review_Final_Report_Main_Body.pdf.

[351] "The purchased care component [of the MHS], which is used when care cannot be provided within the military system, includes civilian network hospitals and providers operated through TRICARE regional contracts." Department of Defense, *Final Report to the Secretary of Defense: Military Health System Review, August 2014*, 2 and 4, accessed November 7, 2014, http://www.defense.gov/pubs/140930_MHS_Review_Final_Report_Main_Body.pdf.

[352] According to DoD, "purchased care data are not available, primarily due to alternative access measures defined by contract specifications, leaving a sizable blind spot for understanding access in the purchased care component." Department of Defense, *Final Report to the Secretary of Defense: Military Health System Review, August 2014*, 4, accessed December 22, 2014, http://www.defense.gov/pubs/140930_MHS_Review_Final_Report_Main_Body.pdf.

[353] Department of Defense, *Final Report to the Secretary of Defense: Military Health System Review, August 2014*, 66, accessed November 7, 2014, http://www.defense.gov/pubs/140930_MHS_Review_Final_Report_Main_Body.pdf. The percentage of referrals meeting the 28-day access standard varied from 53 percent and 84 percent based on Prime Service Area (PSA), which is the area within 40 miles of an MTF. The TRICARE regional contractors are required to establish networks of providers to serve PSAs. Department of Defense, *Final Report to the Secretary of Defense: Military Health System Review, August 2014, 64*, accessed November 7, 2014, http://www.defense.gov/pubs/140930_MHS_Review_Final_Report_Main_Body.pdf.

[354] Merritt Hawkins, *Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates*, 4, accessed October 23, 2014, http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf. The metropolitan areas were Atlanta, Boston, Dallas, Denver, Detroit, Houston, Los Angeles, Miami, Minneapolis, New York, Philadelphia, Portland, San Diego, Seattle, and Washington, D.C. The specialties were cardiology, dermatology, obstetrics-gynecology, orthopedic surgery, and family practice.

[355] Merritt Hawkins, *Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates*, 6, accessed October 23, 2014, http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf.

Limited Provider Networks. Another important part of good access to care is having ample health care providers available to provide treatment. The TRICARE networks of civilian health care providers, however, are limited because TRICARE reimburses providers for health care procedures at a rate equal to or lower than the Medicare reimbursement rate.[356] According to the U.S. Government Accountability Office (GAO), "Beginning in fiscal year 1991, in an effort to control escalating health care costs, the Congress instructed DoD to gradually lower its reimbursement rates for individual civilian providers to mirror those paid by Medicare."[357] GAO also reported that although TRICARE reimbursement rates are generally limited by law to Medicare rates, "network providers may agree to accept lower reimbursements as a condition of network membership."[358] As a result of TRICARE reimbursement rates negotiated by DoD's contractors, civilian providers "would not accept new TRICARE patients even though they would accept new Medicare patients."[359]

According to the American Academy of Pediatrics, "These discounts [below Medicare rates] can be as high as 20 percent, but are usually between 10 and 15 percent."[360] Studies have found because TRICARE offers reimbursement rates below those of other health plans, some providers refrain from accepting TRICARE patients or limit the number of TRICARE patients they will treat.[361]

Provider reimbursement rates have been a concern since TRICARE was implemented in the mid-1990s.[362] Most recently, GAO studied the breadth of the TRICARE network and concluded, "Overall, during 2008-2011, an estimated one in three nonenrolled beneficiaries (about 31 percent) experienced problems finding any type of civilian provider—primary, specialty, or mental health care provider—who would accept TRICARE."[363] The most cited reason why nonenrolled beneficiaries thought they were having issues getting access to providers (whether primary care, specialty care, or mental health) was "doctors not accepting TRICARE payments."[364] When providers themselves were surveyed, the reasons for not accepting new TRICARE patients varied by provider type, but the most common reason specialty providers offered was "reimbursement."[365] DoD beneficiaries' access to a full range of high quality doctors can be limited, especially in locations that are not robust, mature health care markets.[366]

---

[356] Armed Forces, 10 U.S.C. §§ 1079(h), 1079(j), and 1086(f).
[357] Government Accountability Office, *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra*, GAO-11-500 (June 2011), 11n, accessed October 19, 2014, http://www.gao.gov/new.items/d11500.pdf.
[358] Ibid, 11.
[359] Ibid, 15.
[360] American Academy of Pediatrics, Letter to Jonathon Woodson, MD, Assistant Secretary of Defense for Health Affairs, March 27, 2014, 11, accessed October 12, 2014, http://www.autismspeaks.org/sites/default/files/docs/gr/aap_letter_on_fy13ndaa.pdf.
[361] *See, e.g.,* Government Accountability Office, *Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option*, GAO-07-48 (December 2006), http://www.gao.gov/assets/260/255029.pdf.
[362] Government Accountability Office, *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra*, GAO-11-500 (June 2011), 14, accessed October 19, 2014, http://www.gao.gov/new.items/d11500.pdf.
[363] Government Accountability Office, *Defense Health Care: TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries*, GAO-13-364, (April 2013), 18, accessed October 19, 2014, http://www.gao.gov/assets/660/653487.pdf.
[364] Ibid, 22.
[365] Ibid, 31.
[366] Economic analysis can be used to understand the effects of price controls. When price is not allowed to adjust to equalize supply and demand in a market, then the market begins to adjust along nonprice margins to clear. Markets will use the least distorting nonprice margins first (usually aspects of quality such as timeliness of access, clinical

DoD's recent consideration of reducing payment levels for certain autism services is an example of the effect reimbursement rates can have on providers' willingness to accept TRICARE patients. In September 2014, DoD announced it would reduce by 46 percent the payment rates for one-on-one therapy with board-certified behavior analysts for dependents with autism spectrum disorder.[367] As noted in a survey conducted by Navigation Behavioral Consulting, 95 percent of TRICARE providers who treat children with autism spectrum disorder indicated they would reduce the services they offer, and 22 percent declared they would stop accepting TRICARE patients entirely if the reimbursement levels were changed.[368] DoD has since announced it will postpone the change pending further analysis of the prevalent rates in the civilian sector.[369]

A leading concern among TRICARE beneficiaries is the lack of doctors available to them in the TRICARE network. For example, one respondent to the Commission's survey noted, "TRICARE for my children has been a mess. Health Care Providers drop TRICARE frequently and we have to find a new provider often."[370] The Commission found that the principal reason TRICARE networks have an insufficient number of participating doctors is low provider payments. By reimbursing doctors at rates equal to or less than Medicare levels, which are less than market rates, TRICARE has been unable to attract enough quality doctors. In contrast, commercial insurance carriers in the civilian sector offer fair-market value for physicians' services. Furthermore, the civilian health care industry is able to adjust procedure reimbursement rates in response to changes in the supply and demand of physicians, or even to incentivize doctors to provide treatment more effectively and at lower cost. In fact, if DoD were to contract with commercial insurance carriers to provide beneficiaries health care plans, it would have a method for negotiating the rate at which insurance carriers reimburse for procedures performed at MTFs. This tool, as well as the others outlined in Recommendation 5, would allow DoD to attract cases to military hospitals and clinics. For beneficiaries, having a selection of commercial insurance plans would afford them the ability to choose a plan based on network, whether that is a robust network in general or simply the network that includes a particular provider.

Choice

The Commission focused on a few elements of choice most applicable to TRICARE and consistently raised by beneficiaries. In general, the Commission found TRICARE beneficiaries would prefer greater choice in health care.

Preference for Greater Choice. A common theme the Commission heard from beneficiaries was choice. Because the medical care one receives affects each person individually, personal choice is a critical component of a health benefit. Patients can exercise choice in a variety of ways—for instance, the selection of benefits that best

---

quality, etc.) and, if all of these margins are exhausted and the market still has not cleared, ultimately refuse to take the patients. See Yoram Barzel, *Economic Analysis of Property Rights*, 2ed, (London: Cambridge University Press, 1997), for a detailed examination of the effects of price controls.

[367] Cheryl Pellerin, Defense Media Activity, "TRICARE Delays Change in Autism Reimbursement to April," *DoD News*, (October 10, 2014), accessed October 22, 2014, http://www.defense.gov/news/newsarticle.aspx?id=123387.

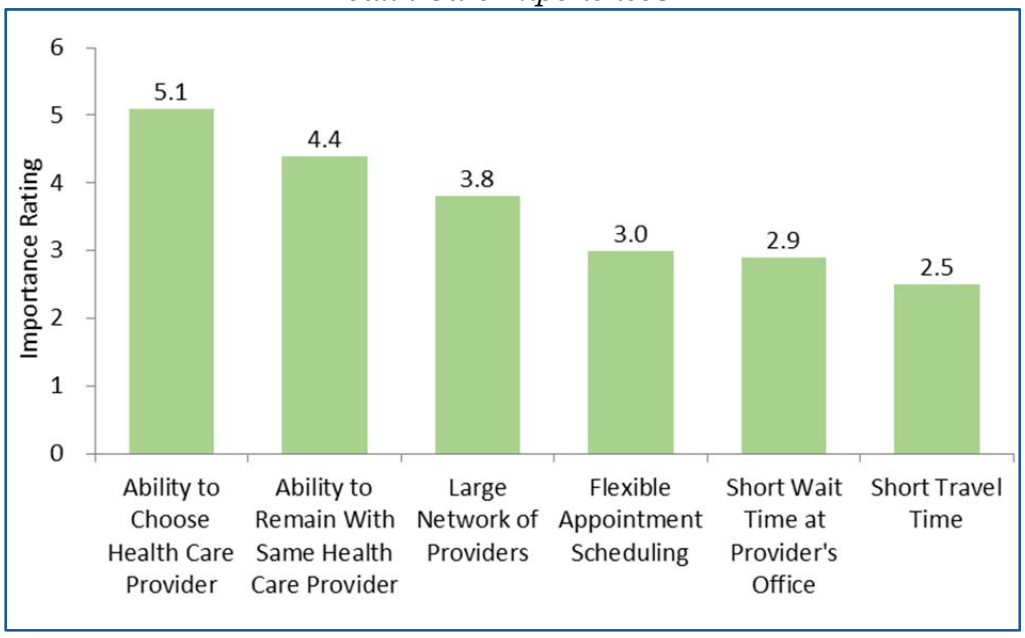
[368] Tim Devaney, "Pentagon to Delay Autism Spending Cuts," *The Hill*, (October 8, 2014), accessed October 22, 2014, http://thehill.com/regulation/defense/220215-pentagon-to-delay-autism-spending-cuts (discussing Navigation Behavioral Consulting's survey on ABA services provided by TRICARE providers, accessed January 5, 2015, http://freeonlinesurveys.com/app/rendersurvey.asp?sid=d5a987g5xf3fjca541500&refer=).

[369] Cheryl Pellerin, Defense Media Activity, "TRICARE Delays Change in Autism Reimbursement to April," *DoD News*, (October 10, 2014), accessed October 22, 2014, http://www.defense.gov/news/newsarticle.aspx?id=123387.

[370] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

meets one's medical needs, the preference for physicians, and trade-offs between a health plan's costs and features. In fact, choice was advocated in sensing sessions with the Service members and family members, write-in comments from beneficiaries, and the evidence gathered in the Commission's survey of Service members and retirees. For example, a survey respondent explained the importance of choosing one's provider: "I feel that it is very important to be able to choose a health care provider, because when you are receiving care, you begin to trust that provider. When you find a provider that KNOWS you, and what works for YOU, that is important."[371] The Commission specifically asked about several aspects of choice in its survey. For all three categories of survey respondents (AC, RC, and retirees), choice of health care provider was the highest valued attribute from a list of six health care attributes provided.[372] For AC and RC members, the second most valued attribute was access to a large network of providers, a characteristic that encourages choice (this attribute was third for retirees).[373] For retirees, the perceived value of increasing choices among health care providers, which was only one of the six health care attributes presented, was higher than the value of a 35 percent grocery discount at commissaries or a 20 percent one-time cost of living adjustment.[374] Figure 14 provides the importance ratings for retiree survey respondents for the six attributes included.

Figure 14. Retirees' Importance Ratings: Health Care Experiences[375]



The results of the Commission survey are consistent with research reported in academic literature. In a study on employer-sponsored insurance with no or very limited choice among health care plans, researchers found that workers would be willing to forfeit 16 percent of their employer-provided health care subsidies for the

[371] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[372] The six attributes were (in order of preference for AC respondents) ability to choose provider, a large network of providers, flexibility in appointment scheduling, ability to remain with same provider (continuity of care), wait times at provider office, and travel time to provider.
[373] For active AC respondents, this attribute was second in average ranking but third in median perceived value.
[374] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[375] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.

freedom to use these subsidies to obtain their choice of plan from a menu of plans.[376] This research is especially pertinent because it studied workers who have very few choices among employer-provided health care plans, sometimes only one option. This situation is similar to TRICARE. In a scenario where beneficiaries are provided very few choices of plans, "The restriction of employee choice may prevent individuals and families from selecting the healthplan that best suits their needs, and from trading off added benefits against the associated premium increases."[377]

In the civilian sector, however, it is possible to offer a variety of plans that differ in benefits covered as well as program structure, including the procedures for obtaining care. Such is the case with respect to the Federal Employees Health Benefits Program (FEHBP), a Government-sponsored health program including more than 250 health insurance plans from which Federal civilian employees select coverage.[378] Enrollees, depending on their geographic location, have at least 11 plan options in rural areas and dozens of plan choices in metropolitan areas.[379] Types of plans range from HMOs and FFS plans with PPOs to consumer-driven health plans and high-deductible health plans.[380] In the FEHBP, all plans cover medical and surgical care, mental health and substance abuse treatment, maternity care and pediatrics, preventative care including tobacco cessation (with no cost share or copayment), hospitalization and outpatient care, diagnostic and laboratory testing, physical, occupational, and speech therapy, emergency and ambulance service, and prescription drugs.[381] The plan features that do vary are monthly premiums, copayments, coinsurance, deductibles, OOP maximums, and some covered benefits such as chiropractic care, acupuncture, infertility treatments, and dental care.[382] In an arrangement like FEHBP, users would have the assurance of a core set of standard covered benefits, with the flexibility to choose among plans' coverage and program designs.

A selection of commercial health insurance plans in the style of FEHBP would greatly expand choice in health care and consequently provide beneficiaries demonstrated value, as explained above. This could be a great improvement over TRICARE's three main plans or DoD's FY 2015 proposal to consolidate TRICARE Prime, Standard, and Extra into one plan.[383]

---

[376] Leemore Dafny, Kate Ho, and Mauricio Varela, "Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and Toward an Individual Exchange," *American Economic Journal: Economic Policy*, 5, no. 1, (2013): 33, 56.
[377] Ibid, 32.
[378] Office of Personnel Management, *Federal Employees Health Benefits Program Overview*, provided to MCRMC in Executive Session, January 15, 2014. FEHBP offered 256 plan choices in 2014.
[379] Office of Personnel Management, *The 2015 Guide to Federal Benefits for Federal Civilian Employees*, revised November 2014, RI 70-1, 32, accessed November 13, 2014, http://www.opm.gov/healthcare-insurance/healthcare/plan-information/guide/2015-guides/70-1.pdf; "Healthcare Plan Information," Office of Personnel Management, accessed November 10, 2014, https://www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/.
[380] Office of Personnel Management, *Federal Employees Health Benefits Program Overview*, provided to MCRMC in Executive Session, January 15, 2013. For definitions of consumer-driven health plans and high deductible health plans, see "Plan Types," Office of Personnel Management, accessed November 10, 2014, https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-types/.
[381] Office of Personnel Management, *Federal Employees Health Benefits Program Overview*, 9, provided to MCRMC in Executive Session, January 15, 2013.
[382] Ibid, 10
[383] Office of the Undersecretary of Defense (Comptroller), *United States Department of Defense Fiscal Year 2015 Budget Request Overview* (March 2014), 5-10 – 5-14, accessed November 9, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/fy2015_Budget_Request_Overview_Book.pdf.

Uniform Benefits Coverage Restricts Beneficiary Choice. TRICARE only offers three main health care plans, but restricts choice through a one-size-fits-all approach to covered benefits and determinations of medical necessity. Currently, the military health care benefit is "a uniform program of medical and dental care for members and certain former members of [the] Services, and for their dependents."[384] Because it is a uniform benefit, the TRICARE plan includes a common set of covered benefits for 9.6 million eligible dependents, retirees, and RC members across the world.[385] DoD determines the covered benefits for all beneficiaries based on "whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the condition."[386] This uniformity of health care coverage can prevent beneficiaries from accessing certain medical treatments and services based on their individual needs. For this reason, some groups have advocated for more robust coverage of benefits under TRICARE. For example, the American Academy of Pediatrics (AAP) recently recommended that DoD broaden its benefit package for children of military members by adopting a more comprehensive regimen based on the Early and Periodic Screening, Diagnosis, and Treatment principles of care and the Bright Futures guidelines for preventative care.[387] AAP stated that DoD should change its definition of medical necessity to accommodate children's particular health care needs.[388] The Military Officers Association of America recently made the case more frankly on its website, "One size does not fit all when it comes to meeting the health care needs of our military children."[389]

The appeals process for TRICARE coverage and decisions regarding medical necessity recently have come under scrutiny for being unfair.[390] Military advocacy groups have argued that the appeals process is lengthy, confusing, and arbitrary.[391] In response to a Senate Armed Services Committee inquiry, DoD submitted a report to the Congress

[384] Armed Forces, 10 U.S.C. § 1071. The Commission understands that dental care is offered through commercial insurance.
[385] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, 12, accessed December 19, 2014, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf.
[386] Department of Defense, *TRICARE Appeals Fact Sheet*, accessed August 13, 2014, www.tricare.mil/~/media/Files/TRICARE/Publications/FactSheets/Appeals_FS.pdf.
[387] American Academy of Pediatrics, *Letter to Jonathon Woodson, MD, Assistant Secretary of Defense for Health Affairs,* March 27, 2014, 3-5, accessed October 12, 2014, http://www.autismspeaks.org/sites/default/files/docs/gr/aap_letter_on_fy13ndaa.pdf. AAP notes that TRICARE "largely mirrors the federal Medicare program, which is primarily focused on adults. (p. 3)" AAP therefore urges DoD to adopt the EPSDT standards, which are used in Medicaid and meet the specific "physical, emotional, and development needs of children (p. 4)." Bright Futures is a nationwide health-promotion and preventative-care program for infants, children, and adolescents required in section 2713 of the Affordable Care Act.
[388] American Academy of Pediatrics, *Letter to Jonathon Woodson, MD, Assistant Secretary of Defense for Health Affairs,* March 27, 2014, 3-6, accessed October 12, 2014, http://www.autismspeaks.org/sites/default/files/docs/gr/aap_letter_on_fy13ndaa.pdf.
[389] "TRICARE for Kids Stakeholders Respond to DoD Study," Military Officers Association of America, accessed October 12, 2014, http://moaablogs.org/spouse/2014/09/tricare-for-kids-stakeholders-respond-to-dod-study/.
[390] Committee on Armed Services, *Report to Accompany S. 1197, the National Defense Authorization Act for Fiscal Year 2014*, S. Rpt 113-44 (June 20, 2013), 134, accessed November 21, 2014, http://www.gpo.gov/fdsys/pkg/CRPT-113srpt44/pdf/CRPT-113srpt44.pdf.
[391] Amy Bushatz, "Report: Tricare Appeals Taking a Year," *Military.com*, (June 13, 2014), accessed November 21, 2014, http://www.military.com/daily-news/2014/06/13/report-tricare-appeals-taking-a-year.html?comp=700001075741&rank=2.

on the TRICARE appeals process, which demonstrated the confusing nature of the appeals process.[392]

DoD described how beneficiaries might appeal medical necessity decisions through a multilevel, sequential process that involves requests for the TRICARE contractor's reconsideration, peer reviews conducted by physicians, hearings, and final decisions by the Director of the Defense Health Agency (DHA). In cases when a decision will establish precedent for the TRICARE program, the Assistant Secretary of Defense for Health Affairs makes the final decision.[393]

DoD reported that during the period between 2009 and 2013, the time required for appeals to proceed from initial submission to the third level of appeal (a hearing) was an average of 346 days.[394] The longest period was 424 days in 2009.[395] The DoD report also stated that the Director of the DHA reviews all decisions resulting from appeals hearings and either adopts, rejects, or in the case of setting precedent refers the decision to the Assistant Secretary of Defense for Health Affairs.[396] Between 2009 and 2013, 15 percent of hearings were overturned at higher levels.[397] "Military healthcare advocates called Tricare's ability to simply overturn a hearing officer's decision potentially 'arbitrary.' "[398]

TRICARE's one-size-fits-all approach to covered benefits would not exist if DoD instead offered a program that presented a variety of options in commercial insurance plans. There are clear benefits to having alternatives among plans. When beneficiaries are able to pick their ideal plan from a selection of many offerings, they are empowered to choose from among the different plans' benefits coverage so as to best address their medical needs. Whether or not a procedure is medically necessary would no longer be a DoD decision.

Undesirable Choices for Reserve Component. The Commission found that RC members are faced with difficult choices during mobilization and demobilization. These transitions can be costly for the RC families and disruptive to their health care coverage, especially for Service members who are mobilized in support of a mission that is not a contingency operation. Currently, when RC members are ordered to active duty for more than 30 consecutive days, they and their families gain access to the health and dental benefits of active-duty Service members and their dependents.[399] If mobilized in support of contingency operations, RC members may be eligible for active-duty health benefits starting up to 180 days prior to the date that the active-

[392] Committee on Armed Services, *Report to Accompany S. 1197, the National Defense Authorization Act for Fiscal Year 2014*, S. Rpt 113-44 (June 20, 2013), 134, accessed November 21, 2014, http://www.gpo.gov/fdsys/pkg/CRPT-113srpt44/pdf/CRPT-113srpt44.pdf.
[393] Department of Defense, *TRICARE Appeal Process in Fiscal Year 2014: Report to Congress*, June 4, 2014, accessed August 13, 2014, http://www.tricare.mil/tma/congressionalinformation/report_cong.aspx.
[394] Ibid, 6.
[395] Ibid, 6
[396] Ibid, 4
[397] Ibid, 7.
[398] Amy Bushatz, "Report: Tricare Appeals Taking a Year," *Military.com*, (June 13, 2014), accessed November 21, 2014, http://www.military.com/daily-news/2014/06/13/report-tricare-appeals-taking-a-year.html?comp=700001075741&rank=2.
[399] Armed Forces, 10 U.S.C. §§ 1074, 1074a, and 1076a. Defense Health Agency, *TRICARE Dental Options Fact Sheet*, accessed December 10, 2014, http://www.tricare.mil/CoveredServices/Dental/NGRDental.aspx. "Dental Plans," Defense Health Agency, accessed June 20, 2014, http://www.tricare.mil/Plans/DentalPlans.aspx.

duty service begins.[400] Similarly, RC members who are demobilized from active duty after supporting a contingency operation for more than 30 days are eligible for continued health care benefits for 180 days under the Transition Assistance Management Program (TAMP). [401]

The Commission has learned the practical effect of this authorized benefit can pose great challenges to RC members when they mobilize and demobilize and are moved on and off the TRICARE system. For example, the family of an RC member who has a private-sector job and employer-sponsored insurance for which the member pays a share of the insurance premium could, upon mobilization, transition to TRICARE or remain on its existing health care plan. Either of these options has the potential to burden the family. If the family transitions to TRICARE, it risks the loss of continuity of care if the family's existing health care providers do not accept TRICARE. Continuity again may be lost when the Service member demobilizes and the member and family have to transition back to their civilian health insurance plans. Conversely, if the family stays on an existing health care plan, it risks trading additional, sometimes substantial, costs for continuity of care. In this option, the RC member must continue to pay the employee's share of the insurance premium. In cases where the employer stops paying the employer's share of the premium, the RC member would need to fully fund the existing health insurance. This situation could result in substantial financial hardship for RC members while they are serving on active duty.

These issues experienced during transition periods are even more severe when the RC member is not supporting a contingency operation. In such cases, TAMP benefits are unavailable,[402] so TRICARE coverage ends abruptly upon demobilization. This situation could result in a break in coverage until coverage can resume under the civilian health insurance plan.

Given the hardships RC families experience when their sponsors mobilize and demobilize, it is worth considering a different approach to health care for the RC. In particular, providing RC members access to commercial health insurance may better suit their families' needs and the unique RC experience. Instead of the current TRICARE program, a menu of DoD-sponsored commercial health insurance plans could more closely resemble the plans offered through RC members' employers, especially with regard to provider networks. A DoD-sponsored commercial insurance plan could allow for an easier transition with better continuity of care during mobilization because it is more likely the RC families' current physicians would participate in traditional commercial insurance networks than the TRICARE network for two reasons.

First, as demonstrated earlier, TRICARE's low reimbursement rates cause less participation among providers. Second, health care markets, including their supply of doctors and the rates for procedures, vary substantially by geographic location.[403]

---

[400] Armed Forces, 10 U.S.C. § 1074. Department of Defense, *TRICARE Choices for National Guard and Reserve at a Glance*, 3, accessed December 22, 2014, http://tricare.mil/~/media/Files/TRICARE/Publications/BrochuresFlyers/NGR_Choices_Brochure.pdf. The date that active-duty service begins is registered in the Defense Enrollment Eligibility Reporting System (DEERS).

[401] Armed Forces, 10 U.S.C. § 1145 (a)(1), a(4). National Defense, 32 CFR 199.3(e).

[402] Armed Forces, 10 U.S.C. § 1145 (a)(1), a(4). National Defense, 32 CFR 199.3(e).

[403] As an illustration of how local health care markets vary, see the California Health Care Foundation's (CHCF's) research on six communities in California. CHCF's study determined that the six regions represent diverse health care landscapes due to the local characteristics of health care, including differences in economic, demographic, health care

Whether commercial health insurance carriers operate nationally, regionally, or locally, they specialize in organizing networks and delivering health care suited to local markets. A selection of commercial insurance plans is more likely than TRICARE to reflect the conditions of the local health care market, including a network that incorporates available doctors. Moreover, DoD is considering the further centralization of its TRICARE regional contracts from three regions (North, South, and West) to two (East and West),[404] even though many assert that health care is local.[405] Offering RC Service members commercial health insurance could greatly enhance their access to doctors and strong networks of providers.

Alternatively, to aid the financial burden RC members experience when they purchase their existing civilian health care plan during service on active duty, DoD could fund part of the RC member's existing health insurance plan instead of requiring transition to the DoD-sponsored commercial insurance program.[406] The National Military Family Association testified before the Commission, "instead of trying to jerry rig a TRICARE benefit in rural Pennsylvania [for example] where there isn't the provider knowledge about TRICARE, where we are forcing families to change health plans at a time when they already are experiencing enough stress, let's look for a way to stay with what they have because that community understands them. They are used to their providers. Their providers are used to their medical condition. So we would recommend for those Guard and Reserve families the option of just having some subsidy to remain on their employer-sponsored plan."[407]

Both solutions would resolve the issues RC members experience during mobilization and demobilization, which in turn could reduce the financial hardship for those who pay the total premium and improve the continuity of care they enjoy from their current physicians and preferred health care plans.[408] Even when not transitioning to active duty, a DoD-sponsored commercial insurance plan could provide a better benefit to eligible members of the RC who purchase health care through the DoD.[409] Instead of relying on particularly meager TRICARE provider networks in rural areas far from military installations, RC members would have the opportunity to select from several commercial health insurance plans operating in their area. Providing better choices to the RC, as well as improving other beneficiaries' choice of benefits and plans, could greatly enhance the health benefit available to AC families, the RC, and non-Medicare-eligible retirees.

---

delivery, and health care pricing variables. "Briefing—All Health Care Is Local: California's Diverse Health Economies," California Health Care Foundation, accessed October 23, 2014, http://www.chcf.org/events/2012/briefing-health-care-local. "Local Markets," California Health Care Foundation, accessed December 19, 2014, http://www.chcf.org/almanac/regional-markets.

[404] Defense Health Agency, *TRICARE Managed Care Support T2017*, draft request for proposal in preparation of a future TRICARE Managed Care Support Solicitation T2017, November 4, 2014, accessed November 9, 2014, https://www.fbo.gov/index?id=9535ef216d4e0fa956ea10f9cb4076be.

[405] *See, e.g.,* "Briefing—All Health Care Is Local: California's Diverse Health Economies," California Health Care Foundation, accessed October 23, 2014, http://www.chcf.org/events/2012/briefing-health-care-local.

[406] Under the current system, when RC Service members are mobilized and become eligible for TRICARE, some RC families choose to stay on their civilian health plans, absorbing the cost of the employee's portion of the monthly premium and sometimes the total premium. Total premium refers to both the employee's and employer's share of the premium.

[407] Joyce Raezer, National Military Family Association, testimony given at MCRMC public hearing, Fort Belvoir, Virginia, November 4, 2013, 30, http://www.mcrmc.gov/index.php/schedule.

[408] Total premium refers to both the employee's and employer's share of the premium.

[409] These Service members purchase TRICARE Reserve Select or TRICARE Retired Reserve. National Defense, 32 CFR 199.24 and National Defense, 32 CFR 199.25.

Value

The Commission also determined TRICARE needed improvement with respect to value. Value, as it is used in this report, is described as a high quality health benefit that is provided efficiently. Certain structural aspects of the TRICARE program, including its contracting procedures, its restrictive framework that prevents adaptation, and its lack of tools to limit over-utilization of services, have hindered efficient operations.

Complexity in Contracting. Under TRICARE, there are three regional contractors in the North, South, and West regions of the United States that manage health care operations purchased through civilian providers.[410] The process by which TRICARE's contracts are awarded is complicated, prolonged, and characterized by protests and delays. These contracting delays result in increased program costs.

DoD's process for awarding the three most recent TRICARE managed care support contracts (MCSCs) for the North, South, and West regions began in 2008.[411] Each contract award was protested by unsuccessful bidders. These protests were upheld, triggering corrective actions that resulted in new award decisions in all three regions.[412] The new award decisions were further protested in two of the three regions.[413] Although the new TRICARE contracts were originally scheduled to start in 2010, these repeated protests were not resolved until 2013.[414] "As a result of the bid protest process and [TRICARE Management Activity's (TMA)] implementation of corrective actions to address the issues in the sustained bid protests, the performance periods of the finalized MCSCs are no longer aligned. According to a TRICARE program official, the performance periods for the MCSCs are expected to end in 2015 in the North region, in 2017 in the South region, and in 2018 in the West region."[415] Contracting costs are expected to increase because option years will need to be exercised to align the MCSCs' end dates.[416]

The TRICARE contracting process has also adversely affected patient experience due to difficult transitions between regional contractors. For example, in April 2013 following the transition to UnitedHealth in the TRICARE West region, beneficiaries experienced issues with referral authorization and customer service.[417] The California Medical Association conducted a survey of 321 practices that represented more than 27 different specialties. The study found that 75 percent of practices reported problems during the transition to UnitedHealth, including difficulty processing authorizations and referral requests. Forty-two percent of those practices that had issues with the transition indicated transition issues negatively affected patient

[410] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, 5, accessed November 4, 2014, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf.
[411] Government Accountability Office, *Defense Health Care: Acquisition Process for TRICARE's Third Generation of Managed Care Support Contracts*, GAO-14-195, (March 2014), 5, accessed October 20, 2014, http://www.gao.gov/products/GAO-14-195 (discussing protests by Health Net Federal Services, LLC (B-401652); Humana Military Healthcare Services (B-401652.2, et al.); Health Net Federal Services, LLC (B-401652.3 and B-401652.5); and, United Health Military Veterans Services (agency-level protest)).
[412] Ibid, 15.
[413] Ibid, 15.
[414] Ibid, 5.
[415] Ibid, 20.
[416] Ibid, 20.
[417] Ibid, 20-21.

care.[418] The problems in the delivery of the TRICARE benefit grew so severe that DoD eventually stepped in to provide temporary relief by permitting TRICARE Prime beneficiaries in the West region to see specialists without prior authorization from the managed care support contractor in that region.[419] According to GAO, "Despite these difficulties, approximately 10 months after the start of health care delivery, TMA paid UnitedHealth the remainder of its $10 million transition-in payment after UnitedHealth completed its transition requirements."[420] In GAO's assessment of the transition of MCSCs in the West region, it found "numerous deficiencies in TMA's guidance and oversight" that led to a "complacent approach by [TRICARE Regional Office-West] officials, who did little to hold the contractor accountable during the transition."[421]

The TRICARE contracting process has also contributed to the deterioration of beneficiary access to medical providers. As mentioned above, TRICARE contractors negotiate provider reimbursement rates that are lower than Medicare rates. This situation reduces costs for DoD, but it also reduces access to care for TRICARE beneficiaries. In addition, DoD's TMA decided to reduce TRICARE Prime service areas effective October 1, 2013.[422] This decision also reduced DoD health care costs by further restricting access for beneficiaries. A modernized military health benefit should rely on a more streamlined contracting process that promotes, rather than further restricts, health care access and benefit quality.

Slowness in Adapting to New Models and Innovation. In addition to the challenges noted above that are brought about by the complexity of the TRICARE contracts, the program is also limited in its infusion of new ideas from the private sector, which inhibits the adoption of the latest technological, clinical, or business advancements in the medical industry. This situation can negatively affect beneficiaries, as they are sometimes unable to access the medical technology, procedures, or treatments available to civilians who have private-sector health insurance.

In 2013 beneficiaries receiving care in the TRICARE network lost access to molecular screening for conditions such as cystic fibrosis, Fragile X Syndrome, spinal muscular atrophy, and some cancers due to a technical requirement in the TRICARE contracts. TRICARE discontinued coverage of more than 100 molecular diagnostic tests because these tests were assigned new medical procedure codes that classified them as medical devices.[423] Under the TRICARE regional contracts, DoD will only cover medical

---

[418] "CMA Member Survey Confirms Significant Problems with TRICARE Transition," California Medical Association, accessed October 20, 2014, http://www.cmanet.org/news/detail/?article=cma-member-survey-confirms-significant.
[419] "TRICARE Eases Authorization Rules for West Region Beneficiaries," TRICARE Public Affairs Office, (May 7, 2013), accessed October 20, 2014, http://www.tricare.mil/About/MediaCenter/News/Archives/5_7_13_WestAuthorizations.aspx?p=1.
[420] Government Accountability Office, *Defense Health Care: More-Specific Guidance Needed for TRICARE's Managed Care Support Contractor Transitions*, GAO-14-505, (June 2014), 22, accessed November 20, 2014, http://www.gao.gov/assets/670/664196.pdf.
[421] Ibid.
[422] "TRICARE Moves Forward With Prime Service Area Reductions," Department of Defense, accessed December 17, 2014, http://www.defense.gov/news/newsarticle.aspx?id=120590.
[423] American Clinical Laboratory Association, *Statement submitted for the record, "Defense Health Agency," Hearing before the Subcommittee on Military Personnel, Armed Services Committee, U.S. House of Representatives, February 26, 2014*, accessed December 15, 2014, http://docs.house.gov/meetings/AS/AS02/20140226/101786/HHRG-113-AS02-20140226-SD001.pdf.

devices if the Food and Drug Administration (FDA) has approved them, yet the FDA does not review or approve genetic tests.[424]

What might appear like an abstruse coding policy, in reality, has great consequences for the health benefit available to military families. These tests are considered the standard of care by many professional guidelines.[425] According to the American Clinical Laboratory Association, "Molecular diagnostic tests represent the ever-advancing forefront of diagnostic medicine, and ensure that patients receive appropriate treatment. Without such testing, TRICARE beneficiaries will receive care that is inferior to that available to the general public."[426]

Because the molecular tests continued to be covered at MTFs, this restrictive policy also created disparity among beneficiaries who use the on-base military health system and those who rely on TRICARE's networks of purchased care.[427] Moreover, the policy change was not properly communicated to providers and beneficiaries, who continued to use the tests without reimbursement.[428] In response, the DHA is establishing a demonstration program under which 40 of the lab tests will again be covered under TRICARE.[429] DHA will also form a panel of in-house experts to review other genetic tests for safety and effectiveness.[430] This ad-hoc resolution, which does not fully address the scope and magnitude of this issue, required intervention by dozens of members of the Congress, military service organizations, and nonprofit health advocacy groups.[431]

---

[424] Tom Philpott, "Tricare to Restore Coverage for up to 40 Genetic Lab Tests," *Stars and Stripes*, (July 10, 2014), accessed October 23, 2014, http://www.stripes.com/news/us/tricare-to-restore-coverage-for-up-to-40-genetic-lab-tests-1.292815.

[425] For example, "Cystic Fibrosis testing is the Standard of Care under the VA/DoD Clinical Practice Guideline for Management of Pregnancy and the American Congress of Obstetricians and Gynecologists' (ACOG) Guidelines. Furthermore, accurate EGFR mutation testing has been shown to both lower treatment costs and improve patient outcomes in non-small cell lung cancer (NSCLC), and is recommended for all NSCLC patients prior to initiating chemotherapy in the National Comprehensive Cancer Network (NCCN) guidelines." American Clinical Laboratory Association, *Statement submitted for the record, "Defense Health Agency," Hearing before the Subcommittee on Military Personnel, Armed Services Committee, U.S. House of Representatives, February 26, 2014*, accessed December 15, 2014, http://docs.house.gov/meetings/AS/AS02/20140226/101786/HHRG-113-AS02-20140226-SD001.pdf.

[426] Ibid, 2.

[427] Richard Burr, Kay Hagan, James Inhofe, et al. (letter signed by 51 senators and representatives), letter to Secretary Hagel, February 27, 2014, accessed October 23, 2014, http://www.burr.senate.gov/public/_files/LDTLetter.pdf.

[428] Ibid. Note that DoD has authorized retroactive reimbursement to beneficiaries and laboratories for the approximately 40 genetic tests it now covers through the Defense Health Agency Evaluation of Non-United States Food and Drug Administration Approved Laboratory Developed Tests Demonstration Project. "TRICARE Set to Cover Laboratory Developed Tests," Defense Health Agency, accessed October 23, 2014, http://www.health.mil/News/Articles/2014/08/15/TRICARE-Set-to-Cover-Laboratory-Developed-Tests.

[429] Tom Philpott, "Tricare to Restore Coverage for up to 40 Genetic Lab Tests," *Stars and Stripes*, (July 10, 2014), accessed October 23, 2014, http://www.stripes.com/news/us/tricare-to-restore-coverage-for-up-to-40-genetic-lab-tests-1.292815.

[430] Ibid.

[431] *See, e.g.,* Senator Kay Hagan, *Department of Defense Authorization of Appropriations for Fiscal Year 2015 and the Future Years Defense Program,* from U.S. Senate, March 5, 2014, accessed January 12, 2015, http://www.armed-services.senate.gov/imo/media/doc/14-13%20-%203-5-14.pdf. Richard Burr, Kay Hagan, James Inhofe, et al. (letter signed by 51 senators and representatives), letter to Secretary Hagel, February 27, 2014, accessed October 23, 2014, http://www.burr.senate.gov/public/_files/LDTLetter.pdf. "TRICARE to Restore Coverage for Some Lab Developed Tests," National Military Family Association, accessed October 23, 2014, http://www.militaryfamily.org/feature-articles/tricare-to-restore-coverage.html. American Clinical Laboratory Association, *Statement submitted for the record, "Defense Health Agency," Hearing before the Subcommittee on Military Personnel, Armed Services Committee, U.S. House of Representatives, February 26, 2014*, accessed December 15, 2014, http://docs.house.gov/meetings/AS/AS02/20140226/101786/HHRG-113-AS02-20140226-SD001.pdf. "TRICARE Letter from Genetic Alliance to House and Senate Armed Services Committee Leadership," Genetic Alliance, accessed October 23, 2014, http://www.acla.com/tricare-letter-from-genetic-alliance-to-house-and-senate-armed-services-committee-leadership/.

In 2014, the Congress passed legislation that authorized TRICARE to provide provisional coverage for emerging medical services and supplies.[432] This provisional coverage, however, lasts only 5 years and DoD may cancel it at any time.[433] After the 5-year period when provisional coverage of a medical service or supply expires, DoD is authorized to determine what coverage, if any, TRICARE will include.[434] Although this provisional coverage provides beneficiaries some access to medical innovations, it does not address fully the slowness with which TRICARE incorporates emerging techniques and technology from the medical industry.

In addition to innovations in technology and clinical treatments, the health care industry's systems for paying for and delivering care are also evolving more rapidly than TRICARE. Traditionally, payment and delivery models have been based on either the fee-for-service concept, for which every office visit, hospital procedure, and laboratory test generates an individual claim, or the health maintenance organization concept that coordinates comprehensive services in return for a prepaid, fixed charge. However, in the civilian health care sector, the differentiation between types of plans has become increasingly less distinct.[435] In particular, managed care, with techniques like financial incentives and treatment protocols, has become more common across the industry.[436] Currently there is an upswing in the use of reimbursement systems that are based on value over volume.[437] By employing value-based models, the industry has been able to incentivize physicians and hospitals to coordinate care, avoid unnecessary procedures, produce better health outcomes, and ultimately reduce costs.[438] TRICARE, by contrast, remains tied to the FFS and HMO models.[439] Under a menu of commercial health insurance plans, however, as the industry evolves to use new techniques in payment and delivery of care, the DoD health care program could also achieve better value.

As an illustration of TRICARE's structural issues, NAHCB informed the Commission of TRICARE's outdated delivery model and processes. Specifically, "TRICARE has not kept pace with advances in mental health care delivery, remaining locked in an

---

[432] Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015, H.R. 3979, section 704, accessed December 15, 2014, https://www.congress.gov/bill/113th-congress/house-bill/3979/text.
[433] Ibid.
[434] Ibid.
[435] Kaiser Family Foundation and Health Research & Educational Trust, *How Private Health Coverage Works: A Primer—2008 Update*, 4, accessed October 24, 2014, http://kff.org/health-costs/issue-brief/how-private-health-coverage-works-a-primer/.
[436] Ibid.
[437] "In an effort to control the growth of health care costs, risk-based [or value-based] reimbursement methodologies are slowly replacing fee-for-service as the predominant means through which physicians and providers will be paid." Catherine I. Hanson, "Introduction: Evaluating and Negotiating Emerging Payment Options," in *Evaluating and Negotiating Emerging Payment Options* (Chicago, IL: American Medical Association, 2012), 1.
[438] Value-based models include capitation, bundled payments, shared savings agreements, and pay-for-performance structures. Wes Cleveland, "Capitation," in *Evaluating and Negotiating Emerging Payment Options* (Chicago, IL, American Medical Association, 2012). Edgar Morrison Jr., "Bundled Payments," in *Evaluating and Negotiating Emerging Payment Options* (Chicago, IL, American Medical Association, 2012). Wes Cleveland, "Shared Savings Proposals," in *Evaluating and Negotiating Emerging Payment Options* (Chicago, IL, American Medical Association, 2012). Steve Ellwing, "Pay-for-Performance Programs," in *Evaluating and Negotiating Emerging Payment Options* (Chicago, IL: American Medical Association, 2012). Robert Barbour, "How to Establish Your Baseline Costs," in *Evaluating and Negotiating Emerging Payment Options* (Chicago, IL, American Medical Association, 2012).
[439] Defense Health Agency, Office of General Counsel, *Military Health System (including TRICARE and the TRICARE Program): Summary of Statutory Limits,* revised March 4, 2014, e-mail to MCRMC, March 11, 2014. According to the Office of General Counsel at the Defense Health Agency, "The TRICARE program (as implemented in 32 CFR § 199.17) has a 'triple option' structure: Standard is the default fee-for-service entitlement (10 U.S.C. §§ 1079, 1086 and 1097), Extra is the Preferred Provider Option (10 U.S.C. §§ 1079(n) and 1097(a)(2)), and Prime is the enhanced Uniform HMO Benefit option added by NDAA FY1994 § 731 and satisfying the separate requirements of the DoD Appropriations Act of 1994, § 8025 (10 U.S.C. §§ 1097(a)(1) and 1097a)."

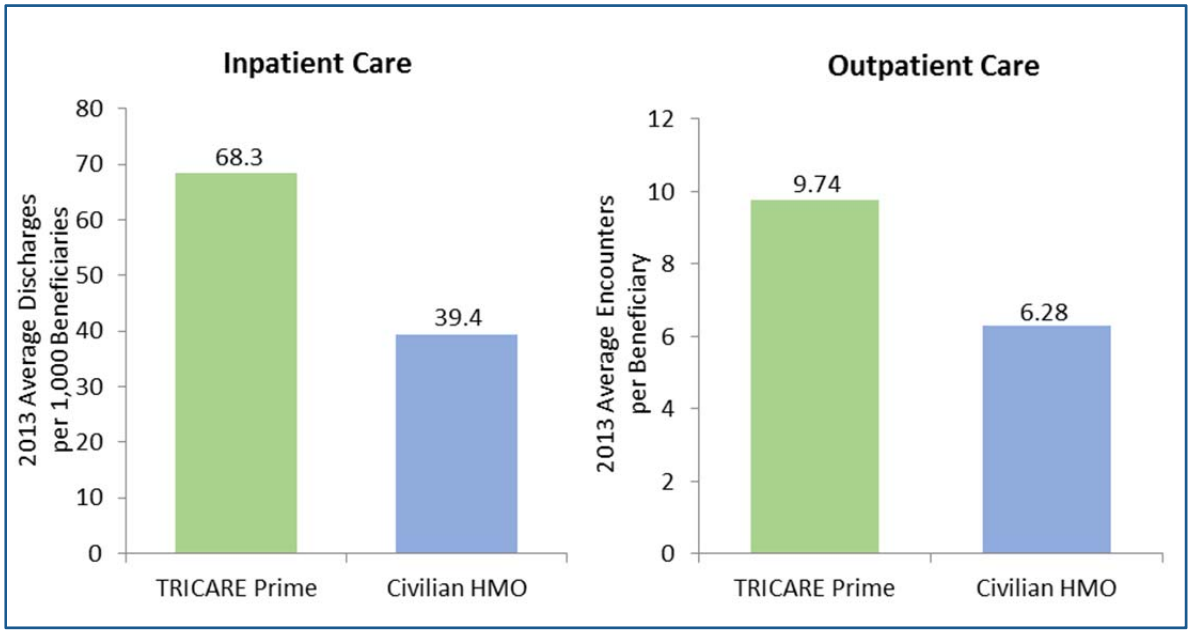
antiquated medical model. For example, TRICARE requirements for psychiatric residential treatment have not been updated in decades and include standards that are more prescriptive than any other public or private payer's, as well as more expensive to implement with no demonstrable relation to quality or effectiveness."[440] NAHCB emphasized these overly burdensome, outdated, and unnecessary TRICARE standards and processes discourage providers from participating in TRICARE networks.[441] This problem is in addition to TRICARE's use of below-market-value reimbursement rates that have already diminished provider participation in TRICARE, as was explained above.

Health care is a constantly changing industry. The features of health care, including technology and the models for paying for and delivering care, rapidly evolve. Rather than attempting to replicate a private-sector health care system within DoD, and consequently following behind, the Commission believes beneficiaries would be better served by having direct access to the innovations found in private-sector health care. Furthermore, under commercial insurance, carriers have the tools, including the advancements in payment and delivery models mentioned above and the monetary and nonmonetary incentives described below, to increase value by operating more efficiently.

Insufficient Tools to Manage Utilization. TRICARE beneficiaries use health care services at a significantly higher rate than do people with civilian health insurance plans. As shown in Figure 15, enrollees in TRICARE Prime during FY 2013 used inpatient services 73 percent more than civilians with HMOs.[442] Similarly, TRICARE Prime outpatient utilization rates were 55 percent higher than their civilian counterparts.[443]

[440] National Association for Children's Behavioral Health, letter to MCRMC, 1, July 31, 2014. "The TRICARE standards keep licensed, accredited, willing providers out of the network by their imposition of overly medical standards, an institutional treatment environment, a lengthy and expensive application process, and the requirement that TRICARE standards be applied to all children and adolescents in the same residential unit as a TRICARE beneficiary, regardless of who is paying for their care."
[441] Ibid.
[442] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, 74, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf.
[443] Ibid, 79.

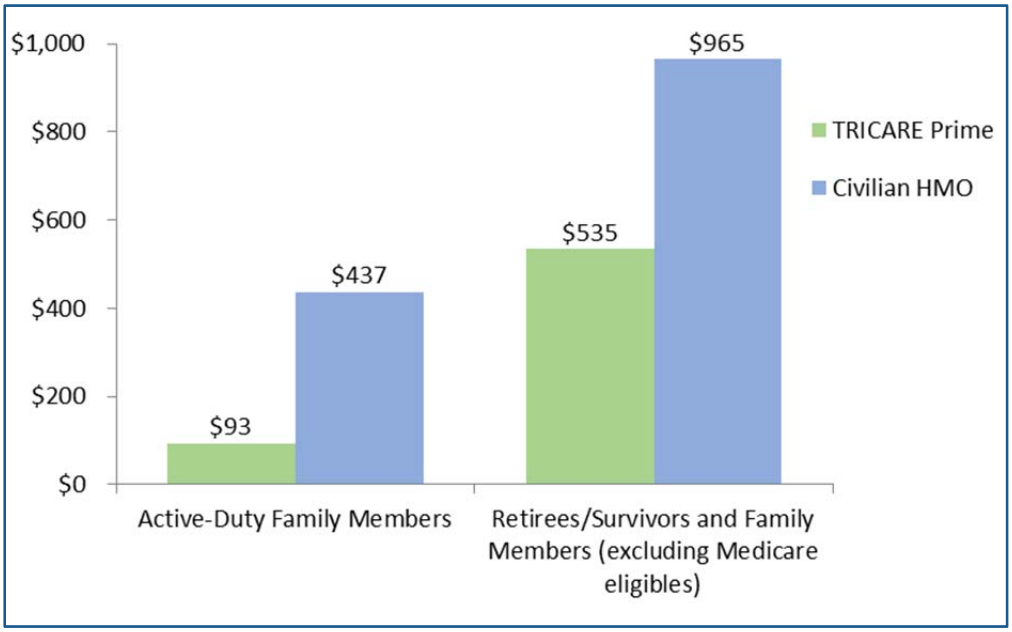
Figure 15. Utilization in TRICARE Prime and Civilian HMOs, FY 2013[444]



TRICARE is unable to effectively manage the rate at which users consume health care because it has limited use of monetary and nonmonetary incentives to influence beneficiaries' behavior and promote better health outcomes. One reason utilization is substantially greater in TRICARE than in the civilian sector is the relatively low OOP expenses—copayments, deductibles, and coinsurance—experienced by TRICARE beneficiaries compared to their civilian counterparts. A military retiree enrolled in TRICARE Prime pays nothing for an outpatient visit if it occurs at an MTF and $12 for providers in the purchased care network.[445] Civilians pay an average of $24 for a primary care outpatient visit in private sector employer-provided plans.[446] The total effect of these differences is that average OOP costs paid in a year are significantly less for a TRICARE beneficiary than for their civilian counterparts, as shown in Figure 16.

[444] Ibid, 74, 79. TRICARE Standard and Extra users have 2.5 times the inpatient utilization than their civilian PPO counterparts, but actually have 32 percent less outpatient utilization (see pages 75 and 80, respectively, of *Evaluation of the TRICARE Program*).
[445] "Prime Network Copayments," Defense Health Agency, accessed December 19, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/PrimeOptions/Copayments.aspx.
[446] Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2014 Annual Survey*, 139, accessed October 1, 2014, http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report.

Figure 16. Average Deductible and Copayment Amounts in TRICARE Prime and Civilian HMOs, FY 2013[447]



If cost shares for DoD beneficiaries were to increase in conjunction with modernization of the military health benefit, this could reduce overall compensation. Raising beneficiaries' costs for health benefits without any compensating change elsewhere would drive a reduction in their total level of military compensation. Civilian health care innovation, however, has developed tools to address this problem. To involve patients in decisions of health care usage and expenses, the civilian health care sector has developed various funding mechanisms like health savings accounts, flexible spending arrangements, and health reimbursement arrangements.[448] DoD's use of allowances for subsistence and housing provides precedent for implementing a similar type of mechanism for military beneficiaries.

While OOP costs are an important tool the health care sector uses to manage consumption of services, they usually are used together with nonmonetary tools to achieve greater results. Nonprice methods lower utilization by, among other things, preventing hospital admissions, shortening inpatient stays, and avoiding readmission. Many argue these techniques also can lead to better health care outcomes through disease management, wellness, and better coordination of care.

An important example of these available techniques is provided by the U.S. Family Health Plan (USFHP), which is a DoD program that offers an alternative to TRICARE Prime in six areas of the country. Beneficiaries enroll in USFHP, pay Prime rates, and

[447] Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress*, 90, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf. Active-duty family members who are Standard and Extra users pay about 46 percent less in deductibles and copayments than their civilian PPO counterparts, and retirees and survivors pay about 28 percent less (see page 92 of *Evaluation of the TRICARE Program*).

[448] See Internal Revenue Service, *Health Savings Accounts and Other Tax-Favored Health Plans, IRS Publication 969*, accessed November 5, 2014, http://www.irs.gov/pub/irs-pdf/p969.pdf.

receive all their care through networks of community-based health care systems.[449] Enrollees who use the USFHP program experience the same copayment structure as TRICARE Prime enrollees,[450] but are in "population health" managed care plans.[451] In other words, USFHP shares the same price tools as the TRICARE Prime program but has at its disposal nonprice tools to manage patient care. These nonmonetary tools include strategies such as identifying high-risk patients, managing complex cases, keeping chronic diseases under control, and promoting wellness and preventative services.[452] The goals of these nonprice tools are to lower avoidable inpatient admissions, prevent inpatient readmissions, shorten the length of stay in hospitals, and reduce emergency room and urgent care visits.[453]

For example, all USFHP designated providers use a 24-hour telephone hotline that gives patients access to nurses or primary care doctors who offer general health information, self-care instructions, assistance scheduling next-day clinic appointments, and advice on whether to use emergency services immediately.[454] Additionally, registered-nurse case managers identify frequent users of emergency services (three or more visits in a year), follow up with the patients to assist them with care and medications, and refer the frequent users to high risk patient care programs if applicable.[455] As a result of these and other nonmonetary techniques, USFHP has found that its participants have 33 percent fewer inpatient days and 28 percent fewer emergency room visits than TRICARE Prime enrollees.[456]

Currently, TRICARE does not employ the complete range of price and nonprice techniques to affect beneficiary behavior and health care outcomes. At the Commission's public hearing in San Antonio, Texas, on January 7, 2014, a representative from Humana Government Business, which holds the TRICARE MCSC in the South region, provided examples of the tools Humana uses in its commercial insurance plans. These include both monetary and nonmonetary incentives to influence beneficiary behavior, such as reduced deductibles and earning iPods for healthy behavior.[457] When asked if Humana was able to use these tools from their commercial practice as part of their TRICARE contract, the Humana representative answered that TRICARE prohibits the MCSCs from incentivizing beneficiaries or

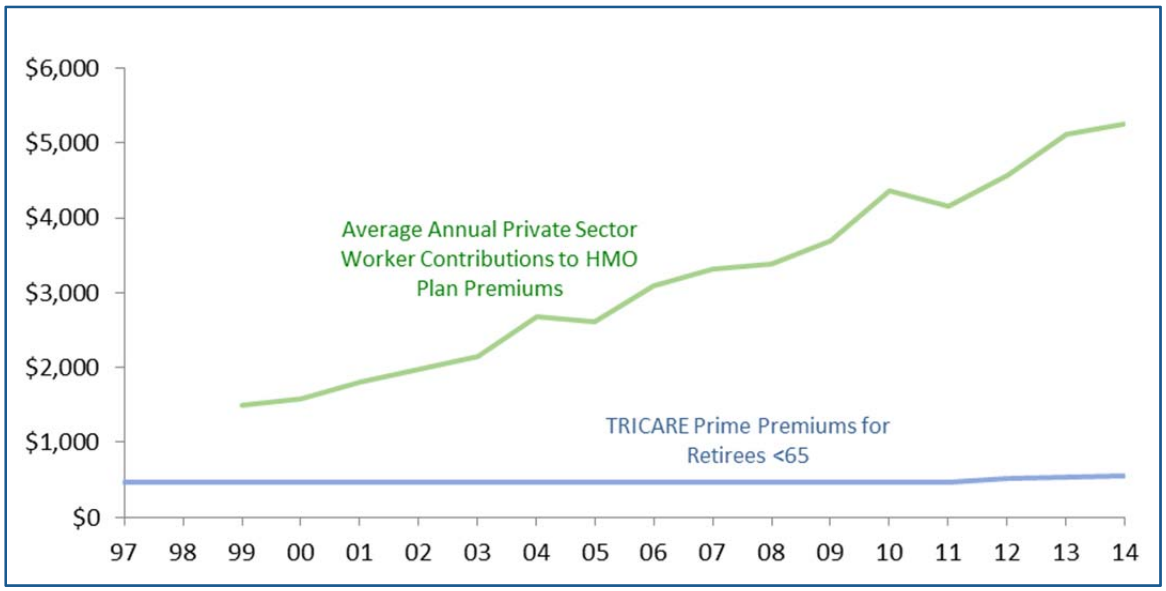
---

[449] For information on USFHP, see MCRMC, *Interim Report*, 86-87, accessed October 11, 2014, http://www.mcrmc.gov/public/docs/reports/MCRMC-Interim-Report-Final-HIRES-L.pdf.
[450] National Defense Authorization Act for FY 1997, Pub. L. No. 104-201, § 726, 110 Stat. 2422, 2596 (1996). "How does the US Family Health Plan compare to TRICARE Prime?" US Family Health Care, accessed April 14, 2014, http://www.usfhp.net/ask.asp#1. "TRICARE USFHP Enrollment Fees," US Family Health Plan, accessed June 20, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/USFHP/EnrollmentFees.aspx. "TRICARE USFHP Copayments," US Family Health Plan, accessed June 20, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/USFHP/NetworkCopayments.aspx. "TRICARE Prime Enrollment Fees," Defense Health Agency, accessed June 20, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/PrimeOptions/EnrollmentFees.aspx. "TRICARE Prime Network Copayments," Defense Health Agency, accessed June 20, 2014, http://www.tricare.mil/Costs/HealthPlanCosts/PrimeOptions/Copayments.aspx.
[451] US Family Health Plan Alliance, letter to MCRMC, October 6, 2014.
[452] Ibid.
[453] US Family Health Plan Alliance, *Managed Care Approach Narrative*, memorandum to MCRMC staff, 1, received July 7, 2014.
[454] Ibid, 3.
[455] Ibid, 1.
[456] Inpatient hospital utilization equaled 400 days for USFHP and 600 days for TRICARE Prime (measured in days per 1,000 beneficiaries). Emergency room utilization equaled 325 visits for USFHP and 451 visits for TRICARE Prime (measured in visits per 1,000 beneficiaries). US Family Health Plan Alliance, letter to MCRMC, October 6, 2014.
[457] Sandra Delgado, Interim Chief Medical Officer for Humana Government Business, testimony given at MCRMC public Hearing, 22-23, San Antonio, TX, January 7, 2014 http://www.mcrmc.gov/public/docs/meetings/20140107/MCRMC_JBSH_7_Jan_14_AM_2.pdf.

providers.[458] With regard to "the ability for a managed-care support contractor to incentivize beneficiaries to take ownership over their own health, as many other commercial health plans currently do, [i]t's something that [MCSCs] are prohibited from doing. We cannot incentivize a beneficiary to take responsibility over their health."[459]

Monthly premiums generally do not affect the day-to-day utilization of services the way OOP expenses do, but it is worth noting TRICARE's unique situation with its enrollment fees. First, active-duty families and retirees do not pay an enrollment fee, or premium, for TRICARE Standard or Extra. Second, TRICARE Prime enrollment fees have largely remained constant for decades. For retirees younger than age 65 enrolled in TRICARE Prime, annual premiums were set in 1995 at $230 and $460 for individuals and family plans, respectively.[460] These premiums remained unchanged until 2012, when annual premium increases were tied to military retirement pay increases.[461] As shown in Figure 17, stagnant TRICARE Prime premiums have resulted in wide dispersions between the health costs of military retirees and other health care plans. In 1999, military retiree premiums for TRICARE Prime represented 31 percent of the civilian HMO average; by 2014, this had fallen to only 10 percent.

Figure 17. Annual Family Premiums, TRICARE Prime vs. Private Sector Health Care Plans[462]



[458] Ibid, 23-24.
[459] Ibid, 19.
[460] Department of Defense, *Evaluation of the TRICARE Program, Fiscal Year 2012 Report to Congress*, 7, accessed December 19, 2014, http://mldc.whs.mil/public/docs/library/health/2012_-_DoD_-_TRICARE_Evaluation_Report_-_FY12.pdf.
[461] Armed Forces, 10 U.S.C. § 1097(e)(2). National Defense Authorization Act for FY 2012, Pub. L. No. 112-81, § 701(b) (2011).
[462] Data from the Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2014 Annual Survey,* 98, accessed October 1, 2014, http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report. Department of Defense, *Evaluation of the TRICARE Program, Fiscal Year 2012 Report to Congress,* 7, accessed June 20, 2014, http://mldc.whs.mil/public/docs/library/health/2012_-_DoD_-_TRICARE_Evaluation_Report_-_FY12.pdf. Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress,* 9, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf.

When the TRICARE program went into effect in 1996, the cost share for retirees younger than 65 was 27 percent of total health care costs.[463] By keeping cost-sharing for active-duty families and retirees younger than 65 nearly constant for 20 years, the beneficiaries' share of the program costs have declined significantly, causing a growing portion of the expense to be passed on to the Government. By FY 2014, the cost shares for non-Medicare-eligible retirees had declined to about 4 to 5 percent for individuals and 5 to 6 percent for families.[464] In comparison to the costs borne by the employee or annuitant in the civilian sector, TRICARE beneficiaries' cost-sharing rates are small. On average, civilian employees paid 29 percent of the premium for their family health coverage in 2014. Their employers contributed the remaining 71 percent.[465]

Efficiency in Program Operation. Managing the TRICARE program, including associated overhead costs, is more expensive than administering a program that offers commercial insurance plans. The Commission estimates DoD will have spent approximately $314 million in FY 2013 to administer the TRICARE health care benefit.[466] These figures are calculated based on Budget Activity Group (BAG) 5, "Management Activities," which finances headquarters operations in the Defense Health Agency and military Services. Of the seven BAGs, Management Activities is the one most closely associated with overhead functions. The Commission found it challenging to estimate the true costs to administer TRICARE because such costs are not readily visible in the Defense Health Program budget accounts. Although it is difficult to calculate the amount of military, civilian, and contractor personnel engaged in the administration of TRICARE, the Commission notes DoD allocated almost 2,900 total personnel to BAG 5, Management Activities in FY 2013.[467]

Although it differs from TRICARE, the FEHBP provides health care to more than 8.2 million participants, making it about the same size as TRICARE in terms of beneficiary population.[468] FEHBP offers beneficiaries more than 250 insurance plan choices provided by nearly 100 different contracts.[469] These plans are purchased on "evergreen" contracts that are renewed each year, allowing for flexibility, adaptation to current trends, and low contracting costs. Yet the Office of Personnel Management

---

[463] Office of the Undersecretary of Defense (Comptroller), *United States Department of Defense Fiscal Year 2015 Budget Request Overview* (March 2014), 5-10, accessed April 14, 2014. http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/fy2015_Budget_Request_Overview_Book.pdf.

[464] Commission calculation based on data from Military Health System Management Analysis and Reporting Tool: Inpatient Admissions (SIDR), Professional Encounters (CAPER), PC Institutional (TED-I), PC Non-Institutional (TED-N), and Pharmacy (PDTS) tables, and FY 2015 Budget Submission, accessed October 28, 2014.

[465] Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2014 Annual Survey*, *September 2014*, 85, accessed October 1, 2014, http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report.

[466] Department of Defense, *Defense Health Program Fiscal Year 2015 Budget Estimates, Volume 1: Justification Estimates, Operations and Maintenance, Management Activities*, MACT-3, accessed November 20, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/budget_justification/pdfs/09_Defense_Health_Program/VOL_I_Sec_7_E_OP-5_Management_Activities_DHP_PB15.pdf.

[467] Ibid, MACT-9. The figure presented is a sum of active military average strength, civilian full-time equivalents, and contractor full-time equivalents in the BAG 5 Personnel Summary.

[468] Office of Personnel Management, "Federal Employees Health Benefits Program Overview," provided to MCRMC in Executive Session, January 15, 2014. There was an average of 9.5 million beneficiaries eligible for TRICARE, and an average of 8 million actual users of the program in fiscal year 2013. Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress,* 19, accessed November 20, 2014, http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202014)%201.pdf.

[469] Office of Personnel Management, *Federal Employees Health Benefits Program Overview*, provided to MCRMC in Executive Session, January 15, 2014. FEHBP offered 256 plan choices through 97 contracts with carriers in 2014.

(OPM)[470] administers this program with about 100 employees[471] who are paid for out of the FEHBP trust fund using resources from plan premiums instead of appropriated funds.[472]

OPM is required by statute to dedicate no more than 1 percent of plan premiums for FEHBP administrative expenses.[473] In 2014, the total cost of FEHBP premiums (the Government share plus the employees' share) was $47 billion,[474] 1 percent of which equals $470 million. OPM informed the Commission that it routinely requires less than 0.1 percent of the premiums to administer FEHBP.[475] This means that OPM required less than $47 million in 2014 to administer FEHBP. If OPM does not use the full 1 percent dedicated for administrative expenses, the unused portion returns to the trust fund for contingency reserves.[476]

The difference in operating costs and personnel required to manage the TRICARE and FEHBP programs is profound. Nevertheless, the TRICARE and FEHBP programs, as well as the roles of DoD and OPM, are fundamentally different. Essentially, OPM functions as the program manager, while DoD performs that role and others, including self-funded insurance carrier[477] and hospital administrator.[478]

Although FEHBP has many attractive features, the Commission believes that it would not be appropriate for military beneficiaries to be enrolled with Federal civilians in the FEHBP as currently configured because of the unique requirements of the military, such as those related to readiness, and recognition of military service. MTFs provide a training platform that maintains the readiness of the military medical force. To continue to attract the right kind of complex medical cases to support this training mission (e.g., trauma surgery), the MTFs need to remain a key element of military health care delivery. Typically, FEHBP plans do not incorporate MTFs as venues of care.

---

[470] The Office of Personnel Management provided support for the Commission's analysis; however, such support does not represent an endorsement of, or suggest any opinion on, the report, study, or recommendations.
[471] Office of Personnel Management, *Congressional Budget Justification: Performance Budget Fiscal Year 2015*, March 2014, 182-83, accessed November 20, 2014, http://www.opm.gov/about-us/budget-performance/budgets/congressional-budget-justification-fy2015.pdf. Office of Personnel Management, e-mail to MCRMC, November 20, 2014.
[472] Employees Health Benefits Fund, 5 U.S.C. § 8909(b)(1).
[473] Employees Health Benefits Fund, 5 U.S.C. § 8909(b)(1).
[474] Office of Personnel Management, *Fact Sheet: 2013 Federal Benefits Open Season for Health Benefits, Dental and Vision Insurance and Flexible Spending Accounts,* provided to MCRMC in Executive Session, January 15, 2014. Office of Personnel Management, e-mail to MCRMC, November 21, 2014.
[475] Information provided by Office of Personnel Management, e-mail to MCRMC, November 6 and 25, 2014.
[476] Employees Health Benefits Fund, 5 U.S.C. § 8909(b)(2).
[477] The health benefit provided to military beneficiaries is a version of self-funded insurance. Self-insurance is a "plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered." "Definitions of Health Insurance Terms," Bureau of Labor Statistics, accessed October 19, 2014, http://www.bls.gov/ncs/ebs/sp/healthterms.pdf. Under the current system, DoD is obligated to provide health care to its beneficiaries and covers open-ended payments for services. In the self-insurance model, "the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for each out of pocket claim as it is incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully-insured plan." "Self-Insured Group Health Plans," Self-Insurance Institute of America, Inc., accessed October, 19, 2014, http://www.siia.org/i4a/pages/Index.cfm?pageID=4546.
[478] Note that the $339 million in BAG 5, "Management Activities," does not include the full cost of performing the functions cited above, e.g. running the MTFs.

Additionally, military members have made great sacrifices for their country and their health benefit should reflect this sacrifice. The Commission believes FEHBP cost shares of approximately 30 percent for employees and 70 percent for the Government[479] are not appropriate for military members. Although it is possible to have different cost shares for different subpopulations in FEHBP (e.g., Postal employees), doing so could create confusion and might increase the chance that later decisions are made to harmonize the cost shares of the populations. Military beneficiaries need a concrete recognition of military service that is reflected in their cost shares and protected in the basic program design.

Many of the recent reform proposals to address growing costs in DoD's health care budget have focused principally on low cost shares and consequent over-utilization of services.[480] DoD has proposed increases to TRICARE fees several times in recent years.[481] As stated in conjunction with the President's Budget for FY 2015, the cost-sharing modifications DoD proposed were intended "largely to control health care costs."[482] The Commission believes, however, that to achieve better value and modernize the health care benefit, reform efforts must consider other aspects of TRICARE's structure besides cost shares. Increasing beneficiaries' cost shares is merely one way to achieve efficiencies. Other ways include a combination of monetary and nonmonetary tools that more effectively manages utilization than monetary tools alone and new advancements in payment and delivery models that lower costs. Additionally, the FEHBP program demonstrates that OPM is able to administer a strong health benefit with relatively low overhead expenses. Under a program of commercial health insurance that can use both monetary and nonmonetary tools to

---

[479] Office of Personnel Management, *Federal Employees Health Benefits Program Questions & Answers*, provided to MCRMC in Executive Session, January 15, 2013. By law [Balanced Budget Act of 1997 (Public Law 105-33, approved August 5, 1997)], "… the Government contribution equals the lesser of: (1) 72 percent of amounts OPM determines are the program-wide weighted average of premiums in effect each year, for self only and for self and family enrollments, respectively, or (2) 75 percent of the total premium for the particular plan an enrollee selects." "Cost of Insurance," Office of Personnel Management, accessed October 24, 2014, https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/cost-of-insurance/#govshare.

[480] For example, see Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care* (Washington, DC: Government Printing Office, 2014). Lawrence J. Korb, Laura Conley, and Alex Rothman, Center for American Progress, *Restoring Tricare: Ensuring the Long Term Viability of the Military Health Care System*, accessed October 6, 2014, http://cdn.americanprogress.org/wp-content/uploads/issues/2011/02/pdf/tricare.pdf. Maren Leed and Brittany Gregerson, *Keeping Faith: Charting a Sustainable Path for Military Compensation*, (Washington DC: Center for Strategic & International Studies, 2011).

[481] Department of Defense, *Draft National Defense Authorization Act for Fiscal Year 2007*, section 702, 63-64, accessed October 3, 2014, http://www.dod.mil/dodgc/olc/docs/FY2007NDAA_BillText.pdf. Office of the Secretary of Defense, *Operations and Maintenance Overview: Fiscal Year 2007 Budget Estimates*, 15, accessed October 2, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/docs/fy2007_overview.pdf. Department of Defense, *Draft National Defense Authorization Act for Fiscal Year 2008*, section 701, 87-88, accessed October 3, 2014, http://www.dod.mil/dodgc/olc/docs/FY2008NDAA_BillText.pdf. Department of Defense, *Draft National Defense Authorization Act for Fiscal Year 2009*, section 701, 56-57, accessed October 3, 2014, http://www.dod.mil/dodgc/olc/docs/FY2009_NDAA_BillText.pdf. Office of the Undersecretary of Defense (Comptroller), *United States Department of Defense Fiscal Year 2012 Budget Request Overview*, 3-3, accessed October 3, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2012/FY2012_Budget_Request_Overview_Book.pdf. Department of Defense, *Draft National Defense Authorization Act for Fiscal Year 2013*, section 701, 51-57, accessed October 3, 2014, http://www.dod.mil/dodgc/olc/docs/14March2012NDAABillText.pdf. Department of Defense, *Draft National Defense Authorization Act for Fiscal Year 2014*, section 701, 40-50, accessed October 3, 2014, http://www.dod.mil/dodgc/olc/docs/26April2013NDAABillText.pdf. Department of Defense, *Draft National Defense Authorization Act for Fiscal Year 2015*, section 701, 58-71, http://www.dod.mil/dodgc/olc/docs/1April2014NDAABillText.pdf.

[482] Office of the Undersecretary of Defense (Comptroller), *United States Department of Defense Fiscal Year 2015 Budget Request Overview*, 5-10, accessed April 14, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/fy2015_Budget_Request_Overview_Book.pdf.

achieve efficiency, DoD, with the assistance of OPM, could offer a robust benefit at a better value with far less of the burden and expense required of DoD today.

Conclusions:
AC families, RC members, and retirees could receive a better health care benefit by allowing them to choose from a selection of commercial insurance plans offered through a DoD health benefit program administered by OPM. Through this proposal, DoD could increase beneficiaries' choice, enhance their access to care, and drive better value.

Under an insurance model, the ease and timeliness of patients' access to health care would improve because beneficiaries would not be subject to DoD's lengthy and frustrating process for making appointments and obtaining referrals. Providing such a benefit would also increase beneficiaries' access to care by greatly improving the network of health care providers in their insurance networks, especially in rural areas or those without substantial military presence. It would particularly assist RC members, as well as retirees, who often live away from major active-duty installations.

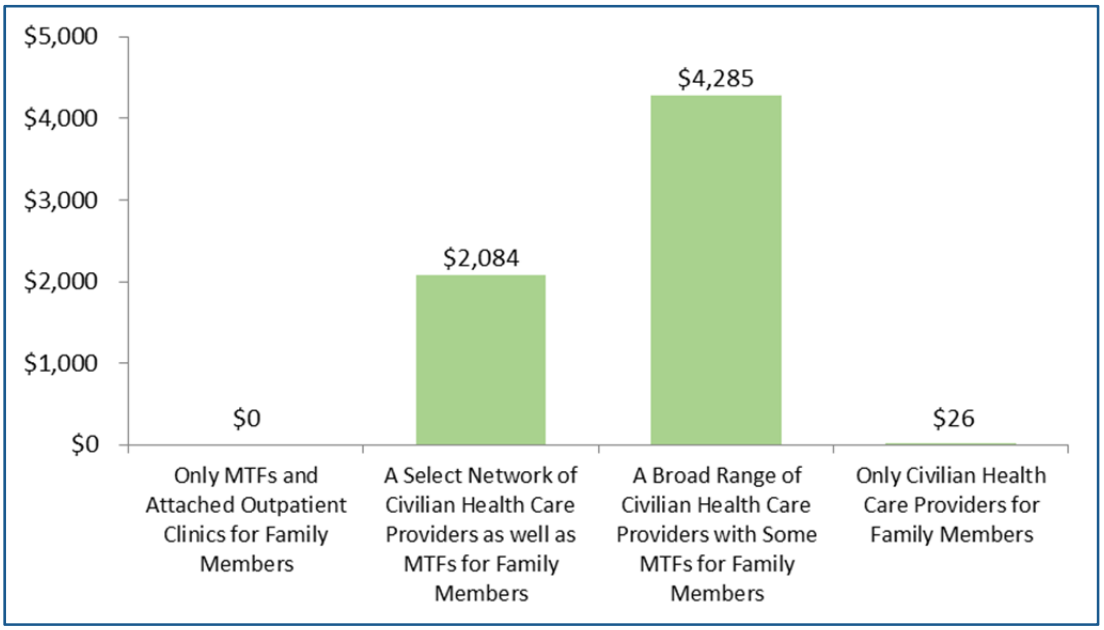
Additionally, by allowing them a choice of plans, beneficiaries could select insurance coverage that ensures a baseline of high quality health care and best aligns to their individual needs. A DoD health benefit program that offers commercial insurance would also more closely resemble or overlap with RC families' health plans they purchase from the civilian sector. This approach would aid continuity of care when RC members are mobilized and demobilized.

Finally, instead of relying on TRICARE, a system that structurally does not provide a high quality health care program efficiently, DoD would achieve better value by sponsoring a selection of existing commercial insurance plans. The insurance plans would pay market rates for health care procedures, rather than DoD's sub-Medicare rates, thereby resulting in much more robust provider networks. The plans would be contracted through OPM similar to the FEHBP program, which would reduce operating expenses and remove the program from the complex, drawn-out DoD contracting process that has been leveraged to erode TRICARE benefits because of budgetary considerations. Providing commercial insurance plans would give beneficiaries access to the medical industry's most recent innovations and procedures. Under this proposal, commercial insurance plans would make use of modern monetary and nonmonetary tools to control excessive utilization. Such tools ultimately would allow the system to operate more efficiently, which avoids passing increased program costs on to beneficiaries.

AC family members would continue to receive health care generally at no cost. Service members with dependents would receive a new Basic Allowance for Health Care (BAHC) to cover the premiums and OOP costs for an average health care plan. RC members who are mobilized would also receive this BAHC either to apply toward a DoD plan or to cover the employee share of their existing health care plans. This ability to remain on their existing health care plan would improve the continuity of care for RC family members. Non-Medicare-eligible retirees would continue to have access to the military health benefit program, at premiums below the civilian levels in recognition of their sacrifices for our Nation. Finally, TRICARE-for-Life would be maintained in its current form to provide high quality health care for Medicare-eligible retirees.

The Commission's survey indicates beneficiaries would strongly prefer this recommendation to the status quo. Although AC family members would have the option of choosing more (or less) expensive plans with different copayment levels, the BAHC would ensure that beneficiaries have an option with no substantive increase to their cost shares. The recommendation, more importantly, would increase attributes of the health care benefit that are highly valued by these beneficiaries. In a survey question on the choices of health care providers their family members were allowed to see, AC respondents overwhelmingly valued a broad range of civilian health care providers with some MTF care over the status quo of a select network of civilian providers with MTF care. Figure 18 provides the valuations for each option in the survey question. According to these results, the Commission's recommendation would increase AC members' valuation of their health benefit by about $2,200 per year from this one attribute alone.[483]

Figure 18. Active-Duty Service Members' Perceived Value: Provider Choice[484]

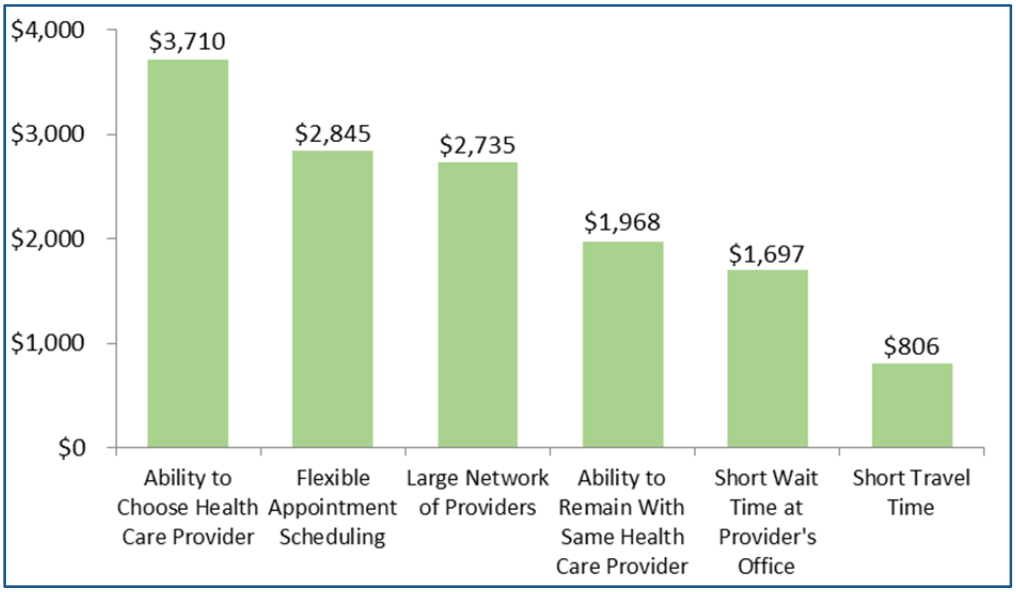


In a related survey question, AC respondents evaluated six aspects of their health care experience. In a similar result to the previous question, choice was the most highly valued attribute followed closely by flexibility in appointment scheduling and the size of the network. The Commission's recommendation could improve these attributes and gives beneficiaries direct control over their health benefit through the plans they choose. Figure 19 provides the complete break out of the valuations for the six attributes for active-duty survey respondents. The survey allows for a comparison of valuation of different compensation designs. Examining just health benefits, the

[483] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[484] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014. This figure displays the average amount in dollars that survey respondents valued compensation alternatives. Presentation in dollar values allows the value of compensation features to be directly compared.

survey reveals that up to 90 percent of AC respondents would prefer the Commission's recommendation (for their family members) than the current benefit.[485]

Figure 19. Active-Duty Service Members' Perceived Value: Health Care Experience[486]



It is critical that this health care insurance plan be designed to support DoD's medical readiness mission. MTFs must be included in the insurance carriers' health care provider networks so that beneficiaries can continue to receive care at MTFs and MTFs can continue to receive the cases necessary to fulfill their training mission. Furthermore, copayments and other OOP costs should be lower at MTFs than in other medical facilities to provide beneficiaries financial incentives to seek care in MTFs. Finally, insurance program contracts should be established as evergreen agreements that are renewed annually, to allow regular adjustments of costs shares and to reflect the most current innovations in medical practice.

Recommendations:

- Active-duty Service members, for reasons related to operational readiness, should continue to receive their health care through their units or the direct care system (MTFs). As is the case today, some specialist care will be attained in the private sector. When active-duty Service members are referred to the private sector for care, they should have access to an unlimited network of providers at no cost to the Service member.

[485] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014. The Commission survey allows for comparison of different compensation designs. If all six attributes identified in Figure 6 were increased substantially, then the survey results predict that 89.9 percent of AC members would prefer the Commission's recommendation over the current health benefit design. The survey does not allow for partial increases in the six attributes, though, and the degree to which these attributes are experience in the current health benefit varies by location and other factors. It may be the case that the increases in each attribute vary across beneficiaries, making the survey prediction of approximately 90 percent an upper-bound estimate.

[486] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014. This figure displays the average amount in dollars that survey respondents valued compensation alternatives. Presentation in dollar values allows the value of compensation features to be directly compared.

- For AC families, RC members, retirees not eligible for Medicare, and their families, survivors, and certain former spouses, the Congress should establish a new health care program that offers beneficiaries a selection of commercial insurance plans to replace TRICARE. This new health benefit should:
  - Offer an array of health plan options that vary in type (e.g., preferred provider organizations and health maintenance organization), covered benefits, and price.
  - Offer a selection of plans that broadly represents what is available in the commercial market without unnecessary restrictions, meets or exceeds a baseline of health plan quality, and continuously advances with the health care industry.
  - Present several choices in any geographic region.
  - Include dental and vision coverage. The TRICARE Dental Program and the TRICARE Retiree Dental Program should remain in place. Additionally, the new health care program should contain some health plans that include partial dental coverage.[487] Beneficiaries also should have access to stand-alone vision plans under the new health care program, which they currently do not have under TRICARE.
  - Allow beneficiaries to continue to have access to MTFs as a venue of care. Insurance companies should include MTFs in their networks and reimburse MTFs for the care delivered as they do any other provider.
  - Allow beneficiaries to change plans during the annual open season or at a life-changing event such as a permanent change of duty station.
  - Ensure insurance plans include catastrophic caps to alleviate large, unplanned health bills.
- Active-duty Service members should receive BAHC, a nontaxable allowance, to offset health care cost shares for their family members.
  - BAHC should be based on the costs of average plans available in the family's location.
  - DoD should use BAHC to transfer directly to the insurance carrier the premium for the plan the family has selected. The remainder of the BAHC should be available for the family members to pay copayments, deductibles, and coinsurance. DoD should make available to active-duty families an account for the accumulation and future use of unused BAHC.
  - BAHC should be set at a level that sufficiently offsets or completely covers costs, or even affords families a surplus each month after costs are paid.

[487] Partial dental coverage refers to insurance coverage for accidental dental injuries and routine preventative and diagnostic services.

- Families should be able to use their BAHC to purchase health care through a spouse's employer if desired.

- When AC families struggle with a high-cost chronic condition or a catastrophic event or illness, there should be a DoD program available to assist them with medical expenses until they reach their health plan's catastrophic caps and are no longer required to pay OOP costs. Active-duty families should apply to this program for additional funding to cover copayments that substantially exceed their BAHC. An annual total of $50 million should be budgeted for this catastrophic and chronic condition assistance. (See Appendix D for more information about costing related to this program.)

Table 7 provides more detail on who would be eligible for BAHC, how it would be computed, what would be specified in law, and other details of its implementation. Figure 20 notionally displays how BAHC would be calculated. TRICARE Choice is the name used for the proposed program that would offer beneficiaries a selection of commercial health insurance plans.

Table 7. Frequently Asked Questions Regarding Basic Allowance for Health Care

Who would receive a BAHC?	BAHC would be provided to every Service member of the Uniformed Services in active-duty status who has at least one dependent recorded in Defense Enrollment Eligibility Reporting System (DEERS). Service members would receive BAHC for any dependents up to age 26.
How would DoD track and allocate the BAHC?	Service members or authorized spouses would have to certify in DEERS that they have purchased health care for their dependents. If they purchase a health plan through TRICARE Choice, it will automatically be recorded in DEERS. If they purchase a certified health care plan offered outside of TRICARE Choice, the Service member would be required to provide the information to DEERS. Payments from the Defense Finance and Accounting Services (DFAS) are aligned with DEERS information, therefore DEERS information must be accurate to enable the DFAS automatic payment function.
How would the insurance carriers receive the BAHC for payment of the health plan premium?	The portion of the BAHC used to pay the premium of the insurance plan selected by the Service member would appear as an allotment on the Service member's Leave and Earnings Statement. This portion of BAHC would be paid directly into the OPM trust fund for use by the insurance plan selected. If the Service member indicates a non-TRICARE Choice plan in DEERS, DFAS would make payment directly to that insurance carrier.
How would active-duty Service members receive the BAHC to pay for their family members' out-of-pocket health expenses?	The portion of the BAHC to be used for out-of-pocket costs (copayments, coinsurance, and deductibles) would be paid to active-duty Service members as a cash payment in their direct deposit. BAHC would be a nontaxable allowance.

How would BAHC be calculated?	The BAHC formula will be specified in law as 28% of the total premium of the health plan selected in a location in the prior year by the median active-duty family member unit plus the average copayment amount by all active-duty family member beneficiaries in that location in the prior year. The geographic unit (e.g., state versus metropolitan statistical area) will not be specified in law and will be at the discretion of the program. In the first year, when no prior year data are available, a projection of likely plan choices and utilization behavior for the population will be used to compute the values. The legislative language creating the BAHC will include the specific formula: BAHC=0.28*(Total Premium of Median Plan)+Copayment Amount

Figure 20. Illustrative Calculation of Basic Allowance for Health Care[488]

How BAHC is Computed (Annual Amount)

Total Current Year Premium of Median Plan Selected in Prior Year	$8,507
28% of Total Plan Premium Becomes BAHC Amount	$2,382
Average Copayment Amount Added to BAHC	$920
Total BAHC Amount (sum of premium and copayment amount)	$3,302

- All RC members should be able to purchase a plan from the DoD program at varying cost shares. Members of the Selected Reserve should have a reduced cost share of 25 percent to encourage RC health and dental readiness and streamline mobilization of RC personnel. Other RC members new to the benefit should have higher cost shares corresponding to their category of service. When mobilized, RC members should receive active-duty health care. Under this new benefit, RC members with families should receive the BAHC and either select a plan from DoD's program or remain on their current (civilian) plan and apply the BAHC to those costs.

- Medicare-eligible retirees should continue to receive health care to supplement Medicare benefits consistent with TRICARE for Life.

- The cost contribution for non-Medicare-eligible retirees should gradually increase over many years, but remain lower than the average civilian employee cost share as recognition of military members' service.

[488] Actual BAHC values would depend upon local market conditions, Service-member choices, and plans available.

- The TRICARE Young Adult program would no longer be necessary, as commercial health insurance plans that offer dependent coverage should make coverage available to dependents until age 26.

Tables 8 and 9 describe in more detail how the Commission's recommendation would affect each type of beneficiary and current DoD health care programs.

Table 8. Effects of the Commission's Health Benefit Recommendations by Beneficiary Category

Beneficiary Category	Impact
Active-duty Service members	No impact on benefit, costs, or where care is delivered. Active-duty Service members would continue to receive their health care through the direct care system (their units or MTFs). When referred to the private sector for specialist care, they would have access to an unlimited network of providers at no cost to the Service member. DoD would have the authority to contract with a third-party administrator to pay claims for care that active-duty Service members receive in the private sector.
Active-duty family members (ADFMs)	Currently use TRICARE Prime, Standard, Extra, etc. These plans would be eliminated and replaced with TRICARE Choice. Dependents up to age 26 would be covered under TRICARE Choice. A 28% premium cost share and higher out-of-pocket expenses would be charged to beneficiaries, but sponsors of ADFMs would be compensated for this increased cost share with the BAHC. They would continue to have access to the TRICARE Dental Program. Under TRICARE Choice, they also would have access to health plans with partial dental coverage.[489] Under TRICARE Choice, they would have access to vision coverage not available under TRICARE.
Members of the Selected Reserve on inactive-duty	Currently purchase TRICARE Reserve Select. TRS would be eliminated and replaced with TRICARE Choice. Premium cost share would reduce to 25% to improve RC medical and dental readiness. They would continue to have access to the TRICARE Dental Program. Under TRICARE Choice, they also would have access to health plans with partial dental coverage. Under TRICARE Choice, they would have access to vision coverage not available under TRICARE.
Members of the Selected Reserve called to active-duty for more than 30 consecutive days (including pre- and postmobilization transition, i.e., TAMP)	Service members would receive the same care as active-duty at no cost. Dependents currently receive TRICARE benefits, which would be eliminated and replaced with TRICARE Choice. Dependents would incur a 28% premium cost share and out-of-pocket expenses but their sponsors would be compensated for this with a BAHC. They would continue to have access to the TRICARE Dental Program. Under TRICARE Choice, they also would have access to health plans with partial dental coverage. Under TRICARE Choice, they would have access to vision coverage not available under TRICARE.

[489] Partial dental coverage refers to insurance coverage for accidental dental injuries and routine preventative and diagnostic services.

Beneficiary Category	Impact
Other Reserve Component (not currently eligible for TRICARE, TRS, or TRR)	No TRICARE benefits today. Would be eligible for TRICARE Choice with cost shares corresponding to their category of service, but higher than the 25% cost share afforded the inactive Selected Reserve. They would continue to have access to the TRICARE Dental Program. Under TRICARE Choice, they also would have access to health plans with partial dental coverage. Under TRICARE Choice, they would have access to vision coverage not available under TRICARE.
Non-Medicare-eligible retirees	Currently use TRICARE Prime, Standard, or Extra. These plans would be eliminated and replaced with TRICARE Choice. When fully implemented, non-Medicare-eligible retirees would pay a 20% premium cost share. The cost share would gradually increase at a rate of 1% per year for 15 years to adjust from the current 5% cost share to the ultimate 20% cost share. Non-Medicare-eligible beneficiaries would pay out-of-pocket expenses. They would not receive a BAHC. They would continue to have access to the TRICARE Retiree Dental Program. Under TRICARE Choice, they also would have access to health plans with partial dental coverage. Under TRICARE Choice, they would have access to vision coverage not available under TRICARE.
Medicare-eligible retirees	Currently use TRICARE for Life and would continue to do so.
Retired Reserve Component members (after retirement but under age 60)	Currently use TRICARE Retired Reserve (TRR). TRR would be eliminated and replaced with TRICARE Choice. Like today, the Government would not subsidize the cost. They would continue to have access to the TRICARE Retiree Dental Program. Under TRICARE Choice, they also would have access to health plans with partial dental coverage. Under TRICARE Choice, they would have access to vision coverage not available under TRICARE.
Dependent survivors, certain former spouses, Medal of Honor recipients and their families, and others registered in DEERS	Currently use TRICARE, which would be eliminated and replaced with TRICARE Choice. These beneficiaries would pay a premium cost share at a level consistent with their cost shares today. They would have access to the dental coverage they receive under TRICARE, as well as partial dental coverage available under some health plans in TRICARE Choice. Under TRICARE Choice, they would have access to vision coverage not available under TRICARE.
Other Uniformed Services and their dependents (Coast Guard, Public Health Service Commissioned Corps, and National Oceanic and Atmospheric Administration Commissioned Officer Corps)	Currently use TRICARE, which would be eliminated and replaced with TRICARE Choice. They would have access to the dental coverage they receive under TRICARE, as well as partial dental coverage available under some health plans in TRICARE Choice. Under TRICARE Choice, they would have access to vision coverage not available under TRICARE.

Table 9. Effects of the Commission's Health Benefit Recommendations by Current Program

Program	Impact
TRICARE Prime	Program would be eliminated and replaced by TRICARE Choice for ADFMs. For active-duty Service members, there would be no impact on benefits, costs, or where care is delivered. DoD would have the authority to contract with a third-party administrator to pay claims for care active-duty Service members receive in the private sector.
TRICARE Standard	Program would be eliminated and replaced by TRICARE Choice.
TRICARE Extra	Program would be eliminated and replaced by TRICARE Choice.
TRICARE for Life (TFL)	Benefit would remain in place and would not be directly affected by Commission recommendation. Care would still be provided and claims would still be paid first through Medicare in most cases. DoD would still contract with a third-party administrator to pay claims and coordinate claims processing with Medicare administrators and medical providers. There would be an indirect impact on the minimal cases in which TFL is primary payer because of the elimination of TRICARE Prime, Standard, and Extra programs and infrastructure. DoD must retain certain responsibilities related to the TFL program, including upholding and, as appropriate, seeking changes to policies on medical services allowable under the DoD Medicare wrap-around program. When Medicare does not cover services but TFL does, TFL beneficiaries would obtain care through an unlimited network of providers that the third-party administrator verifies are licensed by the state and credentialed within the specialty in which they are providing services. The providers would submit claims to the third-party administrator, which would handle claims processing. In overseas settings in which Medicare does not operate, TFL would remain the primary payer and DoD would retain the authority to contract with a third-party administrator to process the claims. TFL users would continue to have access to pharmacy benefits through DoD.
TRICARE Young Adult (TYA)	Program would be eliminated. Plans under TRICARE Choice would cover dependents up to age 26 even if these dependents are married, not living with their parents, attending school, not financially dependent on their parents, or eligible to enroll in their employer's plan.
TRICARE Reserve Select (TRS)	Program would be eliminated and replaced by TRICARE Choice. Premium cost share would be 25%.
TRICARE Retired Reserve (TRR)	Program would be eliminated and replaced by TRICARE Choice. Like today, the Government would not subsidize the cost.
Active-Duty Dental Program (ADDP)	Program remains in place and operates as it does today.
TRICARE Dental Program (TDP) for active-duty families	Program remains in place and operates as it does today. ADFMs would retain the same premium cost share they experience under TDP. Additionally, TRICARE Choice would contain some health plans with partial dental coverage.

Program	Impact
TRICARE Dental Program (TDP) for RC families	Program remains in place and operates as it does today. RC members would retain the same premium cost share they experience under TDP. Additionally, TRICARE Choice would contain some health plans with partial dental coverage.
TRICARE Retiree Dental Program (TRDP)	Program remains in place and operates as it does today. Retirees would retain the same premium cost share they experience under TRDP. Additionally, TRICARE Choice would contain some health plans with partial dental coverage.
TRICARE Pharmacy	The pharmacy benefit would remain in place. DoD would manage the pharmacy program and continue to use the DoD formulary and Federal Supply Schedule pricing. Beneficiaries using TRICARE Choice, as well as Medicare-eligible retirees using TFL, would obtain medications from retail, mail-order, and MTF settings. DoD would retain the authority to contract with a third-party administrator to perform functions such as managing the retail pharmacy network, distributing mail-order medications, and processing claims. Such contracts would require the pharmacy benefits manager to integrate pharmaceutical treatment with health care and to implement robust medication therapy management.
U.S. Family Health Plan (USFHP)	The USFHP program would continue but would no longer be associated with TRICARE Prime. USFHP designated providers could participate in TRICARE Choice by contracting with OPM to offer health plans to beneficiaries.
TRICARE Prime Remote	Program would be eliminated and replaced by TRICARE Choice for ADFMs. For active-duty Service members, there would be no effect on benefit, costs, or where care is delivered. DoD would have the authority to contract with a third-party administrator to pay claims for care active-duty Service members receive in the private sector.
TRICARE Prime Overseas	Program would be eliminated and replaced by TRICARE Choice for ADFMs. For active-duty Service members, there would be no effect on benefit, costs, or where care is delivered. DoD would have the authority to contract with a third-party administrator to pay claims for care active-duty Service members receive in the private sector.
TRICARE Prime Remote Overseas	Program would be eliminated and replaced by TRICARE Choice for ADFMs. For active-duty Service members, there would be no effect on benefit, costs, or where care is delivered. DoD would have the authority to contract with a third-party administrator to pay claims for care active-duty Service members receive in the private sector.
TRICARE Standard Overseas	Program would be eliminated and replaced by TRICARE Choice for ADFMs. For active-duty Service members, there would be no effect on benefit, costs, or where care is delivered. DoD would have the authority to contract with a third-party administrator to pay claims for care active-duty Service members receive in the private sector.

- To ensure affected Service members and beneficiaries can navigate the new insurance program with ease, DoD should institute a program of education and benefits counseling (see Recommendation 3).
- The proposed health care program should be administered by OPM in a way that incorporates the experience and knowledge of both the DoD and OPM to achieve the best health care benefit possible, with the greatest amount of flexibility and industry innovation, and in the most efficient manner available.

- DoD should develop and provide to OPM recommendations on the unique needs of the eligible Uniform Services beneficiary population. DoD should also make recommendations to OPM on matters involving MTFs, namely the inclusion of MTFs in carriers' networks, copayments levels at MTFs, and adjustments to procedure reimbursement rates for EMC-related care delivered in MTFs. Details of the benefit, as well as contract negotiations, should be the responsibility of OPM. DoD should not exclude from the program any benefits that OPM determines are commonly available in FEHBP. DoD should retain the budget authority for the health care provided to AC dependents, members of the RC, and non-Medicare-eligible retirees and transfer funds to OPM for insurance operations, as it does today for DoD civilian employees.

- The Congress should leverage OPM's experience in administering similar health care programs to manage the routine business operations of the program, such as the contracts with and distribution of funds to insurance carriers. This arrangement should include managing annual "evergreen" contracts, performing a strict evaluation of financial solvency of carriers, transmitting annual call letters to carriers, reviewing potential plans against DoD requirements, and managing the trust fund and its associated payments.

Table 10 provides more detail on the roles and responsibilities of OPM, DoD, insurance carriers, and beneficiaries under the Commission's recommendation.

Table 10. Roles and Responsibilities Under the Health Benefits Recommendation

OPM	DoD
▪ Contracting for and approving or disapproving carriers for participation in the health benefit program; ▪ Taking action to ensure the offering of plans broadly represents what is available in the commercial market without unnecessary restrictions and meets a baseline of health-plan quality ▪ Negotiating benefit and rate changes with carriers; ▪ Approving the certified text on benefits for the brochures; ▪ Publishing regulations, instructions, forms, and documents pertaining to the program; ▪ Receiving and depositing premium withholdings and contributions, remitting premiums to carriers, and accounting for the Employees Health Benefits Fund; ▪ Making final determinations of the applicability of the health benefit program law to specific employees or groups of employees; ▪ Auditing carriers' operations under the law; ▪ Performing a strict evaluation of carriers' financial solvency; ▪ Resolving disputed health insurance claims between the enrollee and the carrier.	▪ Providing recommendations to OPM on the unique needs of the eligible Uniformed Services beneficiary population, without excluding from the program any benefits OPM determines are commonly available in FEHBP; ▪ Providing recommendations to OPM on the inclusion of MTFs in carriers' networks and rate negotiation for copayments at MTFs and procedure reimbursement rates for EMC-related care delivered in MTFs; ▪ Retaining budget authority for the health benefit for active-duty dependents, members of the RC, and non-Medicare-eligible retirees and transferring funds to OPM for insurance operations, as it does today for DoD civilian employees; ▪ Remitting and accounting for withholdings and contributions; ▪ Administering and dispersing BAHC through Defense Finance and Accounting Services; ▪ Providing eligible persons with information on their rights and responsibilities under the health benefit program; ▪ Conducting a program of education and benefits

counseling to ensure affected Service members and beneficiaries can navigate the health benefit program;
- Establishing a DoD office responsible for interacting with eligible beneficiaries on the health benefit program, including counseling and advising employees; determining individual eligibility for enrollment, effective dates of health benefits actions, and other related matters; processing health benefits actions and ensuring that election forms are properly completed; reviewing enrollment reconsideration requests; stocking and distributing health benefits forms and literature; maintaining records; and managing the catastrophic- and chronic-condition assistance program.

Insurance Carriers	Beneficiaries
▪ Adjudicating claims of, and providing health benefits to, beneficiaries in accordance with its contract with OPM; ▪ Typesetting, printing, and distributing brochures; ▪ Furnishing each person enrolled in its health plan an identification card or other evidence of enrollment; ▪ Acting on enrollee requests for reconsideration of disputed claims; ▪ Maintaining financial and statistical records and reporting on the operation of its plan; ▪ Developing and maintaining effective communication and control techniques to ensure that its subcontractors and local offices comply with regulations and OPM instructions.	▪ Being aware of their plan's benefit package, premium charges, exclusions and limitations, precertification and preauthorization requirements, and provider networks (if applicable); ▪ Reviewing the benefit and rate changes made to their plan during open season and determining whether their plan will still meet their needs in the upcoming year; ▪ Filing the appropriate forms on a timely basis to enroll, change, or cancel enrollment; ▪ Filing claims on a timely basis with the necessary documentation (if necessary); ▪ Updating DEERS when their address changes or when a dependent is added to or removed from dependent status.

- All health care programs should be financed through trust funds.

  - To finance the new health care program for active-duty families, RC members and families, non-Medicare eligible retirees, and all other eligible beneficiaries, the Departments of Defense, Homeland Security, Commerce, and Health and Human Services should transfer funding to the Employee Health Benefits Fund managed by OPM. OPM should keep the funding for FEHBP and the new health care program segregated in the trust fund.

  - The Medicare-Eligible Retiree Health Care Fund (MERHCF) should be expanded to cover the health care and pharmacy programs for non-Medicare eligible retirees. The health care for non-Medicare eligible retirees should be accrual funded, similar to how Medicare-eligible retiree health care is today. A portion of the outlays from the MERHCF should be paid to the OPM Employee Health Benefits Fund to purchase insurance plans for non-Medicare eligible retirees.

  - To finance the existing pharmacy and dental programs for active-duty families and RC members and families and pharmacy, dental, and health

care for active-duty Service members, a new trust fund should be created and managed by DoD for health care expenditures appropriated in the current year.

- Catchment areas around MTFs, an element of TRICARE Prime today, should be rescinded, allowing MTFs to attract cases unrestricted by geographic vicinity.

Implementation:

- Title 10, U.S. Code, addresses matters concerning the Armed Forces. A new chapter should be added to Title 10 to create a new health care program for dependents of members of the Uniformed Services, members of the Uniformed Services in reserve status, and non-Medicare-eligible retirees. The new program should be similar in nature to the Federal Employees Health Benefits Program currently administered by OPM, found at Chapter 89, Title 5, U.S. Code. The new chapter should provide for authorities and requirements that are similar but not identical to those found in Chapter 89, Title 5, U.S. Code. The new chapter should authorize DoD to make recommendations regarding the requirements of the new health care program, while requiring OPM to be responsible for administering the program.

- Title 5, U.S. Code, should be amended to authorize and set forth requirements for OPM to administer the new health care program on behalf of DoD.

- Chapter 55, Title 10, U.S. Code, governs medical and dental care for Uniformed Services members and certain former members, and for their dependents. The laws providing for the benefits for active-duty Service members and Medicare-eligible retirees should remain substantially the same except for technical and conforming amendments necessitated by the other changes to Title 10 resulting from the new health care program.

- Chapter 55, Title 10, U.S. Code, governs the pharmacy and dental benefits for the Uniformed Services. The laws providing for pharmacy and dental benefits should remain substantially the same except for technical and conforming amendments necessitated by the changes to Title 10 resulting from the new health care program.

- Various titles of the U.S. Code address the issue of allowances for the Uniform Services. These titles should be amended to authorize receipt of BAHC as an allowance.

  - Relevant sections of Title 10 of the U.S. Code should be amended to authorize receipt of BAHC as an allowance.

  - Title 26, U.S. Code, contains the provisions of the Internal Revenue Code. Title 26 should be amended to allow BAHC to receive similar tax treatment as other non-taxable allowances received by members of the Uniformed Services, such as BAH and BAS.

  - Title 37, U.S. Code, governs pay and allowances of the Uniformed Services. Chapter 7, Title 37, U.S. Code, should be amended to authorize the receipt of BAHC as an allowance. 37 U.S.C. § 101(25) should be amended to include BAHC in the definition of "regular military compensation."

- Title 10, U.S. Code, should be amended to add a new section which establishes and governs a trust fund for monies appropriated for provision of pharmacy, dental, and health care for active-duty Service members, pharmacy and dental care for Reserve Component Service members, and pharmacy and dental care for the dependents of the Uniformed Services.

- Chapter 56, Title 10, U.S. Code, governs the DoD Medicare-Eligible Retiree Health Care Fund. Chapter 56 should be amended to expand coverage to include all retirees, not just Medicare-eligible retirees.

- Section 8909, Title 5, U.S. Code, governs the Employees Health Benefits Fund, which finances health insurance for Federal civilian employees. Section 8909 should be amended to include funding for the proposed health care program herein with the requirement that funding for the Federal Employees Health Benefits Program and the proposed health care program remain separate in the trust fund.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed. Such as:

  - Replace instructions for TRICARE with instructions for the new health care program; and

  - Define roles and responsibilities of DoD and OPM in administering the new health care program.

Recommendation 7: Improve support for Service members' dependents with special needs by aligning services offered under the Extended Care Health Option to those of state Medicaid waiver programs.

Background:
The Exceptional Family Member Program (EFMP) provides support to Service members who have family members with special medical or educational needs.[490] Exceptional Family Members (EFMs) may be spouses, children, or dependent parents who require special medical or educational services for a diagnosed physical, intellectual, or emotional condition.[491] EFMP provides assignment coordination to ensure EFMs have access to needed medical and educational services.[492] When appropriate assignment coordination occurs, family members receive the care and support they require, and the Service member can focus more clearly on mission-related responsibilities. EFMs who meet specific eligibility criteria[493] can also register for TRICARE Extended Care Health Option (ECHO) program. This program provides financial assistance for services and supplies not available through TRICARE that are certified by TRICARE to confirm, arrest, or reduce the severity of the disabling effects of a qualifying condition.[494]

The ECHO program provides coverage for assistive services, durable medical equipment, and other services to support EFMs.[495] ECHO members may receive expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC) or applied behavior analysis (ABA) reinforcement services under the DoD Enhanced Access to Autism Services Demonstration.[496] ECHO provides up to 16 hours of respite care during any month when at least one other ECHO benefit is received.[497] Respite care must be received from a TRICARE-authorized home health agency.[498] EHHC beneficiaries may receive respite care for up to 8 hours per day for 5 days per week for EFMs with a plan of care that requires more than two interventions during the 8-hour period per day that the primary caregiver would normally be sleeping.[499]

---

[490] Military Family Readiness, DoDI 1342.22, Enclosure 3, 18-19 (2012).
[491] DoDI 1315.19 defines "family member" the same as "dependent." DoDI 1342.22 provides that "dependent" will be given the same definition as that found in 37 U.S.C. § 401(a), which defines "dependent" as a spouse, a dependent parent, or an unmarried child who is either under a given age or is incapable of self-support due to a mental or physical incapacity. DoDI 1315.19 provides criteria to be used in determining when a family member is a "family member with special needs." Criteria include certain diagnosed physical, intellectual, and emotional conditions.
[492] Military Family Readiness, DoDI 1342.22, Enclosure 3, 19 (2012).
[493] Conditions that qualify for ECHO coverage may include, but are not limited to, a diagnosis of moderate or severe mental retardation, serious physical disability, extraordinary physical or psychological condition of such complexity that the beneficiary is homebound, diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (younger than age 3) that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability, and multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems. National Defense, 32 CFR 199.5(b)(2). *See also* U.S. Department of Defense Military Health System, *Extended Care Health Option Fact Sheet*, accessed November 20, 2014, http://www.tricare.mil/~/media/Files/TRICARE/Publications/FactSheets/ECHO_FS.pdf.
[494] National Defense, 32 CFR 199.5(c). *See also* U.S. Department of Defense Military Health System, *Extended Care Health Option Fact Sheet,* accessed November 20, 2014, http://www.tricare.mil/~/media/Files/TRICARE/Publications/FactSheets/ECHO_FS.pdf.
[495] Ibid.
[496] Ibid.
[497] Ibid.
[498] Ibid.
[499] National Defense, 32 CFR 199.5(e). *See also* U.S. Department of Defense Military Health System, *Extended Care Health Option Fact Sheet*, accessed November 20, 2014, http://www.tricare.mil/~/media/Files/TRICARE/Publications/FactSheets/ECHO_FS.pdf.

As shown in Table 11, Service members with dependents registered in ECHO pay a monthly cost-share, based on their rank, for every month beneficiaries use ECHO benefits.[500] The current ECHO benefit cap is $36,000 per fiscal year per dependent.[501] EHHC is not included in this cap, but is capped at the maximum fiscal-year amount TRICARE would pay if the beneficiary resided in a skilled nursing facility based on the beneficiary's geographic location.[502] As of July 25, 2014, the ABA Autism Demonstration is no longer subject to this cap.[503]

Table 11. Monthly Cost-Shares for ECHO Participation[504]

Sponsor Pay Grade	Monthly Cost-Share	Sponsor Pay Grade	Monthly Cost-Share	Sponsor Pay Grade	Monthly Cost-Share
E1 to E5	$25	E9, W1, CWO2, O3	$45	O7	$100
E6	$30	W3, W4, O4	$50	O8	$150
E7, O1	$35	W5, O5	$65	O9	$200
E8, O2	$40	O6	$75	O10	$250

Service families are also eligible to apply to receive state Medicaid services for their EFM(s) in the state where they currently reside, including services available through state Medicaid waiver programs.[505] Waivers are used by states to develop new services and extend benefits to new populations beyond those typically provided by Medicaid.[506] Multiple types of waiver programs are available. The home- and community-based services (HCBS) waiver most closely aligns with the services active-duty family members with EFMs often express they need, including respite care, transportation support, and day-care for those with intellectual or developmental disabilities.[507] Unlike Medicaid, in which the family's income is considered as part of the eligibility process, income eligibility for HCBS waivers is based solely on the EFM's income,[508] allowing states to extend the Medicaid benefit to families that may not otherwise have access.[509] The purpose of the HCBS waiver is to meet the needs of individuals who choose to receive their long-term care services and support in their home or community, rather than in institutional settings.[510] ECHO participants are required to access these state and local services prior to accessing services under ECHO.[511] Table 12 summarizes the services offered under the HCBS waiver and ECHO programs.

---

[500] National Defense, 32 CFR 199.5(f)(2)(i).
[501] National Defense, 32 CFR 199.5(f)(3)(i).
[502] Ibid.
[503] *See* Federal Register, A Notice by The Defense Department on 06/16/2014, *Comprehensive Autism Care Demonstration,* accessed October 24, 2014, https://www.federalregister.gov/articles/2014/06/16/2014-14023/comprehensive-autism-care-demonstration#table_of_contents.
[504] National Defense, 32 CFR 199.5(e). See also U.S. Department of Defense Military Health System, *Extended Care Health Option Fact Sheet*, accessed June 20, 2014, http://www.tricare.mil/Plans/SpecialPrograms/Echo.aspx.
[505] The Public Health and Welfare, 42 U.S.C. § 1396a(a)(10)(ii)(VI). The Public Health and Welfare, 42 U.S.C. § 1396n.
[506] West Virginia University, *Medicaid and Military Families with Children with Special Healthcare Needs: Accessing Medicaid and Waivered Services*, 16, accessed June 26, 2014, http://www.militaryonesource.mil/12038/MOS/EFMP/EFMP_MedicaidReport.pdf.
[507] Ibid.
[508] The Public Health and Welfare, 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI). The Public Health and Welfare, 42 U.S.C. § 1396n.
[509] West Virginia University, *Medicaid and Military Families with Children with Special Healthcare Needs: Accessing Medicaid and Waivered Services*, 21-22, accessed June 26, 2014, http://www.militaryonesource.mil/12038/MOS/EFMP/EFMP_MedicaidReport.pdf.
[510] *See* The Public Health and Welfare, 42 U.S.C. § 1396n, originally enacted as § 1915(c) of the Social Security Act of 1935.
[511] Armed Forces, 10 U.S.C. §1079(f)(4).

Table 12. Statutory Guidelines for HCBS Waivers and ECHO

HCBS Waiver[512]	ECHO[513]
Adult Day Care: Daytime, community-based program for functionally impaired adults that provides a variety of health, nutrition, social, and related services in a protective setting to those who are otherwise being cared for by family members. Its purpose is to enable individuals to remain at home and in the community and to encourage family members to care for them by providing relief from the burden of constant care.	Training, rehabilitation, special education, and assistive technology devices.
Adult Day Habilitation Services: Day program usually serving individuals with mental retardation/developmental disabilities, teach skills such as cooking, recreation, and work skills. The individual may work part of the day with other individuals with disabilities in assembly and production work for piece rate wages or below minimum wages (Work Activities Center). In some sites, the recipient attends a center with peers learning nonvocational or prevocational skills.	Training, rehabilitation, special education, and assistive technology devices.
Adult Day Health Services: Adult day care setting that provides more health-related services.	Inpatient, outpatient, and comprehensive home health care supplies and services that may include cost effective and medically appropriate services other than part-time or intermittent services (within the meaning of such terms as used in the second sentence of section 1861(m) of the Social Security Act).
Assistive Technology: A range of equipment, machinery and devices that share the purpose of assisting or augmenting the capabilities of individuals with disabilities in almost every area of daily community life, including mobility, independence in activities of daily life, communication, employment learning and so forth. Specialized examples include wheelchairs and ramps, and electronic and printed picture/icon communication devices, but also can include tape recorders and tapes for messages, materials, instructions and so forth normally presented on paper, special large or punch switches available at a local electronics store, level door handles (as opposed to knobs) that are available at any hardware store, and telephones with single function keys for dialing certain numbers that are available at most department stores.	Training, rehabilitation, special education, and assistive technology devices.

[512] The Public Health and Welfare, 42 U.S.C. § 1396n, originally enacted as § 1915(c) of the Social Security Act of 1935. West Virginia University, *Medicaid and Military Families with Children with Special Healthcare Needs: Accessing Medicaid and Waivered Services*, 100-01, accessed June 26, 2014, http://www.militaryonesource.mil/12038/MOS/EFMP/EFMP_MedicaidReport.pdf.
[513] Armed Forces, 10 U.S.C. § 1079(f)(4). National Defense, 32 CFR 199.5.

HCBS Waiver[512]	ECHO[513]
Adaptive Equipment: Physical and/or mechanical modifications to the home, vehicle or the recipient's personal environment.	N/A, although the law states "such other services and supplies as determined appropriate by the Secretary, notwithstanding the limitations in subsection (a)(13)."
Case Management: Services that assist individuals' access to needed medical, social, educational, and other services.	…and case management services with respect to the qualifying condition of such a dependent…
Personal Care Attendant: Services such as help balancing a checkbook, grocery shopping, developing a budget, paying bills, etc.	Custodial care, notwithstanding the prohibition in section 1077 (b)(1) of this title.
Habilitation Services: Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and includes prevocational, educational, and supported employment.	Training, rehabilitation, special education, and assistive technology devices.
Homemaker Services: Assistance with general household activities and ongoing monitoring of the well-being of the individual.	Custodial care, notwithstanding the prohibition in section 1077 (b)(1) of this title.
Home Health Aide: Health care professional who assists with specific health problems.	Inpatient, outpatient, and comprehensive home health care supplies and services that may include cost effective and medically appropriate services other than part-time or intermittent services (within the meaning of such terms as used in the second sentence of section 1861(m) of the Social Security Act).
Nursing Care Services: Services provided by or under the direction of a registered nurse.	Inpatient, outpatient, and comprehensive home health care supplies and services that may include cost effective and medically appropriate services other than part-time or intermittent services (within the meaning of such terms as used in the second sentence of section 1861(m) of the Social Security Act).
Personal Care Services: Direct supervision and assistance in daily living skills and activities (e.g., assisting the individual with bathing and grooming).	Custodial care, notwithstanding the prohibition in section 1077 (b)(1) of this title.

HCBS Waiver[512]	ECHO[513]
Respite Care: Short-term supervision, assistance, and care provided due to the temporary absence or need for relief of recipient's primary caregivers. This may include overnight, in-home or out-of-home services. Training for the family in managing the individual. Day treatment or other partial hospitalization, psycho-social rehabilitation services and clinical services for people with a mental illness.	Respite care for the primary caregiver of the eligible dependent.
Vocational Services: Supported employment, prevocational education, and other services not covered by other sources.	Training, rehabilitation, special education, and assistive technology devices.

For additional information on ECHO and EFMP, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 4.1.13.4 and Section 5.1.10.8).*

Findings:
The list of HCBS waiver benefits authorized by the Social Security Act[514] and the list of ECHO benefits authorized through TRICARE[515] are very similar, although actual implementation of the two programs varies.[516] A DoD-commissioned study published in November 2013 by West Virginia University found that Service families with special needs use Medicaid as a resource to obtain specific supplementary services and coverage.[517] Examples include respite care, transportation, supplies like diapers for older children, durable medical equipment, and nutritional products such as formula that are either not provided or not fully covered by TRICARE.[518]

Respite care is one of the greatest needs among families that have children with intellectual and developmental disabilities, such as autism.[519] Home and community-based waiver programs are seen as a lifeline to supplement the limited respite care benefits provided by the military health system or by the respite care programs of the various Services.[520]

Access to HCBS waiver benefits is a substantial issue for military families with EFMs. Service members are required to re-apply for benefits each time they move to a new state.[521] Many Service members encounter waiting lists that exceed their time assigned to a location.[522] Table 13 provides waiver waiting list estimates indicating the number of people waiting for services in each of the top 10 states with the largest active-duty

[514] The Public Health and Welfare, 42 U.S.C. § 1396n.
[515] Armed Forces, 10 U.S.C. § 1079.
[516] Military Family Advisory Network (MFAN), briefing to MCRMC, February 28, 2014.
[517] West Virginia University, *Medicaid and Military Families with Children with Special Healthcare Needs: Accessing Medicaid and Waivered Services*, 4, accessed June 26, 2014, http://www.militaryonesource.mil/12038/MOS/EFMP/EFMP_MedicaidReport.pdf.
[518] Ibid.
[519] Ibid.
[520] Ibid.
[521] West Virginia University, *Medicaid and Military Families with Children with Special Healthcare Needs: Accessing Medicaid and Waivered Services*, 19, accessed June 26, 2014, http://www.militaryonesource.mil/12038/MOS/EFMP/EFMP_MedicaidReport.pdf.
[522] Ibid, 5.

military populations for FY 2012.[523] The average waiting period during this time across all HCBS enrollment groups and all states was 27 months and the average waiting period for the largest enrollment group (EFMs with intellectual or developmental disabilities, representing 303,909 of the total 523,710 individuals on HCBS waiver waiting lists) was 47 months.[524]

Table 13. HCBS Waiting Lists, FY 2012

State	Waiting List Estimate	State	Waiting List Estimate
California	2,117	Washington	1,281
Virginia	7,816	Florida	51,379
Texas	160,243	Hawaii	0
North Carolina	16,869	Kentucky	0
Georgia	11,242	South Carolina	6,004

As a result, there are reported cases in which military family members leave a child in one state to live with relatives while the Service member is assigned to a new installation in a different state.[525] This situation occurs when the child is receiving waivered services in the current state of residence and the same service is either not available or only available after a long waiting period in the state to which the Service member has been assigned.[526]

In FY 2013, 8,094 individuals participated in ECHO,[527] representing 6.3 percent of EFMP families.[528] Of these, 423 accessed ECHO only for primary services such as equipment, supplies, education, and training services.[529] The total cost of these primary services was $1.7 million.[530] The other 7,671 individuals also participated in either EHHC or ABA, at a cost of $152.6 million.[531]

Conclusions:
As evidenced by the similarity in benefits authorized under the HCBS and ECHO programs, as well as the directive to use state and local services before accessing ECHO, the Congress intended ECHO as an alternative to unavailable waiver benefits. Yet ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs when those programs are inaccessible to Service members and their EFMs. With the exception of home health care services and ABA therapy services, the ECHO program is not highly utilized. This is due to a lack of needed services.

---

[523] Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2010 Data Update*, accessed November 10, 2014, http://kff.org/medicaid/report/medicaid-home-and-community-based-service-programs.
[524] Ibid.
[525] West Virginia University, *Medicaid and Military Families with Children with Special Healthcare Needs: Accessing Medicaid and Waivered Services*, 40, accessed June 26, 2014, http://www.militaryonesource.mil/12038/MOS/EFMP/EFMP_MedicaidReport.pdf.
[526] Ibid.
[527] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, October 20, 2014.
[528] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, October 20, 2014 and Department of Defense Annual Report to Congress on Plans for DoD for Support of Military Family Readiness, FY 2013, 45, received from Department of the Army, e-mail to MCRMC, May 22, 2014.
[529] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, October 20, 2014.
[530] Ibid.
[531] Ibid.

Recommendations:

- Services covered through ECHO should be increased to more closely align with state Medicaid waiver programs, to include allowing for consumer-directed care.[532] Expanded services should be subject to the ECHO benefit cap of $36,000 per fiscal year, per dependent. Specific examples include, but are not limited to:

  - expanding respite care hours to align more closely with state offerings as well as allowing families to access those hours without receiving another ECHO benefit during the same month the respite care is received

  - providing custodial care

  - providing adult diapers where necessary and appropriate

Implementation:

- 10 U.S.C. § 1079 governs medical care for dependents of Uniformed Services members. No change to this governing statute is recommended.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed. Such as:

  - 32 CFR 199.5(e) should be amended to align ECHO-provided services with those provided by state Medicaid waiver programs. As described above, these changes should include, but should not be limited to, expanding respite care hours to align more closely with state offerings, removing requirements that respite care is only available to households that receive another ECHO benefit, providing custodial care, and providing adult diapers when necessary and appropriate.

[532] *See* The Public Health and Welfare, 42 U.S.C. § 1396n(k)(3)(B).

Recommendation 8: Improve collaboration between the Departments of Defense and Veterans Affairs by enforcing coordination on electronic medical records, a uniform formulary for transitioning Service members, common services, and reimbursements.

Background:
The Department of Defense (DoD) and the Department of Veterans Affairs (VA) operate two of the nation's largest health care systems, providing health care to approximately 16 million active-duty Service members, retirees, veterans, and their families each year.[533] To coordinate efforts and improve cost effectiveness between these systems, which together provide health care to Service members throughout their lives, the Congress established the DoD–VA Joint Executive Committee (JEC).[534] The JEC is cochaired by the Under Secretary of Defense (Personnel & Readiness) and the Deputy Secretary of Veterans Affairs,[535] who determine the Committee's size and structure, its administrative and procedural guidelines for the operation of the Committee, and staffing and resources.[536] Subcommittees include the Health Executive Committee (HEC), the Benefits Executive Committee (BEC), DoD–VA Interagency Program Office (IPO), Interagency Care Coordination Committee (IC3), and subordinate working groups.[537] The JEC's current charter (signed 14 October 2014) states it has responsibility to do the following:

- *oversee development and execution of VA/DoD Joint Strategic Plan (JSP)*
- *provide oversight to the JEC sub-committees (HEC, BEC, IPO, IC3) and their working groups*
- *identify opportunities to coordinate and share services and resources that would improve delivery of services for qualified beneficiaries*
- *submit an Annual Report to Secretaries and Congress on decisions made and actions taken by JEC, its subcommittees, and independent working groups* [538]

The JEC is working to coordinate numerous health care activities between DoD and VA. For example, its Acquisition and Medical Materiel Management Working Group identifies, reviews, and implements joint medical materiel sharing initiatives.[539] The Pharmacy Ad Hoc Working Group explores joint initiatives "with the goal of reducing redundancies, increasing efficiencies, and maximizing buying power."[540] The Psychological Health/Traumatic Brain Injury Working Group works to increase and sustain communication and collaboration between VA and DoD on related medical

[533] Government Accountability Office, *Electronic Health Records, VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration*, GAO-14-302 (2014), Highlights, accessed October 15, 2014, http://www.gao.gov/products/GAO-14-302.
[534] National Defense Authorization Act FY 2004, Pub. L. No. 108-136, § 583, 117 Stat. 1392, 1490 (2003) (codified at Veterans' Benefits, 38 U.S.C. § 320).
[535] Veterans' Benefits, 38 U.S.C. § 320, *JEC Membership*, accessed November 19, 2014, http://www.tricare.mil/DVPCO/downloads/JEC4-1.ppt.
[536] Veterans' Benefits, 38 U.S.C. § 320.
[537] Veterans' Benefits, 38 U.S.C. § 320, JEC organization chart obtained from DoD-VA Collaboration Office, October 16, 2014.
[538] DoD-VA Collaboration Office, new JEC charter, e-mail to MCRMC, October 16, 2014.
[539] Department of Veterans' Affairs, *VA/DoD Joint Executive Committee Annual Report Fiscal Year 2013*, 61, accessed November 19, 2014, http://www.va.gov/op3/docs/StrategicPlanning/VA_DoD_JEC_Annual_Report_for_FY_2013_signed_3.pdf.
[540] Ibid, 82.

conditions, including identification, evaluation, and provision of associated services.[541] DoD is a member of VA's Medical Advisory Panel (MAP) and VA is a member of DoD's Pharmacy and Therapeutics Committee (PTC). These groups determine their respective department's drug formulary.[542]

The JEC is responsible for coordinating efforts between DoD and VA with regard to electronic health records (EHR), drug formularies and deliveries, resource sharing, and interagency billing.[543] DoD's EHR relies on multiple legacy medical information systems, such as the Armed Forces Health Longitudinal Technology Application (for ambulatory clinical documentation), the Composite Health Care System (for pharmacy, radiology, and laboratory order management), and Essentris (for inpatient treatment).[544] The VA operates Veterans Health Information Systems and Technology Architecture (VistA), which was developed by VA clinicians and IT personnel and consists of more than 100 separate computer applications.[545] To improve information sharing between these systems, the departments have conducted numerous initiatives since 1998. These efforts to achieve interoperability included linking and sharing computable data between the departments' health data repositories, establishing and addressing interoperability objectives to meet specific data-sharing needs, developing a virtual lifetime electronic health record to track patients through active service and veteran status, and implementing information technology capabilities for the first joint federal health care center.[546] The Congress has mandated further interoperability on multiple occasions, including pharmacy data sharing in the National Defense Authorization Act (NDAA) for FY 2003[547] and full interoperability in the NDAA for FY 2008[548] and NDAA for FY 2014.[549]

The JEC is also responsible for developing strategies to ensure transitioning Service members have access to consistent medication. For example, its Pain Management Working Group is responsible for developing processes to make certain "eligible beneficiaries receive the highest standards of pain care, delivered seamlessly across both health care systems."[550] DoD's drug formulary is developed by its PTC.[551] The VA has a national formulary (VANF) as the only drug formulary authorized for use in the Veterans Health Administration (VHA).[552] The VANF is developed by VA's Pharmacy

[541] Ibid, 14.
[542] U.S. Department of Defense Pharmacy & Therapeutics Committee Charter, 4, accessed January 8, 2015, http://pec.ha.osd.mil/P&T/PDF/Charter DoD P&T Committee May 2009 - signed.pdf. Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook 1108.08 2009,* 1, accessed December 20, 2014, http://www.pbm.va.gov/directive/vhadirective.pdf.
[543] *See generally*: The Department of Veterans Affairs (VA) and the Department of Defense (DoD) Joint Executive Committee (JEC), *Joint Strategic Plan (JSP),* accessed December 20, 2014, http://www1.va.gov/op3/docs/StrategicPlanning/VA_DoD_JEC_JSP_FY_2013_2015.pdf
[544] Government Accountability Office, *Electronic Health Records, VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration*, GAO-14-302 (2014), 4, accessed October 15, 2014, http://www.gao.gov/products/GAO-14-302.
[545] Ibid, 3.
[546] Ibid, 6, 11.
[547] Bob Stump National Defense Authorization Act for FY 2003, Pub. L. No. 107-314, § 724, 116 Stat. 2458, 2598 (2002).
[548] National Defense Authorization Act for FY 2008, Pub. L. No. 110-181, § 1635, 122 Stat. 3, 460 (2008).
[549] National Defense Authorization Act for FY 2014, Pub. L. No. 113-66, § 713, 127 Stat. 672, 794 (2013).
[550] VA/DoD Joint Executive Committee, *Annual Report Fiscal Year 2013,* 40, accessed December 20, 2014, http://www.va.gov/op3/docs/StrategicPlanning/VA_DoD_JEC_Annual_Report_for_FY_2013_signed_3.pdf.
[551] Armed Forces, 10 U.S.C. § 1074g, National Defense, 32 CFR 199.21(c). DoD Pharmacy and Therapeutics Committee Charter, 1, accessed January 13, 2015, http://pec.ha.osd.mil/PT_min_charter.php?submenuheader=5.
[552] U.S. Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook 1108.08: Formulary Management Process (February 26, 2009),* 3, accessed June 20, 2014, http://www.pbm.va.gov/directive/vhadirective.pdf.

Benefits Management office,[553] which works with the VA MAP and Veterans Integrated Service Network (VISN) formulary leaders.[554] VISNs are prohibited from maintaining local drug formularies at individual medical care facilities.[555] To facilitate patient care, VA maintains a process to request nonformulary drugs determined to be clinically necessary.[556] Requests are subject to a list of pharmaceutical products for which substitution is not permitted,[557] and denied requests can be appealed by the requesting physician.[558] As mentioned above, DoD and VA have representatives on the MAP and PTC, respectively.[559]

The JEC also identifies opportunities for resource sharing agreements (RSA), which improve joint coordination and cost-effectiveness between the departments.[560] There are currently approximately 200 RSAs in place[561] covering clinical and nonclinical services such as inpatient services, radiology, and laundry services.[562] Larger strategic alliances between the departments, with commitments of 5 years or more, include 10 department-initiated DoD and VA joint ventures and the Congressionally mandated DoD–VA Medical Facility Demonstration Project Federal Health Care Center (FHCC) in North Chicago.[563] These joint ventures, which generally involve joint capital planning and shared risk,[564] include facilities in Charleston, South Carolina;[565] Las Vegas, Nevada;[566] and El Paso, Texas. [567] To provide financial encouragement for increased resource sharing, the Congress established the Joint Incentive Fund (JIF) in 2002. The JIF is a DoD and VA program that identifies, incentivizes, implements, funds, and

---

[553] Ibid, 2.
[554] Ibid, 2.
[555] Ibid, 3.
[556] Ibid,6.
[557] Ibid,14.
[558] Ibid, 8.
[559] Armed Forces, 10 U.S.C. § 1074g, National Defense, 32 CFR 199.21(c), DoD Pharmacy and Therapeutics Committee Charter, accessed January 13, 2015, http://pec.ha.osd.mil/PT_min_charter.php?submenuheader=5.
[560] Veterans' Benefits, 38 U.S.C. § 320. Veterans' Benefits, 38 U.S.C. § 8111. Armed Forces, 10 U.S.C. § 1104. DODI 6010.23, *DOD and Department of Veterans Affairs (VA) Health Care Resource Sharing Program* (October 3, 2013).
[561] DoD/VA Coordination Office, Defense Health Agency, e-mail to MCRMC, October 9, 2014.
[562] Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook 1660.04*, para 6.b., http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1776. Gulf Coast Veterans Health Care System, briefing to MCRMC, May 21, 2014.
[563] *Memorandum of Understanding Between the Department of Veterans Affairs and the Department of Defense Health Care Resources Sharing Guidelines*, 3, accessed December 20, 2014, http://www.tricare.mil/dvpco/downloads/MOU.pdf. National Defense Authorization Act for FY 2010, Pub. L. No. 111-84, tit. XVII, 123 Stat. 2190, 2567. DoD/VA Coordination Office, Defense Health Agency, e-mail to MCRMC, October 19, 2014. DoD/VA Coordination Office, Defense Health Agency, email to MCRMC, October 9, 2014. VA/DOD Joint Executive Committee, *Annual Report Fiscal Year 2013*, 64, accessed December 17, 2013, http://www.va.gov/op3/docs/StrategicPlanning/VA_DoD_JEC_Annual_Report_for_FY_2013_signed_3.pdf.
[564] *Memorandum of Understanding Between the Department of Veterans Affairs and the Department of Defense Health Care Resources Sharing Guidelines*, para. IV(D)(2), (31 Oct 2008), http://www.tricare.mil/dvpco/downloads/MOU.pdf. NDAA for FY 2010, Pub. L. No. 111-84, tit. XVII, 123 Stat. 2190, 2567. DoD/VA Coordination Office, Defense Health Agency, email to MCRMC, October 9, 2014. VA/DOD Joint Executive Committee, *Annual Report Fiscal Year 2013*, 64, accessed December 17, 2013, http://www.va.gov/op3/docs/StrategicPlanning/VA_DoD_JEC_Annual_Report_for_FY_2013_signed_3.pdf.
[565] Naval Health Clinic Charleston, Ralph H. Johnson VA Medical Center, 628th Medical Group-Joint Base Charleston and Naval Hospital Beaufort, accessed October 16, 2014 http://www.charleston.va.gov/features/VA_DoD_Joint_Venture_Wins_Federal_Executive_Award.asp.
[566] "Mike O'Callahan Federal Medical Center," 99th Medical Group-Nellis AFB and VA Southern Nevada Healthcare System, accessed October 16, 2014, http://www.lasvegas.va.gov/locations/Mike_O_Callahan_Federal_Medical_Center.asp.
[567] "History," William Beaumont Army Medical Center- Fort Bliss and El Paso VA Health Care System, accessed October 16, 2014, http://www.elpaso.va.gov/about/history.asp.VA/DoD Joint Executive Committee, *Annual Report Fiscal Year 2013*, 64, accessed Jan. 9, 2015, http://www.va.gov/op3/docs/strategicPlanning/VA_DOD_JEC_Annual_Report_for_FY_2013_signed_3.pdf/

evaluates creative coordinating and sharing initiatives at the facility, intraregional, and national levels.[568]

General RSA guidelines are outlined in DoD Instruction (DoDI) 6010.23: *DoD and Department of Veterans Affairs (VA) Health Care Resource Sharing Program* and Veterans Health Administration Handbook 1660.04: *VA–DoD Direct Sharing Agreements*.[569] DoDI 0010.23 states, "the HEC shall oversee the DoD–VA Health Care Resource Sharing Program activities of each agency"[570] and "the heads of [military] medical facilities [will] participate in regular meetings with VA counterparts to monitor emerging opportunities…for resource sharing."[571] Similarly, the VA Handbook states, "VA medical facilities and VISNs [have] the flexibility to negotiate sharing agreements"[572] and "VA TRICARE Regional Office Liaisons responsibilities include…identifying new areas for economies of scale."[573] These documents further indicate each component engaged in interaction will designate points of contact and establish DoD–VA sharing program offices within respective departments, to be overseen by the HEC.[574] DoDI 6010.23 also mandates the annual military treatment facility (MTF) and regional business planning process must include assessment of opportunities for resource sharing with the VA.[575] Given this general guidance, along with DoD and VA's interpretation of 38 U.S.C. § 8111 "as intending resource sharing to be largely a grassroots endeavor,"[576] most RSAs are negotiated and implemented within local markets by local commanders.[577] Sharing is accomplished when it is mutually beneficial [financially] for both organizations.[578]

To further facilitate RSAs, the statute stipulates, "the [DoD and VA] Secretaries shall jointly develop and implement guidelines for a standardized, uniform payment and reimbursement schedule for [health care] services."[579] The HEC developed a health care resource sharing reimbursement methodology.[580] The Financial Management Work Group (FMWG), under the HEC, developed a discounted national rate structure.[581] The methodology basically applies "CHAMPUS Maximum Allowable Charge (CMAC) rates less 10 percent…as the reimbursement methodology for health care reimbursement between medical facilities, for institutional and professional

---

[568] 38 U.S.C. § 8111 (d).
[569] Resource sharing is also outlined in Veterans' Benefits, 38 U.S.C. § 8111, *Sharing of Department of Veterans Affairs and Department of Defense health care resources* and Armed Forces, 10 U.S.C. § 1104, *Sharing of health-care resources with the Department of Veterans Affairs.*
[570] DoDI 6010.23, Jan 23 2014, Enclosure 3, para 1.a.(3)
http://www.dtic.mil/whs/directives/corres/pdf/601023p.pdf
[571] Ibid, enclosure 2, para 3.d.(3)
[572] Department of Veterans Affairs and Veterans Health Administration, *VHA Handbook 1660.04* para 5.a. and b
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1776.
[573] Ibid. para 5.c.(2)
[574] DoDI 6010.23, January 23, 2012, para 2 and 3b http://www.dtic.mil/whs/directives/corres/pdf/601023p.pdf.
Department of Veterans Affairs and Veterans Health Administration, *VHA Handbook 1660.04* para 5.a. and b
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1776.
[575] DoDI 6010.23, January 23, 2012, Enclosure 3, 3.a. http://www.dtic.mil/whs/directives/corres/pdf/601023p.pdf
[576] Government Accountability Office, *VA And DoD Health Care: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities*, GAO 12-992, 44 and 48, accessed December 20, 2014, http://www.gao.gov/assets/650/648961.pdf.
[577] 38 U.S.C. § 8111 € (3) (A). DoDI 6010.23 (January 23, 2012), Enclosure 2, 3d(4).
[578] 38 U.S.C. § 8111 and DoDI 6010.23, January 23, 2012, Enclosure 3, para 3.b.(1).
[579] 38 U.S.C. § 8111 papa € (2).
[580] Veterans Affairs/Department of Defense Health Executive Council, *Memorandum of Agreement Health Care Resource Sharing Reimbursement Methodology,* 1, accessed October 14, 2014,
http://tricare.mil/DVPCO/downloads/MOA/MOA-ReimbursementMethodology.pdf. This methodology does not apply to TRICARE Managed Support Contractors.
[581] Ibid.

charges."[582] The FMWG also developed billing guidance for inpatient[583] and outpatient services.[584] These standard rates can be regionally adjusted to account for local variations.[585]

Findings:
The Commission found numerous, ongoing weaknesses exist in joint collaboration and cost-effectiveness between the health care services of DoD and VA. For example, although DoD and VA have identified many common health care business needs and shared interests related to ensuring quality health care for Service members, veterans, and their families, the departments continue to spend large sums of money on separate EHR systems and capabilities to achieve interoperability between the systems.[586] The EHRs and data interoperability applications to date have yet to achieve seamless electronic sharing of health data between the departments, to the detriment of Service members, veterans, retirees, and taxpayers. The NDAA for FY 2008 required DoD and VA to jointly develop and implement an EHR system or capabilities that allow for full interoperability between the two agencies to accelerate the exchange of health care information and support health care delivery.[587] It also directed the departments to establish the DoD–VA Interagency Program Office (IPO) to be a single point of accountability for their efforts to implement these systems or capabilities by the September 30, 2009 deadline.[588] The departments indicated they met the interoperability objectives required at that time, and they continued to plan additional initiatives to increase the interoperable capabilities, stating that clinicians' needs for interoperable EHRs are not static.[589] In 2011, to avoid continued challenges in trying to achieve interoperability between two separate systems, the departments committed to developing and fielding a joint, integrated EHR (iEHR) by 2017.[590] The departments also rechartered the IPO with increased authority and expanded responsibilities for leading the iEHR effort.[591] In 2013, however, DoD and VA abandoned this plan, citing challenges meeting deadlines, expense, and excessive time to deliver capabilities as reasons for doing so.[592]

Although data-sharing initiatives have increased the amount of information shared in various capacities overall, a number of them have faced persistent challenges, including project planning and management weakness, inadequate accountability, and poor oversight, limiting the departments' ability to achieve full interoperability.[593] The departments announced in early 2013 they would pursue separate paths to modernize

---

[582] Ibid, para 3.A.
[583] Veterans Affairs/Department of Defense Health Executive Council, *Department of Veterans Affairs (VA)-Department of Defense (DoD) Health Care Resource Sharing Rates-Billing Guidance Inpatient Services*, accessed October 14, 2014, http://tricare.mil/DVPCO/downloads/BillingGuidance-signed.pdf.
[584] Veterans Affairs/Department of Defense Health Executive Council, *VA-DoD Health Care Resource Sharing Rates-Billing Guidance Outpatient Services*, accessed October 14, 2014, http://tricare.mil/DVPCO/downloads/MOA/MOA-BillingGuidanceOutpatientServices.pdf.
[585] Veterans Affairs/Department of Defense Health Executive Council, *Memorandum of Agreement Health Care Resource Sharing Reimbursement Methodology*, 1, accessed October 14, 2014, http://tricare.mil/DVPCO/downloads/MOA/MOA-ReimbursementMethodology.pdf.
[586] Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, October 27, 2014.
[587] National Defense Authorization Act for FY 2008, Pub. L. No. 110-181, § 1635(d), 122 Stat. 3, 461 (2008)
[588] Ibid.
[589] Government Accountability Office, *Electronic Health Records, VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration*, GAO-14-302 (2014), 9, accessed October 15, 2014, http://www.gao.gov/products/GAO-14-302.
[590] Ibid, 15.
[591] Ibid, 15-16.
[592] Ibid, 17.
[593] Ibid, 9.

their EHRs and ensure interoperability between the two systems rather than develop a single system.[594] VA announced VistA Evolution as the upgrade to the existing VistA, with initial operating capabilities (IOC) and full operating capabilities (FOC) expected by FY 2014 and 2017, respectively.[595] DoD decided to pursue a competitive acquisition of a completely new commercial EHR system, releasing a request for proposals in August 2014.[596] DoD's new comprehensive EHR is intended to replace current legacy systems, including outpatient, inpatient, and operational level capabilities.[597] IOC and FOC for the new system are planned for FY 2017 and FY 2022, respectively.[598]

Given the history of challenges in achieving interoperability, whether current interoperability efforts will be successful or cost-effective is questionable. When the departments decided to pursue separate EHR systems, they rechartered the IPO as the entity responsible for establishing, monitoring, and approving the clinical and technical standards profile and processes to ensure seamless integration of health data between the two departments and private health care providers.[599] Additionally, the IPO is to work with the Office of the National Coordinator for Health Information Technology of the Department of Health and Human Services to ensure the new EHRs comply with national data standards and architectural requirements.[600] When the departments abandoned the iEHR, they asserted their new, multiple-system approach would be less expensive and more expedient.[601] These assertions are questionable because the departments have not developed collective, comprehensive, comparative cost and schedule estimates to substantiate this claim or justify their decision to implement separate systems.[602]

The departments are, however, continuing to make progress with sharing data and increasing interoperability efforts as outlined in their briefs to the Congress, as directed per the NDAA for FY 2014.[603] In a January 27, 2014 presentation on their EHR plans, the DOD and VA EHR Program Plans brief outlined the program objectives, organization, responsibilities of the departments, technical objectives, including design principles and milestones, data standards being adopted by the programs, outcome-based metrics proposed to measure the performance and effectiveness of the programs, and the level of funding for fiscal years 2014 through 2017.[604] VistA Evolution funding, however, only reflected the FY 2014 Budget

---

[594] Ibid, 17.
[595] Ibid, 21.
[596] Secretary of Defense Memorandum, *Integrated Electronic Health Records* (May 21, 2013), Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, October 27, 2014. Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, November 13, 2014..
[597] Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, September 30, 2014.
[598] Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, April 30, 2014, Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, October 27, 2014..
[599] Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, October 27, 2014. DoD/VA Interagency Program Office Charter, December 2013. See also Government Accountability Office, *Electronic Health Records, VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration*, GAO-14-302 (2014), 25, accessed October 15, 2014, http://www.gao.gov/products/GAO-14-302.
[600] National Defense Authorization Act for FY 2014, Pub. L. No. 113-66, § 713, 127 Stat. 672, 794 (2013).
[601] Government Accountability Office, *Electronic Health Records, VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration*, GAO-14-302 (2014), 19, accessed October 15, 2014, http://www.gao.gov/products/GAO-14-302.
[602] Ibid, 33.
[603] Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, October 27, 2014. Department of Defense, Department of Veterans Affairs, *U.S. DoD/DVA Data Sharing Progress Quarterly Report, 3rd QTR, FY 2014*.
[604] Ibid.

requirements.[605] The departments have been working together to move forward from read-only data shared through the Federal Health Information Exchange and Bi-Directional Health Information Exchange applications to enhance interoperability that provides data that is more integrated into clinical workflow.[606] These efforts include mapping data domains to existing national data standards and integrating them into the Joint Legacy Viewer, thereby improving clinicians' ability to examine DoD or VA patient records.[607]

Record sharing is vital to transitioning Service members who are leaving the DoD system with complex medical issues and ongoing health care needs. The Commission heard from several beneficiaries about the difficulties that poor records sharing can cause during the transition from the DoD to the VA system. One survey respondent wrote, "The [DoD] medical software should be linked with the VA clinics, so when people get out, their records can be transferred into the VA system automatically."[608] One person wrote in a letter to the Commission, "Hold DoD to [a] system of medical records compatible with [the] VA system.… [There are] too many excuses and wasted funds to date."[609]

Another critical example of insufficient coordination between the departments is when drug formularies for transitioning Service members continue to differ between the DoD and VA. Currently, several key drugs appear on the DoD formulary that do not appear on the VA formulary.[610] For example, the VA formulary does not contain two pain medications (celecoxib and acetaminophen with codeine) and two psychiatric medications (escitalopram oxalate and duloxetine HCL) that are among DoD's top-10 prescribed drugs in these classes.[611] Similarly, the Government Accountability Office (GAO) conducted a study of all psychiatric and pain medications on DoD's and VA's formularies and found that 43 percent of the medications on DoD's formulary were not on VA's formulary.[612]

GAO found inconsistencies in the nonformulary request process and identified a lack of metrics for the adjudication of the requests.

> *"VISNs and medical centers are responsible for implementing the nonformulary drug request process, and there is variation in the approaches that VISNs and medical centers take. For example, some VISNs and medical centers have more automated approaches to adjudicating nonformulary drug requests and collecting and reporting required data than others. In response to recommendations we made in*

[605] Ibid.
[606] Ibid.
[607] Defense Healthcare Management Systems, Program Executive Office, e-mail to MCRMC, October 27, 2014.
[608] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[609] MCRMC letter writer, comment form submitted via MCRMC web site, October 18, 2013.
[610] Based on comparison of the following: Department of Veterans Affairs, Veterans Affairs National Formulary (February 2014), http://www.pbm.va.gov/nationalformulary.asp. Department of Veterans Affairs, Veterans Health Administration, pharmacy data provided by email from VHA (April 16, 2014). U.S. Department of Defense, Defense Health Agency, *Basic Core Formulary*, http://pec.ha.osd.mil/bcf.php?submenuheader=1, U.S. Department of Defense, Defense Health Agency, *Extended Core Formulary*, http://pec.ha.osd.mil/ecf.php?submenuheader=1, U.S. Department of Defense, Defense Health Agency, *DOD Nonformulary Drugs*, http://pec.ha.osd.mil/nonform.php?submenuheader=1, Defense Health Agency, DOD Pharmacy Data for FY 2013 provided by email to MCRMC, May 1, 2014.
[611] Ibid.
[612] *See generally* Government Accountability Office, *VA and DOD Health Care: Medication Needs During Transitions May Not Be Managed For All Servicemembers*, GAO 13-26 November 2012, accessed December 20, 2014, http://www.gao.gov/products/GAO-13-26.

> *our 2001 report, VA established a requirement for routine nonformulary drug requests to be adjudicated within 96 hours. However, some adjudications continue to surpass this threshold, and data reported to monitor timeliness are not always accurate or complete for all VISNs and their medical centers. Additionally, reported data are only required to include average adjudication times for nonformulary drug requests, which do not capture the total number of adjudications that fall outside VA's 96-hour standard. Finally, VA does not require that appeals of denied nonformulary drug requests are resolved within a certain time frame or that the outcomes of appeals are tracked. Given these limitations, additional steps are needed to ensure that veterans receive clinically necessary nonformulary drugs in a timely manner."* [613]

The unavailability of these drugs for transitioning Service members causes unnecessary hardship because finding the ideal medication and dose takes time, and abrupt changes for these medications are not medically advisable.[614] Because of the potential adverse health effects that could arise if medication is not taken as intended, medication management is critical to effective continuity of care for Service members transitioning out of the military.[615] As early as 2002, GAO found there was an increased risk for patient medication errors because DoD and VA have separate and uncoordinated information and formulary systems.[616] GAO recommended the departments improve their capabilities for sharing electronic information.[617] In 2003, GAO reported DoD and VA providers and pharmacists were still unable to electronically access health information to aid in making medication decisions for veterans, such as verifying drug allergies and interactions.[618] A decade later, in 2013, GAO again found DoD and VA efforts to manage transitioning Service members' medications somewhat limited because not all DoD MTFs offered assistance to facilitate transition of care.[619] GAO recommended DoD and VA identify and apply best practices for managing Service members' medication needs during transitions of care.[620] Although both agencies agreed with GAO recommendations, neither DoD nor VA identified actions to address the GAO recommendations.[621]

Additional collaboration between DoD and VA in drug purchasing could reduce costs for both departments. In addition to having access to discount-priced drugs through the Federal Supply Schedule and federal price ceilings, DoD and VA can jointly

---

[613] Government Accountability Office, *VA Drug Formulary: Drug Review Process Is Standardized at the National Level, but Actions Are Needed to Ensure Timely Adjudication of Nonformulary Drug Requests*, GAO 10-776, 29, accessed January 9, 2014, http://www.gao.gov/new.items/d10776.pdf
[614] Government Accountability Office, *DOD and VA Health Care Medication Needs During Transitions May Not Be Managed for All Service Members. GAO-13-26, November 2012*, 2, accessed December 22, 2014, http://www.gao.gov/products/GAO-13-26.
[615] Ibid, Title Page.
[616] Government Accountability Office, *VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients, GAO-02-1017, September, 2002,* 3, accessed December 22, 2014, http://www.gao.gov/products/GAO-02-1017.
[617] Ibid , 4.
[618] *Major Management Challenges and Program Risks- Department of Veterans Affairs, GAO-03-110, January 2003, 32*, accessed December 22, 2014, http://www.gao.gov/products/GAO-03-110.
[619] Government Accountability Office, *DOD and VA Health Care: Medication Needs During Transitions May Not Be Managed for All Servicemembers, GAO-13-26. November 2012,* 14, access December 22, 2014, http://www.gao.gov/products/GAO-13-26.
[620] Ibid, 28.
[621] Government Accountability Office, *Veterans Affairs-Better Understanding Needed to Enhance Services to Veterans Readjusting to Civilian Life, GAO-14-676, September 2014*, 27, accessed December 22, 2014, http://www.gao.gov/products/GAO-14-676.

negotiate national contracts and other agreements, for example prime vendor contracts, which reduce procurement prices even more.[622] In fact, the HEC Acquisition and Medical Materiel Management Working Group reported that DoD and VA reduced costs $468 million from 2012 to 2013 by using acquisition programs based on the use of joint requirements.[623] The DoD and VA pharmacy team identified 28 commonly used pharmaceutical products and manufacturers for potential joint contracting action.[624] It is evident that additional collaboration between DoD and VA in drug purchasing could further reduce costs for both departments.

Regarding RSAs, DoD and VA currently have nonstandardized policies and individualized pricing structures that discourage interaction and make both departments' operations less cost-effective. As reported in September 2012 by GAO, "VA and DOD do not have a fully developed process and a sufficient strategic direction to work across agency boundaries to fully identify collaboration opportunities. Specifically, the departments have not fully developed and formalized a systematic process to review all possibilities for new and expanded collaboration, but instead largely leave the identification of new or enhanced collaboration opportunities to leaders at local VA and DOD medical facilities."[625] During the Commission's public hearings and site visits, those who testified, raised concerns repeatedly that most successful sharing agreements are personality driven, rather than policy directed. For example, during a site visit to Nellis Air Force Base, the Commander, 99th Medical Group, said DoD and VA need to "codify [the successes of agreements] in a deliberate manner at a high level versus relying on personality-driven relationships [between organizations]."[626]

Nonstandard policies have resulted in inconsistent implementation of RSAs, as well as numerous instances of inefficiencies or lost opportunities for collaboration. For example, the GAO highlighted the "incompatible policies and practices" for collaborative efforts between the DoD and VA in business and administrative processes such as credentialing of medical personnel, capturing patient workload, and inpatient access to military bases.[627] Other, more costly examples can be seen in instances of separate medical facility construction. The Naval Hospital Pensacola and the Biloxi VA wanted to build a joint facility on a Navy site in Panama City, Florida. Building a joint facility would have exceeded the VA's statutory limits for minor construction projects (the total funding amount contributes to the statutory limit, rather than only the VA share of cost).[628] The departments could have moved forward with the joint facility as a major construction project, but doing so would have required Congressional authorization.[629] Department officials told GAO major construction projects must first go through an internal priority determination process, and the departments said they would not necessarily have approved this joint major

---

[622] Veterans' Benefits, 38 U.S.C. § 8126(a)(2)) retrieved from http://www.gpo.gov/fdsys/granule/USCODE-2011-title38/USCODE-2011-title38-partVI-chap81-subchapII-sec8126.
[623] VA/DoD Joint Executive Committee, *Annual Report Fiscal Year 2013*, 62, retrieved from http://www.va.gov/op3/docs/StrategicPlanning/VA_DoD_JEC_Annual_Report_for_FY_2013_signed_3.pdf.
[624] Ibid, 83.
[625] Government Accountability Office, *VA and DoD Health Care*, *GAO 12-992, September 2012*, 34, accessed December 22,2014, http://www.gao.gov/assets/650/648961.pdf.
[626] 99th Medical Group Commander and Senior Executive Staff, Nellis AFB, 99th Medical Group, meeting with MCRMC, October 3, 2014.
[627] Government Accountability Office, *VA and DoD Health Care, GAO 12-992*, *September 2012*, introduction page, elaborated in 18-29, http://www.gao.gov/assets/650/648961.pdf.
[628] Ibid, 31.
[629] Ibid, 32.

construction process.[630] Consequently, Navy and VA built two separate clinics in close proximity to each other.[631] "Officials were not certain of the cost impact of providing services in two clinics rather than one, but believed doing so would be less efficient and potentially more costly."[632]

Several examples of effective DoD and VA collaboration do exist and should be used to identify lessons learned and best practices. Most notable among them is the Captain James A. Lovell FHCC in Chicago, Illinois, the first fully integrated DoD–VA medical facility. This facility has made great strides in integrating the two cultures of DoD and VA.[633] Joint Patient Registration registers active-duty Service members into the VA system, allowing Service members to have a seamless transition to Veteran status. Medical Orders Portability allows medical orders entered into one system (either VA or DoD), to be transmitted to the other system, so providers and medical personnel can easily and efficiently manage consultations and other medical orders for their patients.[634] The successful integration of the two departments' facilities and staff into one FHCC, with the ultimate goal of providing effective and compassionate health care to Service members and veterans, shows the potential for further integration of DoD and VA medical centers.

Similar coordination issues also exist with DoD–VA billing. Although a uniform payment and reimbursement schedule has been developed, it is only for clinical services, and the reimbursement methodology still allows for variances and waivers. These rates are not used for nonclinical services; the departments have indicated rates for nonclinical services should be "negotiated independently."[635] Joint ventures and colocated facilities may further adjust the standard rates to account for these more involved sharing arrangements (e.g. staffing, square footage).[636] Waivers to the national rating methodology are allowed when the "standardized rate does not cover marginal costs or is higher than local market rates and both parties desire a larger discount from CMAC."[637] Waivers are discouraged, but if desired, must be approved by both cochairs of the HEC Financial Management Work Group (FMWG).[638]

The reimbursement methodology does not provide the right incentives to minimize Federal spending. For care provided to a VA beneficiary in an MTF, the VA will have to reimburse to DoD the full established rate.[639] If VA sends the patient to another VA facility (as opposed to a closer MTF with capability and access), the subsequent "bill" is only for the cost of travel and per diem, which is typically less than the established rate for the care.[640] From a Federal perspective, however, it is clearly less expensive to

---

[630] Ibid, 32.
[631] Ibid, 31.
[632] Ibid.
[633] "Top 10 Innovations" publication, Captain James A. Lovell Federal Health Care Center, received as part of the MCRMC visit to North Chicago, June 10, 2014.
[634] Ibid
[635] Department of Defense and Department of Veterans Affairs, *VA-DoD Health Care Resources Sharing Rates-Billing Guidance Outpatient Services,* accessed December 22, 2014, http://www.tricare.mil/DVPCO/downloads/MOA/MOA-BillingGuidanceOutpatientServices.pdf.
[636]Outpatient Billing Guidance, page 2, paragraph 3C, accessed 14 October 2014, http://www.tricare.mil/DVPCO/downloads/MOA/MOA-BillingGuidanceOutpatientServices.pdf.
[637] Ibid, para 5.
[638] Ibid, para 5.
[639] VA/DoD Health Executive Council, *Memorandum of Agreement Health Care Resource Sharing Reimbursement Methodology*, accessed December 22, 2014, http://www.tricare.mil/dvpco/downloads/MOU.pdf.
[640] VA/DoD Health Executive Council, *Memorandum of Agreement Health Care Resource Sharing Reimbursement Methodology*, accessed December 22, 2014, http://www.tricare.mil/dvpco/downloads/MOU.pdf. "CHAMPUS National

care for the patient locally and avoid transportation costs. From a patient care perspective, it would be better for the veteran to receive treatment locally, because of increased likelihood of having support systems nearby, such as family and friends. In testimony at the Commission's Norfolk, Virginia, public hearing, RADM Elaine Wagner, Commander Naval Medical Center, Portsmouth, Virginia, stated one of the issues with DoD treating VA patients "is money. We still charge the VA when we do surgeries [on VA patients. And so, for [VA] to send their, for example, open heart surgeries to us. It…costs the VA system money. They can send them to Richmond at no cost. So, when you have an elderly man or woman who needs open heart surgery they and their family now, for the most part, are driving to Richmond because…they get their care free."[641] The DoD/VA Resource Sharing Agreement between VA Southern Nevada Healthcare System and Michael O'Callahan Federal Medical Facility at Nellis Air Force Base includes a "Right of First Refusal" clause.[642] According to such a clause, if one facility is unable to provide care, that facility will first contact the other joint venture facility to determine if capability and capacity exist there before sending the patient elsewhere. There is no evidence of monitoring compliance with this kind of provision.

GAO found there has been a substantial backlog with VA reimbursements to DoD in part because of differences in business practices for assigning diagnostic codes and capturing patient workload.[643] The HEC is working to resolve this backlog and is developing a methodology for streamlined reimbursement.[644] According to this plan, VA will pay prospectively for care, with DoD and VA reconciling reimbursements quarterly. This methodology is consistent with traditional intra-agency agreements in which payment is made up-front based on historical workload.[645] When executed, this methodology will facilitate implementation of RSAs and further collaboration between DoD and VA.

Conclusions:
Service members would benefit substantially from enhanced collaboration between DoD and VA. Joint health care could be accomplished, and would be more cost-effective. To accomplish these goals, the JEC must be granted additional authorities and responsibilities to standardize and enforce collaboration between DoD and VA. For example, the JEC should define common services that routinely would be coordinated between DoD and VA across all local markets. Such a policy would ensure local DoD and VA leaders are collaborating and would help with implementation, standardization, and efficient operation of RSAs.

To ensure DoD and VA make joint decisions, the JEC should be required to certify in advance all expenditures of funds by DoD or VA associated with common services are in compliance with the JEC's strategic plan. Certified expenditures should include, at

---

Pricing System (CMAC System), accessed January 9, 2015, http://www.tricare.mil/CMAC/home.aspx. (The CHAMPUS National Pricing System (CMAC System) is a query-based system that will allow users to review pricing/prevailing fees for a particular procedure code within a selected locality. Payment rates may be calculated based on user data inputs.)
[641] Military Treatment Facility Commanders and the Veterans Administration, Norfolk Public Hearing Testimony, December 13, 2013, http://www.mcrmc.gov/public/docs/meetings/20131203/MCRMC-Norfolk-Dec03-Panel1-20131203.pdf.
[642] VA and DoD Resource sharing Agreement between Southern Nevada Healthcare System and the Michael O'Callaghan Federal Medical Center, Nellis AFB, para 8.
[643] Government Accountability Office, *VA and DOD Health Care: Departmental-Level Actions Needed to Assess Collaboration Performance, GAO 12-992, September 2012*, 18-21, http://www.gao.gov/assets/650/648961.pdf
[644] HEC Decision Brief, October 3, 2014, provided by DHA to MCRMC, October 10, 2014.
[645] Ibid.

a minimum, acquisition of any new capital assets or sustainment, restoration, and modernization of capital assets, for both DoD and VA medical components. The JEC's annual report should include a list of the common-service projects funded during the fiscal year by DoD and VA, identifying which of the projects were certified as consistent with the JEC's strategic plan and, if any were not certified, the reasons such projects were funded without certification.

Common services for DoD and VA should include, at a minimum, EHRs and a uniform DoD/VA formulary for transitioning Service members. A single EHR system is the ideal solution for improving Service member health care and minimizing overall EHR costs. Should DoD and VA adopt separate EHR systems, these systems must have complete interoperability between the departments and with civilian institutions in accordance with the national data standards and architectural requirements of the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services. To further facilitate transition and viewability, VA records should be established for all Service members at all Services points of entry, similar to the Joint Patient Registration Process established at Lovell FHCC.[646] Creating a uniform DoD and VA formulary for certain key drugs frequently prescribed to Service members would help provide continuity of care for those who are transitioning from the DoD to the VA health system. Ensuring psychiatric and pain medications, for example, are continued during transition is particularly important given the potential adverse effects that can be experienced in response to misusing or abruptly discontinuing such drugs.

The reimbursement methodology should be standardized and automated. Local reimbursement variations, as seen in the current methodology, cause payment delays and decrease incentives for further collaboration and resource sharing. DoD medical facilities should be the first choice for VA patients who are not seen in local VA facilities. The rates charged by these facilities for care, which should be based on the standard reimbursement methodology, should not be considered when determining the venue of outside care because both DoD and VA facilities are funded by the Federal Government. The prospective reimbursement arrangements being coordinated through the JEC would improve collaboration and merit support from both departments. Additional processes should be implemented to automate reimbursements to the extent possible, thereby streamlining and encouraging additional collaboration.

Recommendations:

- The JEC should be granted additional authorities and responsibilities to standardize and enforce collaboration between DoD and VA, including:

  - Defining common services that will regularly be jointly conducted throughout DoD and VA health care systems.

  - Creating standard terms for RSAs on common services that can quickly and efficiently be implemented by local commanders.

[646] "Top 10 Innovations" publication, Captain James A. Lovell Federal Health Care Center, received as part of the MCRMC visit to North Chicago, June 10, 2014.

- Monitoring planned expenditures for common services by both DoD and VA, comparing these expenditures to the JEC's strategic plan, and certifying whether the planned expenditures are consistent with that strategic plan.

- Approving in advance any new capital assets acquisition, or sustainment, restoration, and modernization of capital assets, of either DoD or VA medical components.

- Reporting quarterly to the Congress on DoD and VA expenditures, their consistency with the JEC's strategic plan, and reasons for any inconsistent expenditures.

- Overseeing EHR compliance with the Office of the National Coordinator for Health Information Technology standards across both DoD and VA, ensuring health care data can be quickly and easily shared between the departments.

- Ensuring that the DoD and VA immediately begin the process of establishing a health care record within the VA EHR system for all current military Service members. The VA should also immediately begin the process of establishing a health care record within the VA EHR system for all military service members who complete Service-specific enlisted and officer accession programs.

- Monitoring and reporting on the percentage of the military force that is represented with a health care record in both DoD and VA EHR systems.

- Creating a uniform formulary to include all the drugs identified as critical for transition by the JEC beginning immediately with the pain and psychiatric classes of drugs. The JEC should determine classes of drugs critical to ensuring seamless and smooth transition of Service members from the Military Health System to VA Health System. The JEC should review its list of critical drug classes periodically and as the need arises. The JEC must mandate, oversee, and report to the Congress on employment of all joint procurement options, for example joint contracts and prime vendor contracts, to maximize cost savings for the strategic uniform formulary.

- Establishing a standard reimbursement methodology for DoD and VA provision of services to each other. Reimbursements should be real time and automated to the extent possible. The JEC should establish policies under which DoD and VA do not consider reimbursement rates when determining where to send patients, because the reimbursement rates represent only transfer prices within the Federal Government.

Implementation:

- 38 U.S.C. § 320 governs the JEC. 38 U.S.C. § 320 should be amended to require the JEC to define "common services." "Common services" will be evaluated for coordination between the DOD and VA not less than annually. 38 U.S.C. § 320 should be amended to require quarterly reporting to the Congress on DOD and VA expenditures, their consistency with the JEC's strategic plan, and reasons for any inconsistent expenditures. Language should be added to 38 U.S.C. § 320 to expand JEC authority to require the

DOD–VA reimbursement process be executed as an interagency agreement where the JEC ensures successful resolution, which will be included in its annual report to the Congress.

- 10 U.S.C. § 1104 and 38 U.S.C. § 8111 govern the coordination and sharing of health care resources between VA and DOD. These code sections should be amended to create RSA categories that JEC determines can be quickly and efficiently implemented by heads of local medical facilities in a standard manner across all DOD–VA.

- 10 U.S.C. § 1104 and 38 U.S.C. § 8111 should be amended to make the JEC's review and approval a mandatory step in the acquisition, sustainment, restoration, or modernization of any DOD or VA capital assets. DOD and VA should be prohibited from obligating or expending funds for such acquisition, sustainment, restoration, or modernization until the JEC's review and approval occurs.

- 10 U.S.C. § 1074g governs the DOD uniform formulary. It should be amended to establish a process under JEC to determine classes of drugs critical for transition and review them periodically and as the need arises and to create a strategic uniform formulary to include all drugs determined by JEC to be critical for transition. 38 U.S.C. § 320, which governs JEC, should be amended to reflect the JEC's new role in developing a strategic uniform formulary.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed. Such as, but not limited to:

  - VHA Handbook 1108.08, which governs the VA National Formulary.

  - DOD Instruction 6010.23

  - VHA Handbook 1660.04

Quality of Life

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

Background:
The Defense Commissary Agency (DeCA) operates "a worldwide chain of commissaries providing groceries to military personnel, retirees, and their families."[647] DoD operates a separate system of exchanges, providing goods and services similar to commercial department or discount stores.[648] This system includes the Army Air Force Exchange System (AAFES), the Navy Exchange (NEX), and the Marine Corps Exchange (MCX).[649] Together, commissaries and exchanges provide goods and services with total annual sales of more than $17 billion in 2013.[650] There are a limited number of cases where a commissary and an exchange are operated together as a single store including Navy Exchange Markets (NEXMARTs) overseas and a limited number of combined stores in the United States.[651]

In addition to the main commissary and exchange stores that form the foundation of the defense resale system, the exchange systems operate thousands of smaller retail outlets, providing a wide range of services such as convenience stores, gas stations, barber and beauty shops, florists, optical shops, auto repair, car washes, vending, residential services, lunches for military schools, financial services, repair/installation services, and rental services.[652] Over time, exchanges have also assumed responsibility for military uniform stores, book stores, liquor stores, and personal phone and telecommunication services for Service members around the world.[653] Exchanges also support small retail outlets on Navy ships and field tactical exchanges, provide services through embedded Marines in combat zones, and, when called upon, assist with disaster recovery and other emergency response missions.[654] In addition, the Navy Exchange Command (NEXCOM) manages Navy Lodges and the Navy Clothing

---

[647] "About Us," Defense Commissary Agency (DeCA), accessed October 17, 2014, http://www.commissaries.com/about_us.cfm.
[648] *See* Armed Services Exchange Regulations, DoDI 1330.21 (2005). *See also* Armed Forces, 10 U.S.C. § 2481.
[649] Army and Air Force Exchange Service Operations, AR 215-8 and AFI 34-211(I) (2012). Responsibility and Authority for Navy Exchange Operations, OPNAVINST 5450.331A (2008). MCCS Policy Manual, MCO P1700.27B (2007).
[650] AAFES, *Army and Air Force Exchange Service, 2013 Annual Report*, 22, accessed December 16, 2014, http://www.aafes.com/images/AboutExchange/PublicAffairs?2013_annualrpt.pdf. NEXCOM, *Navy Exchange Command 2013 Annual Report*, 14, accessed December 16, 2014, http://www.mynavyexchange.com/assets/Static/NEXCOMEnterpriseInfo/AR13.pdf. Marine Corps Exchange data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, December 16, 2014. DECA, *Defense Commissary Agency, FY 2013 Annual Report*, 7, accessed December 16, 2014, http://www.commissaries.com/documents/whatsnew/afr/afr-2013.pdf.
[651] Armed Forces, 10 U.S.C. § 2487(a)(2). *See also* Armed Forces, 10 U.S.C. § 2488.
[652] Armed Services Exchange Regulations, DoDI 1330.21 (2005), Enclosure 3, 13-14.
[653] Ibid.
[654] Tom Shull, Chief Executive Officer, Army & Air Force Exchange Service Overview, briefing to MCRMC, June 10, 2014. AAFES, meeting to discuss AAFES response to Commissary legislative proposals with MCRMC, July 2, 2014. Robert Bianchi, Chief Executive Officer, Navy Exchange Service Command Overview for Military Compensation and Retirement Modernization Commission, briefing to MCRMC, September 18, 2014. Robert Bianchi, Chief Executive Officer Navy Exchange Service Command Overview, briefing to MCRMC, December 2013. Robert Bianchi, Chief Executive Officer, Navy Exchange Service Command Overview, briefing to MCRMC, September 18, 2014. NAF Business & Support Services (MR) Division, Manpower and Reserve Affairs, HQMC, 23, briefing to MCRMC, September 17, 2014.

and Textile Research Facility, sharing a common IT infrastructure, staff support, and other resources.[655] The MCX shares support staff and other resources with the Marine Corps' Morale, Welfare and Recreation (MWR); Warfighter and Family Services; and Child, Youth, and Teen programs.[656]

Commissaries and exchanges have evolved from loosely organized systems of sutlers and post traders into a complex "ecosystem" of services and benefits. Although the two systems are, by law, operated as separate entities,[657] there are strong interactions between them. For example, AAFES estimates that 20–30 percent of its foot traffic, representing at least $1 billion in sales, is attributable to proximity to commissaries.[658] To limit direct competition, laws, policies, and decisions made by the Defense Resale Board restrict the categories of products and services that each can sell.[659]

Although both commissaries and exchanges provide discounted goods to Service members, they operate using different business models. The commissaries sell groceries at cost[660] plus a 5 percent surcharge[661] and their operations are funded with appropriated funds (APF).[662] Exchanges sell merchandise for profit, more like commercial retailers. Gross profits are used to support the exchange system, covering operating and other expenses; recapitalize facilities and systems; or are provided as dividends to fund MWR programs.[663] Both commissaries and exchanges provide access to U.S. goods in areas of military concentration around the world, and both provide a nonpay financial benefit to patrons through discounts.

Commissaries and exchanges also have different models of coordination with the Military Services. DeCA, as a separate defense agency, reports to the Office of the Secretary of Defense.[664] DeCA also has a Board of Directors (BOD) with representation from all the Military Services.[665] This BOD promotes alignment of commissary services, investments, and operations with the needs of the individual Military Services.[666] AAFES relies on its BOD, which includes Army and Air Force representation, for such alignment.[667] In addition to having a BOD, the NEX is part of

---

[655] Robert Bianchi, Chief Executive Officer, Navy Exchange Service Command Overview, briefing to MCRMC, September 18, 2014.
[656] NAF Business & Support Services (MR) Division, Manpower and Reserve Affairs, HQMC, 23, briefing to MCRMC, September 17, 2014.
[657] Armed Forces, 10 U.S.C. § 2487(a)(1).
[658] Army and Air Force Exchange Service, *Memorandum for ASD (R&FM), Army and Air Force Exchange Service (AAFES) Response to Commissary Legislative Proposal*, March 17, 2014.
[659] *See, e.g.,* Armed Forces, 10 U.S.C. § 2481(a) (establishing "a world-wide system of commissary stores and a separate world-wide system of exchange stores"). *See also* Armed Forces, 10 U.S.C. § 2484 (stating that commissary stores are intended to be similar to commercial grocery stores); Armed Services Exchange Regulations, DoDI 1330.21, Enclosure 3, 13-14 (2005) (permitting exchanges to engage only in enumerated retail activities and stating that commissaries have "primary" role in selling groceries); and Army and Air Force Exchange Service Operations, AR 215-8 and AFI 34-211(I), 61-62, (2012) (enumerating specific items that may be sold by AAFES and stating that food items sold by AAFES "supplement the primary full-line grocery service provided by the commissary system").
[660] Armed Forces, 10 U.S.C. § 2484(e).
[661] Armed Forces, 10 U.S.C. § 2484(d). *See also* Armed Forces, 10 U.S.C. § 2484(h).
[662] Armed Forces, 10 U.S.C. § 2483.
[663] Based on data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, March 31, 2014. In FY 2012, $333 million of $496 million in net income was provided to MWR.
[664] *See* DoD Commissary Program, DoDI 1330.17 (2014), Enclosure 7, 45.
[665] DoD Commissary Program, DoDI 1330.17 (2014), Enclosure 8, 47.
[666] Ibid.
[667] Board of Directors, Army and Air Force Exchange Service, Army Regulation 15–110, 2 (2009). Board of Directors, Army and Air Force Exchange Service, AFI 34–203(I), 2 (2009).

NEXCOM, which is more integrated with the operational Navy.[668] For example, NEX general managers report to the installation commander to ensure that exchanges are responsive to the needs of the command.[669] Installation commanders review financial performance and facility planning and provide input on the general manager's performance evaluation.[670] The MCX is also tightly integrated as part of Marine Corps Community Services (MCCS). Falling under the same organization as MWR and Marine and Family Programs, allocation of resources and exchange profits between all these programs are made in an integrated fashion.[671]

In 2013, the commissaries received $1.4 billion in APF, of which $152 million was spent on second destination transportation costs for transporting U.S. goods overseas.[672] That same year, the exchanges received approximately $397 million in APF.[673] This amount included $170 million for contingency support, covering expenses associated with the transportation of merchandise from warehouses to remote exchange sites, incremental inventory variances above the noncontingency average, danger pay, deployment bonuses, overtime, and foreign post differentials for deployed associates.[674] Also included was $179 million for second destination transportation,[675] and $47 million for direct and indirect exchange operating costs, including a limited number of active-duty military personnel, military travel, and utilities for authorized overseas locations and a limited number of CONUS remote and isolated locations.[676]

For additional information on defense resale, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 5.1.1* and *Section 5.8.2).*

Findings:
In the Commission's survey, town halls, and other public forums, commissary and exchange benefits frequently received strong support, with a primary focus on commissary discounts, yet some Service members did challenge the value of the commissary and exchange benefits. Typically they were skeptical of the claimed savings and the quality of nonbranded products such as produce.[677] Even among skeptics, however, there was consistent acknowledgment of the additional benefit offered overseas, and in remote and isolated locations, where commercial alternatives are either not available or not comparable.[678]

---

[668] Morale, Welfare and Recreation (MWR)/Navy Exchange (NEX) Board of Directors (BOD), OPNAVINST 1700.13B, 1 (2004).
[669] Responsibility and Authority for Navy Exchange Operations, OPNAVINST 5450.331A, 3 (2008).
[670] Ibid.
[671] NAF Business & Support Services (MR) Division, Manpower and Reserve Affairs, HQMC, 23, briefing to MCRMC, September 17, 2014.
[672] Information provided by DeCA, e-mail to MCRMC, May 6, 2014.
[673] Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, November 6, 2014. For a description of the authorized use of APF in military exchanges, *see also* Armed Services Exchange Regulations, DoDI 1330.21 (2005), Enclosure 9, and Establishment, Management, and Control of Nonappropriated Fund Instrumentalities and Financial Management of Supporting Resources, DoDI 1015.15 (2008), Enclosure 4.
[674] Ibid.
[675] Pursuant to 10 U.S.C. § 2643, second-destination transportation funding covers the expenses of transporting exchange supplies and products to destinations outside the continental United States.
[676] Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, November 6, 2014.
[677] Survey respondents, comments submitted via MCRMC survey, July 1, 2014 to October 10, 2014. *See also, e.g.,* MCRMC letter writer, comment form submitted via MCRMC website, June 18, 2014 ("In addition, we MUST do a better job of providing fresh produce that is nice and fresh and not rotten, which is not the case in most commissaries.")
[678] Examples include audience member comments made at MCRMC town hall meeting, Joint Base San Antonio, San Antonio, Texas, January 7, 2014.

In FY 2013, DeCA reported the average discount for commissary patrons to be 30.5 percent[679] and the exchanges reported savings between 20 and 24 percent.[680] In Defense Manpower Data Center's 2013 Living Patterns Survey, 92 percent of active-duty respondents indicated they had purchased goods or services at a military commissary in the previous 12 months.[681] For military exchanges, the level was 96 percent.[682] In surveys conducted by the commissaries and exchanges, patrons indicate a high level of overall satisfaction as compared to industry averages. Exchange surveys in 2013, based on the American Customer Satisfaction Index (ACSI), reported overall patron satisfaction scores of 75 (AAFES), 79 (NEX) and 83 (MCX),[683] compared to the average department and discount store rating of 77.[684] The commissary ACSI score for 2013 was 82 as compared to the industry average of 77.[685] The 2014 Military Lifestyle Survey conducted by Blue Star Families ranked commissaries and exchanges as the most utilized service, with the third highest satisfaction rate, behind MWR and chaplain services.[686] Comments made during the Commission's town halls and other meetings as well in survey responses supported these findings:

> *While there are some items that may be found at a lower individual price on the economy the total combined savings remains constant.*[687]
>
> *The prices at competing grocery stores are what they are because these outfits know that the Commissary Store exists in the community. If that competition goes away we will all pay more.*[688]
>
> *When I went out in town and we tried to get the same amount, we got about half of the groceries that we could afford at the Commissary.*[689]

---

679 "New Price Study Validates 30% Savings," Defense Commissary Agency (DeCA) web site, January 9, 2014, accessed June 11, 2014, http://www.commissaries.com/press_room/press_release/2014/DeCA_01_14.cfm. DeCA reported an average patron savings of 30.5% in FY 2013. If this level of savings is accurate, then the total financial benefit to Service members in FY 2013 was approximately $2.8 billion. Although multiple groups in discussions with MCRMC have challenged this estimate as being overstated, the evidence offered to support these challenges has typically been small, local, market basket surveys that are not structured to represent a world-wide, appropriately weighted average. That being said, DeCA's estimation method has limitations. For example, it only compares products that have identical Universal Price Codes (UPCs) and thus does not consider store brands (private labels) or some very large sizes at commercial grocery and discount stores. Estimated discounts vary based on location and individual shopping patterns, but these variations are typically not communicated to patrons.

680 "AAFES Media Advisory 12-059, Don't Shop 'til you Drop – Survey Says Make the Exchange your First Stop!," Army Air Force Exchange Service, October 10, 2012, accessed May 7, 2014, http://publicaffairssme.com/pressrelease/?p=1000. *See also* NEXCOM Fall 2013 Savings by Market report, survey conducted by RetailData, LLC, December 19, 2013, e-mail to MCRMC, May 21, 2014.

681 Defense Manpower Data Center, *Living Patterns Survey, Tabulation of Responses*,18, http://www.mcrmc.gov/public/docs/report/qol/2013_DMDC_LivingPatternSurvey_Commissary_Usage.pdf .

682 Ibid, 19.

683 David Turner, NAF Business & Support Services (MR) Division, Manpower and Reserve Affairs, HQMC, briefing to MCRMC, September 17, 2014.

684 "Department and Discount Stores," American Customer Satisfaction Index, accessed October 15, 2014, http://theacsi.org/index.php?option=com_content&view=article&id=147&catid=&Itemid=212&i=Department+and+Discount+Stores.

685 Statement of Joseph H. Jeu, Director, Defense Commissary Agency before the Military Personnel Subcommittee of the Committee on Armed Services, U.S. House of Representatives, First Session, 113th Congress, November 20, 2013, accessed October 20, 2014, https://www.commissaries.com/foia/documents/director_statement_before_congress_2013.pdf.

686 Blue Star Families, *2014 Military Family Lifestyle Survey, Comprehensive Report,* 24, accessed December 14, 2014, https://www.bluestarfam.org/sites/default/files/media/stuff/bsf_report_comprehensive_reportfinal_single_pages.pdf

687 Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

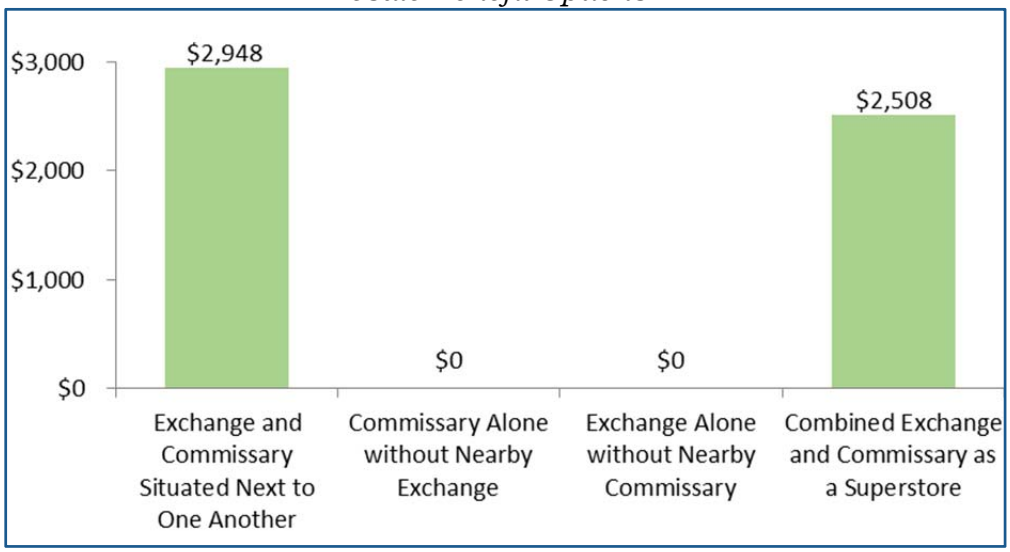
688 Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

689 Audience member, comment made at MCRMC town hall meeting, Norfolk, VA, December 2, 2013.

The Commission's survey found similar results.[690] For the commissary benefit, discounts and convenience were ranked higher than other features such as product assortment, a wide selection of name brand products, or a sense of military community. As the level of discount was hypothetically increased, the perceived value placed on discounts increased even faster.[691]

The Commission's survey also showed that Service members and retirees value commissaries and exchanges that are collocated.[692] As seen in Figure 21, beneficiaries expressed a strong preference for the availability of both benefits in the same location or same store. Conversely, survey respondents did not prefer availability of either store without the other nearby.[693] This result reaffirms the complementary offerings of commissaries and exchanges and reinforces the preference for convenience.

Figure 21. Active-Duty Services Members' Perceived Value: Resale Benefit Options[694]



The commissaries and the three exchange systems perform similar missions, for similar patrons, with similar staff, using similar processes. In 2003, the Deputy Secretary of Defense directed the development of a plan to form a "single optimized Armed Service exchange system."[695] Soon thereafter, the Unified Exchange Task Force (UETF) was formed to perform the associated analysis.[696] Focusing on five areas of support, finance and accounting (FA), human resources (HR), information technology (IT), logistics, and procurement, the UETF worked with exchange staffs to inventory and analyze the processes in each of these areas of support, for each exchange. Table 14 summarizes the task force's assessment of commonality.

---

[690] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[691] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[692] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[693] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[694] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014. This figure displays the average amount in dollars that survey respondents valued compensation alternatives. Presentation in dollar values allows the value of compensation features to be directly compared.
[695] Paul Wolfowitz, Deputy Secretary of Defense, *Memorandum for Secretaries of the Military Departments Chairman of the Joint Chiefs of Staff regarding Future of the Armed Services Exchange Systems*, May 9, 2003.
[696] Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services,* August 26, 2005, provided to MCRMC by the Office of the Under Secretary of Defense for Personnel and Readiness, June 11, 2014.

Table 14. UETF Assessment of Process Commonality in Selected Exchange Functional Areas[697]

Functional Areas	Processes	Estimated Number of Common Processes	Percent Commonality
FA	147	146	99%
HR	121	109	90%
IT	67	67	100%
Logistics	55	55	100%
Procurement*	23	21	91%
TOTAL	**413**	**398**	**96%**

Numerous studies commissioned by DoD or other Federal entities have recommended some form of consolidation or increased cooperation in pursuit of improved cost-effectiveness. Following the "Jones commission," which led to the consolidation of commissaries, in 1990,[698] the "Jones II commission" produced a "DoD Study of the Military Exchange System."[699] The study recommended that, "the military exchange systems be consolidated into a single organization in order to eliminate current redundancies, improve operational efficiencies, and achieve projected annual savings from consolidation of $35 million."[700] In 1991, the Logistics Management Institute (LMI) reviewed the methodology, findings, financial analyses, and conclusions of the 1990 DoD study.[701] The LMI assessment estimated the annual savings associated with exchange consolidation to be $36.6 million,[702] but recommended against immediate consolidation in favor of a series of "first steps"[703] that would "make sound business sense whether or not the exchange systems are eventually consolidated."[704] The LMI assessment recommended waiting 3 years to reevaluate the situation, stating that, "After 3 years, the results of those first steps, together with a clearer picture of troop reductions and the evolving retail environment, will substantially lower the risks of any decision."[705] Most of the first step recommendations were not implemented.[706] A 1995 review by the Government Accountability Office (then known as the General Accounting Office) concluded that "appropriated fund support to the commissaries and exchanges could be reduced about $331.5 million by merging some commissaries and exchanges ($319.5 million) and closing certain other commissaries ($12 million)."[707] An SRA International Inc. review in 1996 determined that full

[697] Ibid, 3. The asterisk following "Procurement" refers to a footnote in the UETF report, which notes that this line of the figure refers only to non-resale procurement, and further notes that no comparable data was available to the UETF regarding revenue-generating contracts or real property processes.
[698] *See* MCRMC, Report of the Military Compensation and Retirement Modernization Commission: Interim Report, June 2014, 124-25, http://www.mcrmc.gov/index.php/reports.
[699] Office of the Assistant Secretary of Defense (Force Management and Personnel), *DoD Study of the Military Exchange System,* September 7, 1990.
[700] Ibid, ch. 1, 10.
[701] "Toward a More Efficient Military Exchange System," Logistics Management Institute, Report PL110R1, July 1991, accessed November 20, 2014, http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA255738.
[702] Ibid, iii.
[703] Ibid, iv.
[704] Ibid, Ch. 1, 7.
[705] Ibid, Ch. 1, 7-8.
[706] Office of the Deputy Assistant Secretary of Defense, Director, Morale, Welfare, Recreation, and Resale Policy, e-mail to MCRMC, October 2, 2014.
[707] General Accounting Office, *Potential Reductions to Operation and Maintenance Program*, GAO/NSIAD-95-200BR, September, 1995, 12, accessed December 21, 2014, http://www.gpo.gov/fdsys/pkg/GAOREPORTS-NSIAD-95-200BR/pdf/GAOREPORTS-NSIAD-95-200BR.pdf. Note that this recommendation was rejected by a DoD Study group in December 1995. Although the study group did not have the resources available to come to any definitive

integration was viable, and estimated annual savings to be $176 million.[708] The UETF's 2005 report examined a 1999 PricewaterhouseCoopers (PwC) study which recommended a "Unified Exchange" model, predicting that the use of best-practice processes and systems would produce a more creative, more flexible, and more responsive organization.[709] PwC estimated $206 million in annual savings as a result of full integration.[710] The UETF, originally chartered to evaluate full exchange integration, was redirected by its executive board to limit its study to partial integration, establishing Shared Services Business Units in five areas of support.[711] Using this model, the UETF estimated steady-state annual savings to be $151 million to $162 million.[712] Most of these studies started with an assumption that there would be no reduction in patron benefits and cited ways in which the benefit would improve from a patron perspective as a result of increased cooperation, partial integration, or full consolidation.

In 2000, as an alternative to consolidation, the Under Secretary of Defense for Personnel and Readiness directed the establishment of a formal process to identify efficiencies by individual service exchanges and collectively through cooperative efforts.[713] That same year, the Exchange Cooperative Efforts Board was created. In 2012, DeCA became a voting member of the board, and the board was renamed the Cooperative Efforts Board (CEB).[714] In its 2013 annual report, the CEB cited 33 examples of cooperation,[715] with quantified 2013 savings of approximately $16 million,[716] about 0.4 percent of the combined operating expenses of the exchanges and commissaries.[717] A large portion of these savings resulted from long standing arrangements such as avoidance of merchant fees through NEXCOM's and MCX's use

---

conclusions with regard to the savings, the GAO recommendation was rejected because it did not maintain the commissary pricing model (cost plus 5%) and guarantee no loss of MWR dividend.

[708] Systems Research and Applications (SRA) International, *Integrated Exchange System Task Force Analysis, 1996*, accessed December 21, 2014, http://www.mcrmc.gov/public/docs/report/qol/1996_Exchange_Study-SRA_International-Provided_by_OSD-11JUN2014_DeRA-FN45.pdf.

[709] *See* Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services,* 5-6, August 26, 2005, provided to MCRMC by the Office of the Under Secretary of Defense for Personnel and Readiness, June 11, 2014 (citing PricewaterhouseCoopers, *Joint Exchange Due Diligence*, 1999).

[710] Ibid.

[711] Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services,* E-1, August 26, 2005, provided to MCRMC by the Office of the Under Secretary of Defense for Personnel and Readiness, June 11, 2014.

[712] Ibid.

[713] *Under Secretary of Defense, Review of Exchange Systems in the Department of Defense, July 31, 2000*, accessed December 21, 2014, http://www.mcrmc.gov/public/docs/report/qol/Review_of_Exchange_Systems_in_the_DoD-USD_PR_Memo-31JUL2000_DeRA-FN50.pdf.

[714] Cooperative Efforts Board (CEB) Guiding Charter, March 28, 2012.

[715] Department of Defense, *Memorandum for Principal Deputy Under Secretary of Defense (Personnel and Readiness), 2013 Annual Report on Exchange Systems Cooperative Efforts*, April 29, 2014.

[716] Ibid. Note that the $16 million total does not include savings that are implied but not quantified, savings that occur in years other than FY 2013 (*e.g.,* 9 of the 10 years of the CCTV contract savings), and savings that occurred but were not the result of cooperation between the defense resale organizations (*e.g.,* merchant fees avoided by AAFES as a result of its private-label credit card). The actual savings may be less than $16 million because not all relevant savings were validated.

[717] The 0.4% figure is based on an overall operating expense of $2,467 million, as calculated by combining financial statements provided by the several exchanges and DECA to the commission. *See* AAFES, *Army and Air Force Exchange Service, 2013 Annual Report*, 22, accessed December 16, 2014, http://www.aafes.com/images/AboutExchange/PublicAffairs?2013_annualrpt.pdf; NEXCOM, *Navy Exchange Command 2013 Annual Report*, 14, accessed December 16, 2014, http://www.mynavyexchange.com/assets/Static/NEXCOMEnterpriseInfo/AR13.pdf; Marine Corps Exchange data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, December 16, 2014; DECA, *Defense Commissary Agency, FY 2013 Annual Report,* 7, accessed December 16, 2014, http://www.commissaries.com/documents/whatsnew/afr/afr-2013.pdf.

of the MILITARY STAR® card,[718] and not from recent efforts to cooperatively reduce costs. The deeper level of cooperation proposed in many of the studies mentioned above, including consolidated support processes and staffing, consolidated infrastructure, convergence to common IT systems, and aggressively combined procurement and logistics, have not been achieved under the current structure.

DeCA stated to the Commission that it has already reduced annual operating costs by more than $700 million since 1992 through operating efficiencies.[719] It has also shifted a portion of its costs to military patrons by including distribution and shelf-stocking costs in the cost of goods. Yet the FY 2015 DoD budget submission proposed a 71 percent reduction in the DeCA budget, from $1.4 billion to $.4 billion, over a 3-year period.[720] Such a significant reduction in funding would necessitate a change in the commissary business model. Groceries could no longer be sold at cost, discounts would be significantly reduced, and the financial benefit to Service members would be diminished. Respondents to the Commission's survey indicated that a commissary discount of 10 percent or less offers little to no value.[721] In response to the reductions proposed by DoD, DeCA recommended fundamental changes in the laws and policies governing its operations. DeCA proposed a relaxation of many restrictions imposed upon it as an APF organization engaged in retail sales, allowing it to operate more like commercial grocery stores. DeCA also proposed relaxation of restrictions that limit its ability to compete with the exchanges.[722]

Although they have been able to maintain their MWR contributions, there are also indicators of significant financial pressures on the exchanges. AAFES saw a 6 percent drop in sales from 2011 to February 2014, from $6.5 billion to $6.1 billion, and projects a 23 percent drop in sales between 2011 and 2017, to $5 billion, based largely on expected reductions in the force structure.[723] In the current environment, AAFES would have little to no net profit without the income derived from its private-label credit card, concessions, or the sale of alcohol and tobacco.[724] In December 2013, Moody's downgraded AAFES's long-term issuer rating to Aa3,[725] due to a deterioration in its credit profile as a stand-alone entity.[726] Public discussions and Congressional hearings have included proposals to reduce or eliminate the appropriated funding currently provided to exchanges to cover costs such as overseas utilities and second

[718] The MILITARY STAR® card is a private-label credit card managed by AAFES. Although originally accepted only at AAFES, its use has been expanded to the other military exchanges.
[719] Director, Defense Commissary Agency, briefing to MCRMC, 10, October 7, 2013.
[720] Department of Defense, Office of the Under Secretary of Defense (Comptroller), *National Defense Budget Estimated for FY 2015,* April 2014, 112, 119, accessed October 20, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/FY15_Green_Book.pdf.
[721] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[722] Army and Air Force Exchange Service, *Memorandum for ASD (R&FM), Army and Air Force Exchange Service (AAFES) Response to Commissary Legislative Proposal*, March 17, 2014.
[723] Army and Air Force Exchange Service brief from Director, AAFES, e-mail to MCRMC, February 2014.
[724] Army and Air Force Exchange Service, *Statement of Earnings 2012*, 19, accessed November 7, 2014, http://aafes.imirus.com/Mpowered/book/vaar12/i1/p20.
[725] Moody's rates the creditworthiness of securities on a 9-point scale, ranging from Aaa (the highest) to C (the lowest). Ratings from Aa (the second-highest) to Caa (the third-lowest) can be modified by adding a 1, 2, or 3. AAFES's long-term issuer rating was Aa2 before being downgraded one unit, to Aa3. *See* Moody's Investors Service, *Rating Symbols and Definitions*, accessed October 27, 2014, https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBC_79004.
[726] "Rating Action: Moody's downgrades Army and Air Force Exchange's issuer rating to Aa3," Moody's Investors Service, https://www.moodys.com/research/Moodys-downgrades-Army-and-Air-Force-Exchanges-issuer-rating-to--PR_289276.

destination transportation.[727] Absent changes to the overseas benefit, such cuts would further reduce profitability, patron discounts, and/or MWR distributions.

Conclusions:
The commissary and exchange benefits are valued by many Service members, retirees, and their families, and should be maintained. These resale organizations provide familiar U.S. goods and services, meeting basic needs of Service members and their families, particularly in remote, isolated, and overseas locations. The discounts provide nonpay compensation that contributes to the financial health and readiness of many military families. No evidence was found to show a positive effect on recruiting or retention, but multiple sources confirmed that commissaries and exchanges are considered by many to be a relevant and important contributor to military quality of life.

A consolidated resale organization, with combined resources, increased operational flexibility, and better alignment of incentives and policies, would improve the viability and stability of these systems. It would sustain the benefit while reducing the combined reliance on appropriated funding over time. The increased flexibility and opportunities available to a consolidated organization could enable a deeper level of cooperation to improve quality and drive the efficiencies recommended by numerous studies. The many similarities, overlaps, and redundancies in processes, staffing, and support infrastructures favor the consolidation process. Establishing an executive structure and means of oversight that ensures alignment with the needs and goals of Service members and the Military Services is critical.

Recommendations:

- A single organization should be established that consolidates DoD's commissaries and three exchange systems into a single defense resale system, herein referred to as the Defense Resale Activity (DeRA).

- A DeRA Executive Director should be appointed who reports to a consolidated and simplified BOD. The BOD should replace the boards that currently oversee each of the separate exchange systems and DeCA. The consolidated DeRA BOD should also assume the responsibilities of the Executive Resale Board and the Cooperative Efforts Board and should incorporate expertise from private-sector retail. Supporting committees should be established and empowered as needed.

- A DeRA executive team, along with operational advisors from the current organizations, should immediately be established to define the key attributes of the new organization and plan the transition. This discussion should include a consideration of the recommendations made in this Report and in other consolidation studies. Creation of a single organization should facilitate consolidation of many back-end operation and support functions, alignment of incentives and policies across commissaries and exchanges, as well as consistent implementation of best practices for aligning with the needs of Service members and the Military Services. Core commissary and exchange benefits should be maintained at military installations around the world by continuing the sale of groceries and essential items at cost (plus a surcharge)

[727] *See* e.g., S. 2289, 113th Congress, National Defense Authorization Act for FY 2015, § 907, accessed October 27, 2014, http://www.gpo.gov/fdsys/pkg/BILLS-113s2289is/pdf/BILLS-113s2289is.pdf.

and other merchandise at a discount. Under the combined organization, some or all commissary staff could be converted from APF to nonappropriated funds (NAF) employees to reduce commissary employee costs.

- The branding of the current exchange systems and commissaries initially should be retained. A director for each of these branded exchange systems and the commissaries should be appointed under the DeRA Executive Director. These directors should oversee operation of these systems as needed to represent the unique needs of each military service. Personnel evaluations for these executives should be cosigned by the DeRA executive director and appropriate Service representatives. Branding and organizational structure can be modified over time by the BOD.

- DeRA should assume responsibility for the operation of exchanges but not the other organizations currently managed by NEXCOM and MCCS. If approved by the BOD, the current points of integration and shared resources can be maintained through liaison positions and formal memoranda of agreement. For example, if it is mutually advantageous to share support staff between DeRA and Marine Corps MWR, options are available to continue the arrangement that currently exists with the MCX.

- A portion of Military Service MWR programs should continue to be funded from DeRA profits. The BOD should approve the amount of net revenue to be contributed as MWR dividends and should ensure an equitable distribution among the Military Services.

- Laws and policies should be updated to reflect this consolidated structure and allow greater flexibility related to how products are sourced, where they are sold, and how they are priced, as noted below:

  - Allow the sale of convenience items in commissaries at a profit, including products and services typically found in commercial grocers. Food and other essential items should continue to be sold at cost when sold in commissaries or combined commissary and exchange stores (excluding convenience stores). This expanded commissary product line would include beer and wine, but those sales must align with DoD's efforts to deglamorize alcohol and reduce its abuse.

  - Allow for the payment of second destination transportation costs with NAF. Allow significant flexibility on local sourcing overseas, particularly when it is beneficial to the Service member.

  - Allow more flexibility in the creation of combined stores, as currently controlled by Section 2488 of Title 10 of the U.S. Code.

  - Allow the use of the commissary 5 percent surcharge for similar expenses in the exchanges. Conversely, allow the use of exchange profits to cover commissary costs currently covered by the surcharge.

  - Adjust policies on the sale of "brand name" groceries in commissaries to better accommodate the sale of private-label products.

Implementation:

- 10 U.S.C. Chapter 147 governs the activities of the commissary and exchange systems, as well as other MWR entities. It should be amended throughout, with section and sub-section headings changed to reflect the consolidation of the several exchanges and the commissary system, and statutory text amended as follows:

  - 10 U.S.C. § 2481 should be amended to make clear that commissary and exchange stores may be combined into single stores, and that commissary stores or the commissary sections of combined stores must still sell grocery items at reduced prices. It should also state that the Secretary of Defense will designate the defense resale system's executive director and the DeRA BOD described above.

  - 10 U.S.C. § 2483 should be amended to authorize the defense resale system to receive appropriated and nonappropriated funds, and to use nonappropriated funds generated by the system to cover the expenses of operating the system.

  - 10 U.S.C. § 2484 should be amended to state that the commissaries' requirement to sell items at reduced prices should be limited to the following categories of items: (A) Meat, poultry, seafood, and fresh-water fish. (B) Nonalcoholic beverages. (C) Produce. (D) Grocery food, whether stored chilled, frozen, or at room temperature. (E) Dairy products. (F) Bakery and delicatessen items. (G) Nonfood grocery items.[728]

  - 10 U.S.C. § 2485 should be amended to establish the DeRA BOD described above, granting the Secretary of Defense the authority to establish the board, which should include five voting members—a senior representative from each Military Service and the Under Secretary of Defense for Personnel and Readiness—as well as nonvoting members with experience related to logistics military personnel and entitlements, and other relevant areas. The section should also be amended to allow the Secretary to assign a limited number of active-duty Service members to the defense resale system, when necessary, including to serve as the Executive Director.

  - 10 U.S.C. § 2487 should be amended to eliminate references to the separation of commissaries and exchanges and disestablish the Defense Commissary Agency.

  - 10 U.S.C. § 2488, which sets forth limited conditions under which commissary and exchange stores may be combined, should be repealed.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

[728] Nonfood grocery items are further defined in DoD Commissary Program, DoDI 1330.17 (2014), Enclosure 4, 28-29. In conjunction with the consolidation of commissaries and exchanges, the Commission recommends redefining nonfood grocery items to specifically include categories of personal health such as aspirin and diapers, omitting beauty products such as makeup and perfume.

Recommendation 10: Improve access to child care on military installations by ensuring the Department of Defense has the information and budgeting tools to provide child care within 90 days of need.

Background:
DoD Child Development Programs (CDPs) are intended to "support the mission readiness, family readiness, retention, and morale of the total force,"[729] as well as "reduce the stress of families who have the primary responsibility for the health, safety, and well-being of their children and help them balance the competing demands of family life and the DoD mission."[730] To achieve these outcomes, DoD offers child care services for children from birth through 12 years of age on a full-day, part-day, short-term, or intermittent basis.[731] Children are eligible for care if their sponsors are active-duty military, DoD civilian employees paid from either appropriated funds (APF) or nonappropriated funds (NAF), Reserve Component military personnel on active-duty or inactive-duty training status, combat-related wounded warriors, surviving spouses of Service members who died from a combat-related incident, those acting in loco parentis for the dependent child of an otherwise eligible patron, eligible employees of DoD contractors, or others as authorized on a space available basis. Special rules apply to unmarried and legally separated parents.[732]

Child care services are currently delivered through DoD facilities, including 768 child development centers (CDCs) and 293 school-age care (SAC) facilities; more than 3,000 private homes associated with family child care (FCC) programs; and DoD-approved private-sector programs that participate in community-based child care arrangements.[733] Standards and oversight are in place to ensure basic health, safety, and quality of the delivery options, each of which offers different advantages to DoD and to military families. DoD child care programs on military installations must be nationally accredited and meet DoD certification standards.[734] DoD supported off-installation programs are required to be licensed by state authorities, meet background check requirements, and meet DoD standards or be nationally accredited.[735] DoD certifies each program,[736] conducts inspections[737] and background checks,[738] and imposes limits on the ratio of child care staff to children, as well as the size of groups.[739] Child care costs are subsidized to support affordable, systemwide

[729] Child Development Programs (CDPs), DoDI 6060.02, 2 (2014). (Note: The DoDI 6060.02, Child Development Programs, was updated August 5, 2014. Information in this recommendation reflect changes made since the publication of the Interim Report.)
[730] Child Development Programs (CDPs), DoDI 6060.02, 2 (2014).
[731] Ibid, Enclosure 3, 15 (2014).
[732] Ibid, 2-3 (2014).
[733] Ibid, Enclosure 3, 15, 27 (2014). Numerical information provided by Office of the Deputy Assistant Secretary of Defense, Military Community and Family Policy, e-mail to MCRMC, October 7, 2014.
[734] Ibid, Enclosure 3, 19, (2014).
[735] Ibid, Enclosure 3, 18 and 27 (2014).
[736] Ibid, Enclosure 3, 18 (2014).
[737] Child Development Programs (CDPs), DoDI 6060.02, Enclosure 3, 18 (2014).
[738] Ibid, 15.
[739] Ibid, 46.

fees based on total family income (TFI).[740] DoD specifies that the amount of APF used to operate CDPs shall be no less than the amount collected through child care fees.[741]

Each Military Service and installation determines the type and mix of child care services that best meets the needs of its military families at each location.[742] Table 15 provides a snapshot of child care capacity across the various Military Services and delivery methods as of September 2014.[743] In CDCs and SAC facilities, these figures represent the number of physical spaces available. The capability to deliver services to a child requires both an appropriate physical space and adequate staffing. The number of children served by a space can vary with the type of care provided (e.g., full-time, part-day, short-term, intermittent).

Table 15. Child Care Spaces by Service as of September 2014

	Army	Navy	Air Force	USMC	DoD Total
CDC	27,561	18,599	22,952	6,629	**75,741**
SAC	12,351	11,174	11,021	2,049	**36,595**
FCC	4,050	11,502	3,588	1,022	**20,162**
Community-based	20,807	5,512	2,153	945	**29,417**
TOTAL	**64,769**	**46,787**	**39,714**	**10,645**	**161,915**

When military child care is requested but not available, the child is placed on a waiting list and assigned a priority based on the status of the family's sponsor.[744] The priority system has four levels and provides priority to sponsor groups such as single or dual active-duty Military Service members, combat-related wounded warriors, sponsors with spouses employed full-time or actively seeking employment outside the home, and sponsors with spouses enrolled in an accredited post-secondary institution.[745]

For additional information on military child care, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 5.1.9.2.1).*

Findings:
In FY 2013, military child care served approximately 200,000 children ages 12 and younger.[746] Child care is an important element of family readiness and well-being, and is a critical supplement to other forms of care, such as private-sector child care, parental and family care, and cooperative care. The military child care network often

[740] Ibid, 27-28.
[741] Ibid, 15. Exceptions are made for certain child development centers operating under a long-term facility's contract or lease-purchase agreement.
[742] Ibid, Enclosure 2, 9-12. *See also* Princeton University and the Brookings Institution, "The Future of Children," *Military Children and Families,* 23, no. 2, (2013), 84, accessed on November 10, 2014, http://futureofchildren.org/futureofchildren/publications/journals/article/index.xml?journalid=80&articleid=587.
[743] Department of Defense Office of Personnel and Readiness, *Annual Summary of Program Operations for FY13*, provided in an e-mail from OSD P&R, October 7, 2014.
[744] Child Development Programs (CDPs), DoDI 6060.02, Enclosure 3, 14 (2014).
[745] Ibid. *See also* the Child, Youth, and School Support Services section of *The Report of the Military Compensation and Retirement Modernization Commission: Interim Report* (Section 5.1.9.2.1).
[746] Department of Defense, *Annual Report to the Congressional Defense Committees on Plans for the Department of Defense for Support of Military Family Readiness, Fiscal Year 2013*, 8, accessed December 21, 2014, http://www.militaryonesource.mil/12038/MOS/Reports/FY2013-Report-MilitaryFamilyReadinessPrograms.pdf.

offers services with convenient locations for those living or working near military installations; flexibility to support demanding military schedules; a staff understanding of military lifestyles; and, in many cases, lower fees.

Of the input received through the Commission's survey, town halls, and other meetings, many Service members and families were complimentary of the quality of military child care. They did, however, frequently express concern about an insufficient number of overall spaces to meet the local demand or unavailability during evenings, nights and weekends.

> *I think there should be more child-care slots provided as more members often have working spouses or single-parents.*[747]

> *Regarding child care, the child development centers on base are wonderful and the staff is very loving and nurturing toward the children. My complaint is that at bases with 24-hour operations, there are no 24-hour child care facilities, limited local options, and no family child care homes willing to care for children on nights, weekends, or overnight when active-duty parents have to work. Military parents who are shift workers have to find nannies or some form of alternative care for their children, which is a huge additional expense that is not factored in and a huge stressor.*[748]

At many locations, the demand for military child care exceeds the supply, resulting in waiting lists and associated waiting times. This situation is particularly true for young children. Even though most military parents choose options other than military child care,[749] as of September 2014, DoD reported that there were more than 11,000 children on waiting lists.[750] It is important to note, however, that the waiting list numbers may not accurately reflect unmet demand. Factors such as duplicative entries (i.e., families placing their child's name on multiple, uncoordinated waiting lists) and inefficient updating of the list to remove the names of children who no longer require service can inflate these numbers. Waiting lists can also understate the true demand in situations in which parents who desire military child care instead pursue other options and do not add their child's name to a list due to long waiting times.

Despite these inaccuracies, some general conclusions may be drawn. Waiting lists are generally longer for young children. Based on the September 2014 data, a disproportionate number of children on waiting lists are ages 3 and younger (73 percent).[751] There are multiple factors that could explain this high percentage:

- Evidence indicates that private-sector child care does not provide spaces for infants and toddlers proportional to the demand.[752] According to the National

[747] MCRMC letter writer, comment form submitted via MCRMC web site, May 2014.
[748] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[749] According to the 2012 Demographics of the Military Community, there were nearly 1 million children of AC Service members 12 years old or younger, and more than half a million who were 5 years old or younger. *See* Department of Defense, *2012 Demographics: Profile of the Military Community*. As reported in the Annual Summary of Program Operations for FY13, provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, October 7, 2014. DoD Child Development programs in FY 2013 provided 161,915 spaces serving more than 200,000 children (12 years old or younger).
[750] Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 9, 2014.
[751] Ibid. Of 10,979 children on waiting lists between ages 5 or younger, 8035 were ages 3 and younger.
[752] National Association of Child Care Resource & Referral Agencies, *Making Quality Child Care Possible: Lessons Learned from NACCRRA's Military Partnerships*, accessed November 10, 2014, http://www.naccrra.org/sites/default/files/default_site_pages/2011/lessons_learned_report_2008.pdf.

Association of Child Care Resource & Referral Agencies, based on data provided by child care resource and referral agencies and an analysis of 32 states, "only 20 percent of child care spaces are for infants and toddlers…In contrast, 48 percent of all requests for child care referrals are for infant and toddler care, and data collected by the U.S. Census Bureau show that 57 percent of all mothers return to work by the time their children are a year old."[753]

- The private sector typically charges more for children younger than 3 years of age than it charges for older children.[754] Because military child care fees do not vary with age, the military option is more likely to be less expensive than the private sector for younger children. The average annual cost of full-time care for an infant in private-sector, center-based care ranges from $4,863 in Mississippi to $16,430 in Massachusetts.[755] The maximum annual cost for DoD CDCs ranges from $3,328 to $7,696, depending on TFI.[756]

- Despite a history of longer waiting lists for the youngest children, military child care spaces tend to be evenly distributed across the age groups, or slightly biased toward older children. For example, guidelines provided to Army garrison commanders recommend allocating 30 percent of spaces to children younger than age 2[757] (who represent approximately 35 percent of military children younger than age 6, according to the 2012 DoD demographics report).[758]

- From a financial perspective, costs are reduced and revenues are increased when fewer spaces are allocated to younger children. This situation occurs because older children have a lower required ratio of staff to children and tend to come from military families with higher income, who pay higher fees. Basing fees on TFI offers the greatest benefit to the most financially vulnerable military families. However, it can financially discourage provision of more spaces for younger children. A direct care staff member can generate between $11,232 and $49,920 more in fees per year (depending on the TFI of the parents), when caring for the maximum allowed number of 5-year-olds as compared to the maximum number of infants.[759] Assuming that older children tend to have older parents with higher military income, the potential increase in fee revenue moves toward the higher end of this range. If that same staff member is caring for kindergarten or school-age children, the allowed ratios are even higher (15 children per staff), and the ability to generate additional fees is also higher (between $19,968 and $73,008 additional annual revenue per staff member depending on the TFIs).

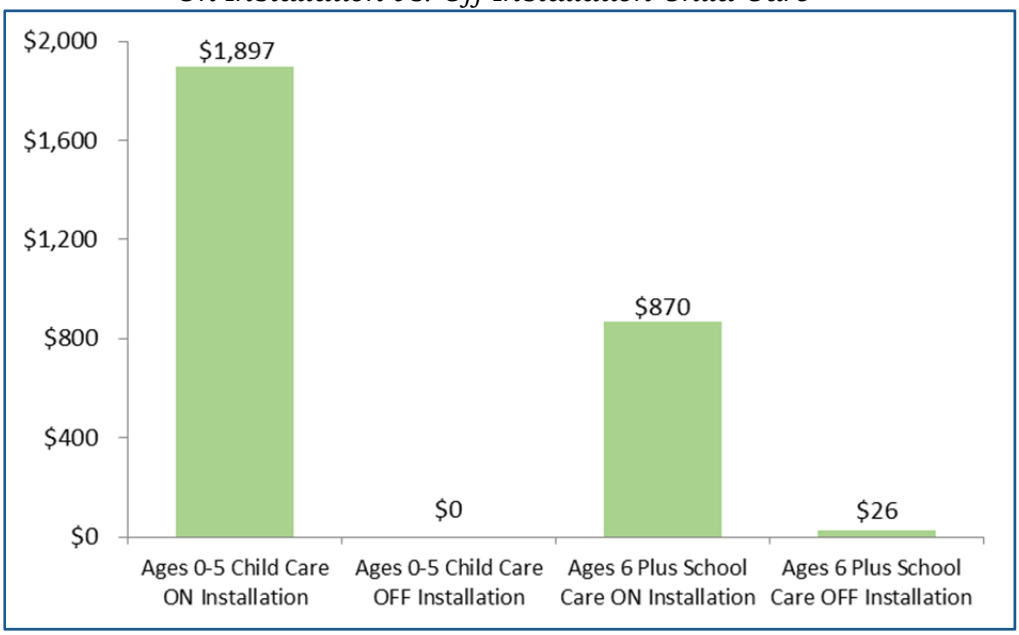
---

[753] Ibid, 24.
[754] Child Care Aware, *Parents and the High Cost of Child Care 2013 Report*, Appendix 1, 40-41.
[755] Ibid, 14, 40–41.
[756] Based on the School Year 2014-2015 fee schedule, assuming care for 52 weeks per year. This is a maximum because it assumes the high end of all fee ranges and includes a market adjustment fee for high cost markets. For the fee schedule, *see* Stephanie Barna, Acting Assistant Secretary of Defense for Readiness and Force Management, *Memorandum: Department of Defense (DoD) Child Development Program Fee Ranges for School Year (SY) 2014-2015*, August 8, 2014.
[757] Department of the Army, *Child Care 101*, 2007.
[758] Department of Defense, *2012 Demographics: Profile of the Military Community*.
[759] The stated range in revenue assumes that the same direct-care staff member, based on maximum DoD care ratios, can care for four infants or 12 preschool children (age 5). This is based on DoD maximum staff-to-child ratios as found in Child Development Programs (CDPs), DoDI 6060.02, 38 (2014). To calculate the maximum difference, it was assumed that all infants are from the lowest TFI category and all preschool children are from the highest TFI category. The opposite approach was used to calculate the minimum difference. Similarly, when a range in fees is permitted, the minimum or maximum fees were selected to produce the minimum and maximum differences. Local market exceptions, which are sometimes permitted, were not included in this calculation.

- Although the salaries of direct care staff are primarily paid from fees, most support costs are paid using APF. The APF cost of providing a preschool (5-year-old) space is significantly lower than the cost for an infant space. An estimate from 2010 showed the annual APF cost for a preschool space ($2,484), to be approximately one-third the cost of an infant space ($8,545).[760] Similarly, the annual APF cost for a school-age space ($1,427) was approximately one-sixth the APF cost of an infant space.[761] These financial incentives can also be seen in the budget request and justification process. When quantifying the expected benefit of additional funding, or assessing the impact of proposed budget cuts, the number of children affected increases if the provided services are calculated using average costs biased by older children.

The Commission's survey also pointed to higher demand for child care services for younger children.[762] The survey's results showed that respondents most valued child care spaces serving children 5 years old and younger in on-installation settings.[763] Figure 22 shows the weighted dollar values provided by respondents for on-installation and off-installation care. Respondents rated on-installation care for children ages 5 and younger as more than twice as valuable as similar care for children ages 6 and older.[764] Respondents rated off-installation care for both age groups as substantially less valuable.[765]

Figure 22. Active-Duty Service Members' Perceived Value: On-Installation vs. Off-Installation Child Care[766]



[760] Department of Defense, *Deputy Secretary of Defense, Annual APF Cost per Center Space Estimated by Age of Child*, PBD 023.
[761] Ibid.
[762] Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
[763] Ibid.
[764] Ibid.
[765] Ibid.
[766] Ibid. This figure displays the average amount in dollars that survey respondents valued compensation alternatives. Presentation in dollar values allows the value of compensation features to be directly compared.

Although waiting lists are important indicators of the unmet demand, waiting times are more important to parents than the number of names ahead of them on the list, because it is on the basis of waiting times that families typically make decisions about employment, education, and alternate forms of care. Recognizing the importance of waiting times, DoD established a goal to provide care across all age categories within 90 days of need.[767] Waiting times are currently not reliably tracked and are not consistently available.[768] The Army confirmed that the 90-day goals were not being met for young children, citing 6- to 9-month waiting times for infants and 3- to 5-month waits for toddlers.[769] It also reports "freezing" waiting lists at 75 percent of their locations until temporary staffing measures, like asking managers to provide direct care, can be reversed.[770] In some cases, this means that new names are not being added to the waiting lists. The Navy confirmed that the average waiting time for infants was 3 to 5 months, but cautioned that the manual methods used to track and report this data may affect its accuracy.[771] The Air Force does not consistently collect or track waiting time data, but was able to provide data for one of its large overseas child care programs. For that location the waiting times for toddlers stand out as being particularly long, up to 7 months.[772] Although not tracked everywhere, the 90-day service goal for child care is formally tracked at joint bases, as part of their common output level standards.[773] As of second quarter FY 2014, only five of 12 joint bases reported meeting the 90-day service standard.[774] Not only do most joint bases not meet the goal, the average waiting time across all 12 bases exceeded the 3-month goal.[775]

DoD is currently fielding MilitaryChildCare.com, an online system for managing child care waiting lists. Among other capabilities, this tool allows parents to see all available DoD-supported child care options in a chosen area, place their child's name on multiple waiting lists, and receive an estimated placement date (waiting time) for each option. If fielded and operated as planned, within 2 years this tool would provide a standardized approach to documenting and tracking waiting times.[776] Based on data from five pilot sites,[777] this system reportedly reduced waiting lists by 12 percent and reduced waiting times by 30-45 days through elimination of duplicative counting, improvements in waiting list management, clearer presentation of options to parents,

[767] Based on information provided by Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy, e-mail to MCMRC, October 23, 2014. Common output level standards (COLS) are contained in the Cost & Performance Visibility Framework Handbook for Joint Basing, an online resource for joint installation commanders. The authority to establish COLS originated with the Initial Guidance for BRAC 2005 Joint Basing implementation. Note that placement includes approved child development programs on and off the joint base, and in authorized FCC homes. Once a viable option has been offered, this standard has been met.
[768] Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 9, 2014.
[769] Ibid.
[770] Ibid.
[771] Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 30, 2014.
[772] Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 9, 2014.
[773] Based on information provided by Office of the Deputy Secretary of Defense, Military Community and Family Policy, e-mail to MCMRC, October 23, 2014. Common output level standards (COLS) are contained in the Cost & Performance Visibility Framework Handbook for Joint Basing, an online resource for joint installation commanders. The authority to establish COLS originated with the Initial Guidance for BRAC 2005 Joint Basing implementation. Note that placement includes approved child development programs on and off the joint base, and in authorized FCC homes. Once a viable option has been offered, this standard has been met.
[774] Second Quarter FY 2014 Cost and Performance Visibility Framework (CPVF) Report Card, Child and Youth COLS number 1: 100% of children are placed within 3 months of request, provided by the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, October 28, 2014.
[775] Ibid.
[776] Office of Commander, Navy Installations Command, e-mail to MCRMC, January 7, 2015.
[777] Pilot sites included Navy and USMC installations in Hawaii, Navy installations in metro San Diego, Key West, and Bahrain, and Nellis Air Force Base in Nevada.

and more efficient purging of expired requests.[778] Although MilitaryChildCare.com currently estimates placement dates (waiting times) using historical averages, there are plans to incorporate a more sophisticated inventory management model based on a projection of available resources.[779]

Even when demand is reliably measured and monitored, and the DoD budget supports expanding child care capabilities, responding to that demand with appropriate facilities and staff in a timely fashion can be challenging. DoD offers competitive wages and emphasizes the importance of a career path for those who start as direct care providers;[780] however, difficulties finding and hiring interested staff members, and the time required for mandated security checks, may inhibit the expansion of services and sometimes result in available space sitting idle.[781] The Commission heard from DoD Child and Youth Program managers that position descriptions for direct care staff do not accurately reflect the duties and responsibilities required. This mismatch between position descriptions and performance expectations sometimes results in staff resignations.[782] Another challenge to meeting the demand for child care occurs when DoD or the Services implement a civilian personnel hiring freeze. In 1991 and 2013 DoD announced civilian personnel hiring freezes that included child care staff, but later issued exemptions to meet the staffing requirements of the Military Child Care Act of 1989.[783]

From a space perspective, CDC and SAC facilities must meet Occupational Safety and Health Administration requirements as well as DoD configuration requirements.[784] Reconfiguring or expanding existing facilities, as well as building new facilities to meet new or changing demand, can require military construction (MILCON) funding. MILCON funding may also be required to reconfigure leased spaces, which can be a preferred alternative from the perspectives of speed and flexibility for providing space. MILCON funds are limited and managed in a way that can result in lengthy approval and funding allocation processes, inhibiting responsiveness to changes in child care demand. As an alternative, in 2006, the Congress authorized the Secretary of Defense to establish a temporary program to engage in unspecified minor military construction projects, using operation and maintenance funds to construct new CDCs and improve or expand existing ones. Using this authority, DoD increased child care capacity by more than 10,000 spaces before the authority expired in FY 2009.[785]

---

[778] Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 9, 2014.
[779] Ibid.
[780] *See* Armed Forces, 10 U.S.C. § 1792(c). *See* Armed Forces, 10 U.S.C. § 1800(3).
[781] Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 9, 2014.
[782] Department of Defense and Services Child Development Program Managers, discussion with MCRMC Quality of Life staff, August 8, 2014.
[783] Department of Defense, *Secretary of Defense Memorandum, Military Child Care Hiring Allocations, August 6, 1991*, 17, accessed December 4, 2014, http://www.dod.mil/pubs/foi/Personnel_and_Personnel_Readiness/Personnel/417.pdf. General Accounting Office, *Defense Budget Issues: Effect of Civilian Hiring Freeze on Fiscal Year 1991 Budget, GAO Report, 5*, accessed December 21, 2014, http://www.gao.gov/assets/80/77823.pdf. "MCOM Plans To Fill Critical Support Jobs, Despite Army-Wide Hiring Freeze," *Stars and Stripes*, (January 31, 2013), http://www.stripes.com/news/imcom-plans-to-fill-critical-support-jobs-despite-army-wide-hiring-freeze-1.205957. *See also* Department of Defense Authorization Act of 1989, Pub. L. No. 101-189, 103 Stat. 1352 (codified as amended at Armed Forces, 10 U.S.C. §§ 1791-1798 (1999)).
[784] Child Development Programs, DoDI 6060.02, Enclosure 3, 30-31 (2014). *See also* Department of Defense, *Policy Memorandum on Department of Defense Unified Facilities Criteria*, May 29, 2002, *See also* Department of the Army, Policy Memorandum, *Army Standard for Child Development Center* (October 2004).
[785] National Defense Authorization Act for FY 2006, Pub. L. No. 109-163 § 2810 (2006). The authority originally expired in 2007, but was extended until 2009, when it was allowed to expire. *See* National Defense Authorization Act for FY 2008, Pub. L. No. 110-181 § 2809 (2008). *See also* Armed Forces, 10 U.S.C. § 2805.

Conclusions:
Military child care is widely acclaimed for its quality and affordability, but is frequently a source of frustration for military families because of its limited availability. While not intended to serve the needs of all military children and families, DoD child care is often the preferred option for military families, addressing the unique challenges of military lifestyles, and providing support that can be critical to the psychological and financial health of the families who need it most. In particular, it can improve family and Service member readiness, yielding an improved ability to cope with demanding schedules, extended deployments, and frequent moves, far away from extended family. The priority system emphasizes care for sponsor groups like single and dual active-duty parents and the means-tested fees reduce the financial burden for the most financially vulnerable families. These prioritization and fee strategies help focus delivery of services to families who are more likely to need assistance, but if the total demand is not reasonably and consistently met, it can become a source of dissatisfaction for some, and worse, a source of family hardship for others, possibly leading to performance and readiness issues.

Current models for planning and resourcing full-time military child care can result in long waiting times, particularly for children who are 3 years old and younger, the ages for which care is typically most expensive and least available from other sources. Service members and their families have communicated to the Commission that the long waiting times sometimes results in situations where they cannot afford alternatives, find it difficult to meet demanding military work schedules, and have to forgo opportunities for spouse employment or education. Although DoD policy clearly states that its child care services are not an entitlement[786] and not every military parent wants or needs military child care, unavailability of this benefit for those who do was an often cited source of frustration affecting quality of life and willingness to serve or accept certain assignments. These effects can be amplified if Service members are frequently relocated to meet the needs of the Military Services, and repeatedly end up at the bottom of long waiting lists with waiting times that consume a substantial portion of their period of assignment.

Recommendations:

- DoD should immediately establish mandatory, standardized monitoring and reporting of child care wait times, disaggregated by age groups, across all types of military child care. This reporting is needed to evaluate performance against the DoD goal of providing care within 90 days of need.

- DoD should implement the changes contained in the proposed rule for Background Checks on Individuals in DoD Child Care Services Programs, published in the Federal Register on October 1, 2014. [787]

- The Secretary should direct that APF and NAF child direct care and professional staff are exempt from future departmental hiring freezes and furloughs.

[786] Child Development Programs (CDPs), DoDI 6060.02, 2 (2014).
[787] Under Secretary for Defense for Personnel and Readiness, *Proposed Rule: Background Checks on Individuals in DoD Child Care Services Programs*, accessed December 21, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-10-01/pdf/2014-23061.pdf.

- DoD should revise child and youth direct care staff position descriptions for staff in CC-2 through CC-5 positions to more accurately describe the requirements and responsibilities of these positions.

- The Congress should reestablish the authority to use operating funds for minor construction projects when creating new, expanding, or modifying CDP facilities serving children from birth to 12 years of age with an emphasis on adding spaces for children ages birth to 3. This authority should allow projects up to $15 million. This proposal has no direct effect on APF as this legislation only grants the associated authority. A budgetary impact would only occur if the Military Services chose to fund construction projects under this authority.

Implementation:

- 10 U.S.C. § 2805 governs unspecified minor military construction. 10 U.S.C. § 2805 should be amended to raise the threshold for minor military construction to $15 million, when the minor military construction project is to create a new child development facility or to expand or modify an existing child development facility.

- 10 U.S.C. Chapter 88, Subchapter II, governs military child care. No change to this governing statute is recommended.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed. Such as:

  - DoD Instruction 6060.02 should be amended to require annual reporting by each installation managing CDPs. The reports should include, by age group and by location, 1) the number of persons on each waiting list at the time of the report; 2) the average length of time spent on the waiting list over the previous year; and 3) the total number of persons over the previous year whose time on the waiting list exceeded DoD's 90-day goal with planned or recommended remediation actions. DoD should implement the changes contained in the proposed rule for Background Checks on Individuals in DoD Child Care Services Programs, published in the Federal Register on October 1, 2014. The Secretary should amend DoD policy to identify APF and NAF child direct care and professional staff as essential personnel and exempt such staff from any and all future hiring freezes and furloughs.

  - DoD should revise its official descriptions of child and youth direct care staff position descriptions for positions CC-2 through CC-5, to more accurately describe the requirements and responsibilities of these positions.

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

Background:
DoD and the Department of Veterans Affairs (VA) provide myriad programs that deliver educational benefits to Service members and veterans. Current education assistance programs include the Post-9/11 GI Bill, the Montgomery GI Bill Active Duty (MGIB-AD), the Montgomery GI Bill Selected Reserve (MGIB-SR), the Reserve Education Assistance Program (REAP), and Tuition Assistance (TA). Key features of these various programs are outlined below.

Post-9/11 GI Bill

Education assistance is available to active-duty members of the military services and veterans with an honorable discharge who have at least 90 days of aggregate service after September 10, 2001, or to individuals who have a minimum of 30 continuous days of service who were discharged due to a service-connected disability.[788] The Post-9/11 GI Bill covers all tuition and fees for in-State students or up to $19,198.31 at private or foreign schools per academic year.[789]

The amount covered varies based on the beneficiary's time in service.[790] A Service member is eligible for 100 percent of the maximum amount payable after 36 aggregate months on active duty.[791] Recipients who are not on active duty and who meet additional eligibility criteria receive a monthly housing stipend equal to the Basic Allowance for Housing (BAH) payable to an E5 with dependents in the same ZIP code as the school.[792] They receive an annual stipend for books and supplies[793] and may also receive a one-time rural relocation benefit payment.[794]

Approved educational programs include graduate and undergraduate degrees, vocational and technical training, on-the-job training, flight training, correspondence training, licensing and national testing programs, entrepreneurship training, and tutorial assistance.[795] Beneficiaries receive up to 36 months of education benefits,[796] which may be used for up to 15 years following separation from active duty.[797] Tuition

---

[788] Veterans' Benefits, 38 U.S.C. § 3311. *See also* Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.9520.
[789] Veterans' Benefits, 38 U.S.C. § 3313. *See also* "Education and Training," Department of Veterans Affairs, accessed September 25, 2014, http://www.benefits.va.gov/gibill/resources/benefits_resources/rates/ch33/Ch33rates080113.asp.
[790] Veterans' Benefits, 38 U.S.C. §§ 3311 and 3313. Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.9520. Pensions, Bonuses, and Veterans' Benefits, 38 CFR 21.9525. Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.9640. *See also* "Federal Benefits for Veterans, Dependents, and Survivors, Chapter 5 Education and Training," Department of Veterans Affairs, accessed June 1, 2014, http://www.va.gov/opa/publications/benefits_book/benefits_chap05.asp.
[791] Veterans' Benefits, 38 U.S.C. §§ 3311 and 3313.
[792] Veterans' Benefits, 38 U.S.C. § 3313.
[793] Ibid.
[794] Veterans' Benefits, 38 U.S.C. § 3318. Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.9660.
[795] Veterans' Benefits, 38 U.S.C. § 3301(3). *See also* Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.9590. *See also* "Post-9/11 GI Bill," Department of Veterans Affairs, accessed September 25, 2014, http://www.benefits.va.gov/gibill/post911_gibill.asp.
[796] Veterans' Benefits, 38 U.S.C. § 3312.
[797] Veterans' Benefits, 38 U.S.C. § 3321.

is paid directly to schools, and the housing stipend, book stipend, and rural relocation payment are paid directly to beneficiaries.[798]

The Post-9/11 GI Bill allows Service members, under certain conditions, to transfer their benefits to their spouses or children. Since August of 2009, Service members who have served 6 years and commit to an additional 4 years of service (YOS) may transfer all or a portion of their benefits to a spouse or children.[799] The spouse may use the benefit for up to 15 years after the Service member's last separation from active duty.[800] Dependent children may use the benefit as soon as they attain a secondary school diploma or reach 18 years of age but may not use the benefit after reaching 26 years of age.[801] Children are entitled to the same monthly housing stipend as a separated Service member, equal to the BAH payable to an E5 with dependents in the same ZIP code as the school, as well as a books and supplies stipend.[802] Spouses of separated Service members are also entitled to a monthly housing stipend. Spouses of active-duty Service members do not receive the stipend, making the level of benefit the same as if the Service member were using it himself or herself while on active duty.[803]

MGIB-AD

Education benefits are provided to Service members who first entered active duty after June 30, 1985,[804] have a remaining entitlement under the Vietnam Era GI Bill,[805] were involuntarily separated under the Voluntary Separation Incentive or Special Separation Benefit program,[806] or are Veterans Educational Assistance Program[807] participants who elected to convert to the Montgomery GI Bill during the open window periods.[808] Service members enroll and pay $100 per month for 12 months.[809]

All incoming Service members, except Service Academy graduates and ROTC scholarship graduates, are automatically enrolled unless they choose to opt out.[810] Participants are entitled to receive monthly education benefits once they have completed a minimum of 3 YOS.[811] Effective October 1, 2014, the basic monthly rate for beneficiaries is $1,717.00.[812] This benefit can be used for degree programs, certificate or correspondence courses, cooperative training, independent study programs, apprenticeship or on-the-job training, and vocational flight training

---

[798] Veterans' Benefits, 38 U.S.C. § 3313(h).
[799] Veterans' Benefits, 38 U.S.C. § 3319. *See also* Post-9/11 GI Bill, DoDI 1341.13, 11 (2013). *See also* Report of the Military Compensation and Retirement Modernization Commission: Interim Report, 255-256.
[800] Veterans' Benefits, 38 U.S.C. § 3321.
[801] Veterans' Benefits, 38 U.S.C. § 3319(g)(2). *See also* Veterans' Benefits, 38 U.S.C. § 3319(h)(5)(A); Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.9530(e).
[802] Veterans' Benefits, 38 U.S.C. § 3319(h).
[803] Ibid.
[804] Veterans' Benefits, 38 U.S.C. § 3011(a)(1).
[805] Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.7045.
[806] Veterans' Benefits, 38 U.S.C. §§ 3018A-3018B. Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.7045.
[807] Veterans' Benefits, 38 U.S.C. § 3018C.
[808] Veterans' Benefits, 38 U.S.C. § 3018. *See also* Montgomery GI Bill (MGIB) Program, DoDD 1322.16 (2002).
[809] Veterans' Benefits, 38 U.S.C. § 3011(b).
[810] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 18, 2014.
[811] Veterans' Benefits, 38 U.S.C. § 3011(b). If the Service member becomes eligible for the Montgomery GI Bill under 38 U.S.C. § 3011(a)(1)(A), then the $100 reduction in pay for 12 months is applicable. Otherwise, it is not.
[812] *See* "Education and Training, Montgomery GI Bill Active Duty (Chapter 30) Increased Educational Benefit," Department of Veterans Affairs, accessed October 2, 2014, http://www.benefits.va.gov/GIBILL/resources/benefits_resources/rates/ch30/ch30rates100114.asp.

programs.[813] Before using these benefits, Service members must complete a high school diploma or the equivalent of 12 semester hours in a program of education leading to a standard college degree.[814] All education benefits are paid directly to Service members.[815]

MGIB-SR

The Montgomery GI Bill is also available to members of the Selected Reserve if they meet the eligibility requirements which include a 4-year obligation to serve in the Selected Reserve, completion of a 2-year obligation as an active-duty Service member, and completion of a high school diploma or equivalency certificate.[816]

REAP

REAP was created in 2004[817] to provide educational assistance to members of the Reserve Component who are called or ordered to active duty in response to a contingency operation as declared by the President or the Congress.[818] To be eligible for benefits, Service members need to have been activated on or after September 11, 2001, for at least 90 consecutive days.[819] Effective October 1, 2014, the basic monthly rate for trainees under REAP is $1,373.60.[820] REAP can be used for college or university degree programs, vocational programs, independent study or distance learning programs, correspondence courses, flight training, on-the-job training and apprenticeship programs, licensing and certification test reimbursement, and entrepreneurship courses.[821]

Tuition Assistance

The Military Services also offer financial assistance for tuition and fees for voluntary, off-duty educational programs in support of Service members' personal and professional goals through TA.[822] TA is available to active-duty Service members, Reservists, and National Guardsmen in an active-duty status.[823] Services may pay all or a portion of tuition and expenses for TA participants.[824] TA was originally created because Service members were not allowed to use their GI Bill benefits while on active duty.[825] Service members can now use Post-9/11 GI Bill benefits while on active duty.[826]

---

[813] Veterans' Benefits, 38 U.S.C. § 3014(a) provides that "the Secretary shall pay to each individual entitled to basic educational assistance who is pursuing an approved program of education a basic educational assistance allowance to help meet, in part, the expenses of such individual's subsistence, tuition, fees, supplies, books, equipment, and other educational costs." Veterans' Benefits, 38 U.S.C. § 3002 provides that the term "program of education" has the same meaning as that found in 38 U.S.C. § 3452(b).
[814] Veterans' Benefits, 38 U.S.C. § 3011(a)(2).
[815] Pensions, Bonuses, and Veterans' Relief, 38 CFR 21.7130-21.7144.
[816] Veterans' Benefits, 38 U.S.C. § 3012(a).
[817] National Defense Authorization Act for FY 2005, Pub. L. No. 108-375, § 527 (2004).
[818] Armed Forces, 10 U.S.C. § 16161.
[819] Armed Forces, 10 U.S.C. § 16163.
[820] *See* "Education and Training, Reserve Educational Assistance Program Increased Educational Benefit," Department of Veterans Affairs, accessed October 2, 2014, http://www.benefits.va.gov/GIBILL/resources/benefits_resources/rates/ch1607/ch1607rates100114.asp.
[821] Armed Forces, 10 U.S.C. § 16162(b) states all education assistance programs approved for assistance under the Montgomery GI Bill are approved for REAP.
[822] Armed Forces, 10 U.S.C. § 2007.
[823] Armed Forces, 10 U.S.C. § 2007. *See also* Voluntary Education Programs, DoDI 1322.25, 16-17 (2014).
[824] Armed Forces, 10 U.S.C. § 2007.
[825] "Part V: Chapter 10 - Tuition Assistance Top-up," Department of Veterans Affairs, accessed April 11, 2014, http://www.benefits.va.gov/warms/docs/admin22/m22_4/part05/ch10.htm#s1004.
[826] *See* Veterans' Benefits, 38 U.S.C. § 3311.

For additional information on education assistance, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 5.8.1).*

Findings:
Education benefits are strong recruiting and retention tools. The 2014 Blue Star Families Military Family Lifestyle Survey determined that approximately 74 percent of Service member respondents indicated they joined the military to receive educational benefits.[827] The number of veterans using GI Bill benefits increased 67 percent, from 564,487 to 945,052 students, between FY 2009 and FY 2012.[828] The Commission's survey indicated tuition assistance was perceived to be more than twice as valuable as quality of life programs such as child care, family support services, and military housing.[829] The Commission also received numerous comments related to the high value that recipients place on education benefits:

> *Post-9/11 GI Bill wonderful benefit.*[830]
>
> *Post-9/11 GI Bill program is the best education benefit offered by the military. Please do not reduce it.*[831]
>
> *I am very satisfied with the Post-9/11 GI Bill, and I believe education benefits are extremely important.*[832]

There are substantial duplications between various education programs that are available to Service members. Originally, the Post-9/11 GI Bill did not cover the same education courses as the MGIB,[833] but the Congress has since enacted legislation to align the programs to ensure both cover the same courses.[834] In addition, the amount of education benefits payable under both the Post-9/11 GI Bill[835] and REAP[836] are based on the number of continuous days served on active duty after September 10, 2001. Table 16 compares these programs.[837]

---

827 Blue Star Families, *2014 Military Family Lifestyle Survey, Comprehensive Report,* 31, accessed December 14, 2014, https://www.bluestarfam.org/sites/default/files/media/stuff/bsf_report_comprehensive_reportfinal_single_pages.pdf.
828 U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, Education Program Beneficiaries, January 2014. *See also* Lauren Kirkwood, More veterans taking advantage of Post-9/11 GI Bill, McClatchy DC, March 17, 2014. Accessed January 7, 2015, http://www.mcclatchydc.com/2014/03/17/221479_more-veterans-taking-advantage.html?rh=1#storylink=cpy.
829 Survey results, MCRMC survey, July 1, 2014 to October 10, 2014.
830 Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
831 Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
832 Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
833 *See* Post-9/11 Veterans Educational Assistance Act of 2008, Pub. L. No. 110-252 (2008), § 5003. The Post-9/11 GI Bill originally did not provide educational benefits for vocational or technical education, unlike the Montgomery GI Bill, but was subsequently amended by Congress in 2009.
834 *See* Post-9/11 Veterans Educational Assistance Improvement Act, Pub. L. No. 111-377 (2011) § 102.
835 Veterans' Benefits, 38 U.S.C. § 3311. S*ee also* Department of Veterans Affairs, *Post-9/11 GI Bill: It's Your Future,* VA Pamphlet 22-09-01, May 2012, accessed September 25, 2014.
836 Armed Forces, 10 U.S.C. § 16161. *See also* Department of Veterans Affairs, *Reserve Education Assistance Program (REAP): Summary of Educational Benefits under the Reserve Educational Assistance Program,* VA Pamphlet 22-05-1, revised September 2008, 29.
837 "Education and Training, Comparison Toll and Payment Chart," Department of Veterans Affairs, accessed October 9, 2014, http://www.benefits.va.gov/gibill/comparison_tool.asp.

Table 16. Features of Post-9/11 GI Bill, MGIB, and REAP

	Post-9/11 GI Bill	MGIB	REAP
Minimum Length of Service	90 days active aggregate service (after 9/10/01) or 30 days continuous if discharged for disability (after 9/10/01)	2 year continuous enlistment (minimum duty varies by service date, branch, etc.)	90 days active continuous service (after 9/10/01)
Maximum # of Months of Benefits	36	36	36
How Payments Are Made	Tuition: Paid to school Housing stipend: Paid monthly to student Books & Supplies: Paid to student at the beginning of the term	Paid to student	Paid to student
Duration of Benefits	Generally 15 years from last day of active duty	Generally 10 years from last day of active duty	Generally 10 years from the day student leaves the Selected Reserve or the day student leaves the IRR
Degree Training	Yes	Yes	Yes
Non College Degree Training	Yes	Yes	Yes
On-the-Job & Apprenticeship Training	Yes	Yes	Yes
Flight Training	Yes	Yes	Yes
Correspondence Courses	Yes	Yes	Yes
Licensing & Certification	Yes	Yes	Yes
National Testing Programs	Yes	Yes	Yes
Work-Study Program	Yes	Yes	Yes
Tutorial Assistance	Yes	Yes	No
Yellow Ribbon Program	Yes	No	No
Transferability	Yes	Yes	No
Maximum amount of benefits (full time)	Up to $19,198.31 (not including BAH equal to E5 with dependents)[838]	$15,453.00[839]	$12,362.40[840]

[838] Veterans' Benefits, 38 U.S.C. § 3313. *See also* "Education and Training," Department of Veterans Affairs, accessed September 25, 2014, http://www.benefits.va.gov/gibill/resources/benefits_resources/rates/ch33/Ch33rates080113.asp. Figure shown is per 9-month academic year.
[839] "Education and Training, Montgomery GI Bill Active Duty, Increased Educational Benefit, Effective October 1, 2014," U.S. Department of Veterans Affairs, accessed October 9, 2014, http://www.benefits.va.gov/GIBILL/resources/benefits_resources/rates/ch30/ch30rates100114.asp. Figure shown is per 9-month academic year.
[840] Ibid. Figure shown is per 9-month academic year.

Even though the features of these programs are similar, participants in the various programs received very different levels of benefits. The average Post-9/11 GI Bill benefits paid in FY 2013 was $13,465 per person.[841] The MGIB and REAP average per-participant benefit in FY 2013 was $8,551[842] and $4,028,[843] respectively. Reservists also qualify for Post-9/11 GI Bill benefits at a greater rate than REAP.[844] Although benefits are greater under the Post-9/11 GI Bill, 878,961 Service members have enrolled in the MGIB since 2008, an average of 146,494 per year.[845]

In addition, there are several features of the Post-9/11 GI Bill that are somewhat misaligned with retention goals or with historical implementation of new education benefits. For example, transferability of Post-9/11 GI Bill benefits at 6 YOS plus an additional 4-year commitment means that Service members as young as 24 can transfer their Post-9/11 GI Bill benefits, and may be only 28 when they leave.[846] The average DoD continuation rate from 1980 to 2010 for a Service member at 6 YOS is 35.3 percent,[847] while the average continuation rate for a Service member at 10 YOS is 19.3 percent.[848] Offering transferability at 10 YOS instead of 6 would enable the Services to increase retention at this critical point in a military career. Even though transferability is a very popular benefit, the Commission received a wide variety of comments related to the requirements for earning transferability:

> *I believe that the Post-9/11 GI Bill Education Benefit Transferability should go back to a 6 year requirement instead of the 4 additional years required.*[849]
>
> *Post 9/11 GI bill is spot on, but I would agree for a minimum time in service to receive the benefit of greater than 10 years.*[850]
>
> *If we keep Tuition Assistance, then the transferability of the Post-9/11 GI Bill should require a longer commitment in order to be transferred, say 15 or 20 years.*[851]
>
> *I think post 9/11 GI Bill should be transferable to spouse but not children.*[852]

---

[841] Department of Veterans Affairs, *Congressional Budget Submission for FY 2015 Volume III Benefits and Burial Programs and Departmental Administration,* VBA-33.
[842] Ibid.
[843] Ibid.
[844] Department of Veterans Affairs, *Post-9/11 GI Bill: It's Your Future, VA Pamphlet 22-09-01, May 2012,* accessed December 21, 2014, https://www.pritzkermilitary.org/explore/library/online-catalog/view/oclc/823319653. Department of Veterans Affairs, *Reserve Education Assistance Program (REAP): Summary of Educational Benefits under the Reserve Educational Assistance Program,* VA Pamphlet 22-05-1, revised September 2008, 29.
[845] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 26, 2014.
[846] Veterans Benefits, 38 U.S.C. § 3319. Post-9/11 GI Bill, DoDI 1341.13, 11 (2013).
[847] Military Continuation Rates DMDC Data–Average from 1980-2010, data provided by DMDC, e-mail to MCRMC, March 2014.
[848] Ibid.
[849] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[850] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[851] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[852] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

> *I don't think the post 9/11 GI bill should be transferrable. I think dependents should have to earn it themselves or the member who earned it should use it. It's too costly of a benefit to be educating the next generation regardless of their affiliation to the military in their adult years.*[853]

Another issue is a misalignment of Departmental incentives related to transferability. While the policy for transferring benefits to dependents is set by DoD,[854] the VA pays for all Post-9/11 GI Bill benefits including transferred benefits.[855] As a result, DoD allows all Service members who meet the requirements to transfer their benefits,[856] although the law states the Secretary "may" permit transfers but is not required to do so.[857] Between August 2009 and September 2014, there were 423,355 Service members who transferred their Post-9/11 GI Bill benefit to 928,078 dependents.[858] Of the Service members who transferred their benefits, 38.5 percent were officers and 61.5 percent were enlisted Service members,[859] compared to a total force that is 16.4 percent officers and 83.6 percent enlisted.[860] As of August 2014, 52 percent of children who received transferred benefits were younger than age 14 at the time of transfer.[861] Between August 2009 and April 2014 VA paid $5.6 billion for dependents who received transferred benefits.[862] VA does not currently have a robust model for out-year cost projections for the Post-9/11 GI Bill or transferability.[863] The Commission estimates the VA would pay an additional $76.5 billion between FY 2015 and FY 2024 for transferred benefits.[864]

The Post-9/11 GI Bill housing stipend often exceeds the actual housing costs of dependent beneficiaries. For example, in academic year 2013-2014, New School University in New York reportedly had the highest estimated room and board cost in the country at $18,490.[865] The BAH per month for an E5 with dependents in New York City in 2013 was $3,258, and for 2014 it was $3,744.[866] Assuming a 9-month academic year, a student using Post-9/11 GI Bill benefits at New School for 2013-2014 would receive $31,752, which is $13,262 more than the estimated cost of room and board. Northwestern Oklahoma State University in Alva, OK reportedly had the

---

[853] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[854] Post-9/11 GI Bill, DoDI 1341.13, 11 (2013).
[855] Veterans Benefits, 38 U.S.C. § 3319.
[856] Information provided by DoD OSD P&R, meetings with MCRMC staff, July 10, 2014, July 18, 2014, and September 8, 2014.
[857] Veterans Benefits, 38 U.S.C. § 3319.
[858] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 18, 2014.
[859] Data calculated from information provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, February 6, 2014 and September 18, 2014.
[860] Department of Defense, *2012 Demographics: Profile of the Military Community,* 10.
[861] Data calculated from information provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, February 6, 2014 and September 18, 2014.
[862] Data provided by VBA, CD-ROM to MCRMC, April 14, 2014.
[863] Information provided by VA, VBA, Education officials, meetings with MCRMC staff, March 7, 2014, July 3, 2014, and August 27, 2014.
[864] The Commission created a model for cost-estimate projections, including estimated rates of inflation for education and housing, which historically exceed general inflation. That model produced an estimate of VA expenses beginning at $4.4 billion in FY 2015 and rising to $9.1 billion in FY 2024; the projected expenses totaled $76.5 billion over that span.
[865] Kelsey Sheehy, "10 Colleges That Charge the Most for Room and Board," *U.S. News & World Report,* (October 29, 2013), accessed November 19, 2014, http://www.usnews.com/education/best-colleges/the-short-list-college/articles/2013/10/29/10-colleges-that-charge-the-most-for-room-and-board.
[866] "BAH Calculator," Department of Defense, Defense Travel Management Office, accessed September 25, 2014, http://www.defensetravel.dod.mil/site/bahCalc.cfm.

lowest estimated room and board cost in the United States in academic year 2013-2014, at $3,900.[867] Using the same assumptions, a student using Post-9/11 GI Bill benefits would receive $8,658 in BAH, $4,758 more than the estimated cost of room and board.[868]

The Post-9/11 GI Bill's housing stipend is also inconsistent with other education benefits. Veterans may receive Post-9/11 GI Bill benefits, including the housing stipend, while receiving unemployment compensation.[869] Other VA education programs that provide a living allowance prohibit participants from also receiving unemployment compensation. For example, Section 8525(b) of title 5 U.S.C. prohibits receipt of unemployment compensation by those receiving a subsistence allowance under the MGIB-AD or an educational assistance allowance under the Survivors' and Dependents' Educational Assistance program.

TA was originally created because Service members were not allowed to use their GI Bill benefits while on active duty.[870] Service members can now use TA or their Post-9/11 GI Bill[871] benefits while they are on active duty. In FY 2013 there were 333,001 TA participants taking undergraduate or graduate level courses. Of the FY 2013 participants, 91.2 percent were enlisted personnel, and only 8.8 percent were officers.[872] TA is not restricted to "professional development" courses; Service members may take courses in any area of study.[873] The Government has only limited educational data about recipients of the Post-9/11 GI Bill and TA programs. For example, neither DoD nor VA is currently collecting data on the education level and YOS of Service members transferring their Post-9/11 GI Bill.[874] Schools receiving Federal funds through the Post-9/11 GI Bill and TA are not required to provide information to DoD or VA regarding students using the Post-9/11 GI Bill or TA to pay for education programs.[875] This has led to the inability for DoD and VA to identify schools that may be aggressively and deceptively targeting Service members, veterans, and their families using the Post-9/11 GI Bill and TA.[876]

---

[867] Delece Smith-Barrow, "10 Colleges with Low Fees Room and Board," *U.S. News & World Report,* (October 8, 2013), accessed November 19, 2014, http://www.usnews.com/education/best-colleges/the-short-list-college/articles/2013/10/08/10-colleges-with-low-fees-for-room-and-board.
[868] "BAH Calculator," Department of Defense, Defense Travel Management Office, accessed September 25, 2014, http://www.defensetravel.dod.mil/site/bahCalc.cfm.
[869] *See* Government Organization and Employees, 5 U.S.C. § 8525(b), which limits access to federal unemployment benefits by individuals receiving some types of public assistance. The statute does not prohibit those receiving a monthly housing allowance under the Post-9/11 GI Bill from also receiving unemployment insurance.
[870] "Part V: Chapter 10 - Tuition Assistance Top-up," Department of Veterans Affairs, accessed April 11, 2014, http://www.benefits.va.gov/warms/docs/admin22/m22_4/part05/ch10.htm#s1004.
[871] Veterans' Benefits, 38 U.S.C. § 3311.
[872] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, October 15, 2014.
[873] *See* Armed Forces, 10 U.S.C. § 2007.
[874] Information provided by VA VBA staff, meeting with MCRMC, July 3, 2014. Also provided by Office of the Under Secretary of Defense for Personnel and Readiness, phone conversation with MCRMC staff, February 5, 2014.
[875] Such data collection is not required in law under either Armed Forces, 10 U.S.C. § 2007 (which governs tuition assistance) or Veterans' Benefits, 38 U.S.C. Chapter 33 (governing the Post-9/11 GI Bill).
[876] *See* U.S. Senate, Committee on Health, Education, Labor and Pensions, *For Profit Higher Education: The Failure to Safeguard the Federal Investment and Ensure Student Success,* Washington: Government Printing Office, July 30, 2012 ("2012 Report"). *See also* U.S. Senate, Committee on Health, Education, Labor and Pensions, *Benefitting Whom? For-Profit Education Companies and the Growth of Military Educational Benefits,* Washington: Government Printing Office, December 8, 2010 ("2010 Report"). *See also* U.S. Senate, Committee on Health, Education, Labor and Pensions, *Is the New GI Bill Working?: For-Profit College Increasing Veteran Enrollment and Federal Funds,* July 30, 2014.

Conclusions:
Duplicative education assistance programs should be sunset to reduce administrative costs and to simplify the education benefit system. Both MGIB and REAP provide similar benefits to the Post-9/11 GI Bill. Yet Service members are enrolling and paying $1,200 for MGIB, while the Post-9/11 GI Bill is a more valuable benefit for most Service members because there is no enrollment or fees. REAP and the Post-9/11 GI Bill both provide education benefits to activated RC members. Sunsetting MGIB-AD and REAP would also be consistent with historical implementation of new educational programs. In the past, when GI Bills were created, they replaced existing benefits.[877] Such replacement did not take place when the Post-9/11 GI Bill was enacted.[878]

Transferability of Post-9/11 GI Bill benefits should be revised to better promote retention. Increasing eligibility requirements to 10 YOS plus an additional commitment of 2 YOS would encourage younger Service members who leave the Service before 10 years to use their educational benefit for themselves. Increasing the eligibility requirement would also align transferability with the Commission's Recommendation on retirement (see Recommendation 1) and better focus transferability on career Service members.

The value of a transferred Post-9/11 GI Bill benefit should be adjusted to match the value of the benefit when used by the Service member on active duty, thus eliminating the housing stipend for dependents of both active-duty and separated Service members. Beneficiaries who are receiving housing stipends should not also be entitled to unemployment compensation, consistent with other military education programs. TA should be used for professional development, and Service members should use the Post-9/11 GI Bill to pursue personal academic development while on active duty.

DoD and the VA should collect additional information regarding usage of the Post-9/11 GI Bill and TA. It is important to know the education levels of Service members when they leave the Service, as well as the education levels of those Service members who elect to transfer their Post-9/11 GI Bill to their dependents, to better understand the effects of transferability. The VA should collect information related to, but not limited to, graduation rates, course competition rates, course dropout rates, course failure rates, certificates and degrees being pursued, and employment rates after graduation. Educational institutions should be required to provide non-personally identifiable information on students who receive Post-9/11 GI Bill benefits.

Recommendations:

- MGIB-AD should be sunset on October 1, 2015. REAP should be sunset restricting any further enrollment and allowing those currently pursuing an education program with REAP to complete their studies. Service members who switch to the Post-9/11 GI Bill should receive a full or partial refund of the

[877] Starting with the Servicemen's Readjustment Act of 1944, Pub. L. No. 78-346, 58 Stat. 284 (1944). The Veterans Readjustment Assistance Act of 1952, Pub. L. No. 82-550 (1952) provided for the vocational readjustment and restoration of lost educational opportunities to individuals serving in the Armed Forces after June 26, 1950, and before a date to be determined by the President or Congress. The Veterans' Readjustment Benefits Act of 1966, Pub. L. No. 89-358 (1966) provided an educational assistance program to individuals serving after January 31, 1955, and required that individuals entitled to benefits under both laws elect which benefits they would receive. The Veterans' Education and Employment Assistance Act of 1976, Pub. L. No. 94-502 (1976) was replaced by MGIB in 1985.
[878] *See* Veterans Benefits, 38 U.S.C. Chapter 33.

$1,200 they paid to become eligible for MGIB benefits. The refund should be proportional to the amount of the Post-9/11 GI Bill benefit used.

- Eligibility requirements for transferring Post-9/11 GI Bill benefits should be increased to 10 YOS plus an additional commitment of 2 YOS. This change strengthens transferability as a true retention tool and aligns transferability eligibility to the Commission's Recommendation on retirement.[879]

- The housing stipend for dependents should be sunset on July 1, 2017.

- Eligibility for unemployment compensation should be eliminated for anyone receiving housing stipend benefits under the Post-9/11 GI Bill.

- DoD should track the education levels of Service members leaving the Service, as well as the education levels of Service members who transfer their Post-9/11 GI Bill to their dependents.

- The VA should collect information related to, but not limited to, graduation rates, course competition rates, course dropout rates, course failure rates, certificates and degrees being pursued, and employment rates after graduation, and include that information in an annual report to the Congress.

- Educational institutions should be required to provide non-personally identifiable information on students who receive Post-9/11 GI Bill and TA benefits, when requested by DoD or VA.

Implementation:
MGIB and REAP:

- *MGIB*: 38 U.S.C. Chapter 30 governs the MGIB. The Chapter should be amended to sunset MGIB, restricting eligibility for MGIB benefits to those Service members who have enrolled in the program before October 1, 2015.

- *REAP*: 10 U.S.C. Chapter 1607 governs the REAP program. The Chapter should be amended to sunset REAP, allowing Service members currently receiving REAP benefits to exhaust their entitlement, but transferring all other REAP-eligible Service members to the Post-9/11 GI Bill and barring any further applications for REAP benefits.

- *MGIB and REAP*: Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

Tuition Assistance:

- *Require TA to be used for "professional development" courses only*: 10 U.S.C. Chapter 101 governs general military training, including TA. 10 U.S.C. § 2007

[879] DoD policy determines the conditions under which Service members may transfer Post-9/11 GI Bill benefits to their dependents, yet the VA actually funds transferred benefits. Although the Commission recognizes a misalignment of departmental incentives in this structure, to avoid subjecting funding for transferred benefits to ongoing DoD budget pressures a recommendation to realign the funding with decision-making was not made.

should be amended to limit TA payments to courses designated as providing "professional development" by the Secretary or his designee.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

Post-9/11 GI Bill Transferability:

- *Extend the time commitment required to obtain the transferability benefit*: 38 U.S.C. Chapter 33 governs the Post-9/11 GI Bill, including the transferability benefit. 38 U.S.C. § 3319 should be amended to increase the YOS requirement for transferability to 10 YOS, plus a commitment to an additional 2 YOS.

- The Congress should approve a Sense of Congress resolution affirming that DoD and the Military Services may approve or deny requests to transfer post-9/11 GI Bill benefits in such a way that encourages retention of individuals in the Military Services, and recommending that they be more selective in granting transferability of Post-9/11 GI Bill benefits, citing their authority in 38 U.S.C. § 3319(a)(2).

- *Require report on educational attainment of Service members who transfer their education benefit*: 38 U.S.C. § 3325 should be amended to require reporting of information of the highest level of education obtained by individuals transferring their Post-9/11 GI Bill benefits.

- *Require report on education levels of Service members at separation*: 10 U.S.C. § 1142 should be amended to require that information be obtained at time of separation, on the highest level of education attained by a Service member prior to separating from military service, and that the education levels of separating Service members be reported annually to the Congress.

- *End housing stipend payments to dependents using transferred education benefits*: 38 U.S.C. § 3319 should be amended to cease payment of a monthly housing stipend to spouses and children receiving transferred benefits after July 1, 2017.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

Unemployment Compensation:

- *Unemployment compensation*: 5 U.S.C. Chapter 85 governs the unemployment insurance program, and Subchapter II of that chapter governs unemployment insurance for ex-Service members. 5 U.S.C. § 8525 should be amended to prevent individuals receiving Post-9/11 GI Bill benefits from simultaneously receiving unemployment benefits.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the

recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

Education Data Collection:

- *Require report on student progress*: Subchapter III of 38 U.S.C. Chapter 33 governs administration the Post-9/11 GI Bill, including data reporting. Subchapter III should be amended to require institutions receiving payments under the Post-9/11 GI Bill to report annually to the Secretary of Veterans Affairs "such information regarding the academic progress of the individual as the Secretary may require." Also, 38 U.S.C. § 3325 should be amended to require the Secretary of Veterans Affairs to include this information in the mandated annual report to the Congress.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

Recommendation 12: Better prepare Service members for transition to civilian life by expanding education and granting states more flexibility to administer the Jobs for Veterans State Grants Program.

Background:
On January 31, 2013, seven Executive Branch agencies entered into a Memorandum of Understanding regarding the parties' collaboration on the redesigned Transition Assistance Program for separating Service members.[880] DoD, in partnership with the Department of Labor (DOL), the Department of Veterans Affairs (VA), and the Small Business Administration (SBA), maintains the Transition GPS[881] program to help Service members and their families prepare for a successful transition to civilian life. Transition GPS services are delivered through a series of coordinated workshops administered by each Service. Transition GPS participants receive preseparation counseling, presentations on the Transition GPS core curriculum,[882] briefings on various Transition GPS tracks,[883] a DOL Gold Card[884] and a capstone event that verifies "a viable plan for transition."[885]

Transition GPS tracks are optional, 2-day workshops that Service members may attend to gain transition assistance tailored to their specific interests.[886] These include an education track, for those pursuing or intending to pursue a higher education degree; a technical and skills training track, for those seeking job-ready skills and industry-recognized credentials in shorter-term training programs; and an entrepreneurship track, administered by SBA, called "Boots to Business," which focuses on feasibility analysis for business planning for those wanting to start a business.[887]

Veterans can present their DOL Gold Card at their local One-Stop Career Center (discussed below) to receive enhanced intensive services such as a job readiness assessment, including interviews and testing; creation of an Individual Development Plan; career guidance through group or individual counseling that helps veterans make training and career decisions; information on labor markets and skills transferability that informs educational, training, and occupational decisions; referrals to job banks, job portals, and job openings; referrals to employers and registered apprenticeship sponsors; referrals to training funded by the Workforce Investment Act

---

[880] Transition Assistance Program for Separating Service Members, (V62-8) MOU (2013). Parties to the MOU are: DoD, VA, DOL, ED, DHS (USCG), SBA, and OPM. This MOU supersedes the September 19, 2006 TAP MOU.
[881] Although never spelled out in the official program name, the "GPS" in "Transition GPS" represents goals, plans, and success. *See* Implementation of Mandatory Transition Assistance Program Participation for Eligible Service Members, DTM-12-007, 14 (2014).
[882] Transition GPS core curriculum includes workshops on transition overview, military occupation code crosswalk, resilient transitions, financial planning, and VA benefits, and an Individual Transition Plan review. *See* Implementation of Mandatory Transition Assistance Program Participation for Eligible Service Members, DTM-12-007, Attachment 2, 5 (2014).
[883] Implementation of Mandatory Transition Assistance Program Participation for Eligible Service Members, DTM-12-007, Attachment 2, 5-6 (2014).
[884] Ibid, Attachment 3, 8.
[885] Ibid, Attachment 4, 11.
[886] Ibid, Attachment 2, 5. *See also* "Transition Assistance Program (TAP) Information," U.S. Department of Labor, accessed September 30, 2014, http://www.dol.gov/vets/programs/tap/.
[887] Implementation of Mandatory Transition Assistance Program Participation for Eligible Service Members, DTM-12-007, 6 (2014). "Transition Assistance Program (TAP) Information," U.S. Department of Labor, accessed September 30, 2014, http://www.dol.gov/vets/programs/tap/.

or third-party service providers; and monthly follow-ups by an assigned case manager for up to 6 months.[888]

One-Stop Career Centers offer employment services for all job seekers across the country, including veterans, after they have transitioned to civilian life. These facilities are part of state workforce agencies or employment commissions[889] and are partially funded through a number of grants under DOL's Jobs for Veterans State Grants (JVSG) program.[890] "The JVSG program functions mainly as a staffing grant, providing salaries and benefits for state merit employees who provide specialized services to veterans with significant barriers to employment, and in limited circumstances, transitioning Service members who were wounded and injured."[891] The JVSG program funds two distinct positions, the Disabled Veterans' Outreach Program (DVOP) employees[892] and the Local Veterans' Employment Representative (LVER).[893] Services such as job search assistance workshops, career counseling, résumé assistance, and job referrals are provided as a priority to all veterans and eligible spouses.[894] In addition to these core support services, DVOP specialists develop expertise in labor market and employment services that are specifically relevant to disabled veterans[895] and LVERs directly contact businesses, Federal agencies, and associations of contractors and employers to encourage the hiring and advancement of qualified veterans.[896] JVSG programs are currently administered by state departments of labor or their equivalent.[897]

For additional information on transition programs for veterans, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 5.5.1* and *Section 5.8.4.1).*

Findings:
Although overall veterans' unemployment has remained lower than that of nonveterans during the last two decades,[898] since 2005, veterans age 18 to 24 have consistently had a higher unemployment rate than nonveterans of the same age group. In 2013, veterans age 18 to 24 had an unemployment rate of 21.7 percent, compared to nonveterans of the same age group at 14.3 percent.[899] This trend has the potential to become more severe as active-duty end strength is currently set to draw

[888] *See* "New Employment Initiative for Veterans," Department of Labor, accessed October 27, 2014, http://www.dol.gov/vets/goldcard.html.
[889] Labor, 29 U.S.C. § 2864(c). Labor, 29 U.S.C. § 2841.
[890] Employees' Benefits, 20 CFR 1001.
[891] Department of Labor, *FY 2014 Congressional Budget Justification, Veteran's Employment and Training Service,* VETS-21.
[892] Veterans' Benefits, 38 U.S.C. § 4103A. Employees' Benefits, 20 CFR 1001.140.
[893] Veterans' Benefits, 38 U.S.C. § 4104. Employees' Benefits, 20 CFR 1001.123.
[894] Veterans' Benefits, 38 U.S.C. § 4215. Employees' Benefits, 20 CFR 1001.101.
[895] Employees' Benefits, 20 CFR 1001, 1001.123.
[896] Department of Labor, *Employment Services for Veterans Brochure.*
[897] Employees' Benefits, 20 CFR 1001.101.
[898] *See* Department of Labor, Bureau of Labor Statistics, Archived BLS News Releases, *Employment Situation of Veterans*, (biennial reports, 1993-2013), accessed November 5, 2014, http://www.bls.gov/schedule/archives/all_nr.htm#VET.
[899] "Economic News Release, Table 2A: Employment status of persons 18 years and over by veteran status, age, and period of service, 2013 annual averages," U.S. Department of Labor, Bureau of Labor Statistics, accessed September 24, 2014, http://www.bls.gov/news.release/vet.t02A.htm.

down from a post-September 11, 2001 high in 2010,[900] increasing the number of veterans who are, or will soon be, in transition.

Inadequate preparations during the Transition GPS program may contribute to the relatively high unemployment rates among separated Service members. Employers seeking to hire veterans often have trouble finding or connecting with qualified veterans.[901] A large company that focuses on hiring veterans stated that veterans who complete Transition GPS do not necessarily have the networking skills to be able to find a job in the private sector.[902] A recent survey on veteran employment challenges revealed that a large majority of recently transitioned Service members identified job-seeking skills as an area where assistance is needed.[903] Veterans would like help with résumé writing, interview skills, and targeting companies for employment. These veterans said networking skills were one of their greatest needs.[904] The same survey revealed that most job seekers believed in-person and online networking to be an effective tool. Actual reported usage of these networking resources is lower than their perceived effectiveness,[905] possibly because of veterans' overall lack of confidence in their skills in this area.

There are still areas of Transition GPS that can be improved.[906] Because of these unemployment rates and improved Federal education benefits provided through the Post-9/11 GI Bill, the number of Service members and veterans furthering their education is at nearly unprecedented levels. The number of veterans using GI Bill benefits increased 67 percent, from 564,487 to 945,052 students, between FY 2009 and FY 2012.[907] A recent survey shows that 44 percent of veterans report either a full-time (30 percent) or part-time (14 percent) student status.[908] Yet the Transition GPS education track is optional, and the parties to the MOU have not performed a joint review of the core curriculum since the program was established.[909] In addition, a Government Accountability Office report examining the metrics used by Transition GPS to measure outcomes such as education or employment after separation concluded the metrics were "incomplete."[910]

---

[900] *See* Report of the Military Compensation and Retirement Modernization Commission: Interim Report, 22 (Figure 15, showing decline in active-duty end strength). *See also* National Defense Authorization Act for FY 2014, Pub. L. No. 113-66, § 401 (2013). *See also* "Budget Cuts to Slash U.S. Army to Smallest Since Before World War Two," *Reuters*, accessed October 28, 2014, http://www.reuters.com/article/2014/02/24/us-usa-defense-budget-idUSBREA1N1IO20140224.

[901] Panel discussion, Defense One and Iraq and Afghanistan Veterans of America, The New Battleground: Veterans Conference, July 31, 2014. MCRMC staff attended the conference and observed the panel discussion but did not participate.

[902] Information provided by JPMorgan Chase official, phone interview with MCRMC, August 11, 2014.

[903] Prudential Financial, Inc., *Veterans' Employment Challenges: Perceptions And Experiences Of Transitioning From Military To Civilian Life,* May 2012.

[904] Ibid.

[905] Ibid.

[906] DoD OSD P&R, meeting with MCRMC, January 14, 2014. DOL VETS, meeting with MCRMC, April 5, 2014. VA, meeting with MCRMC, March 7, 2014 and August 27, 2014.

[907] Department of Veterans Affairs, *National Center for Veterans Analysis and Statistics, Education Program Beneficiaries*, January 2014. *Also see* Lauren Kirkwood, McClatchy DC, *More Veterans Taking Advantage of Post-9/11 GI Bill*, accessed January 7, 2015, http://www.mcclatchydc.com/2014/03/17/221479_more-veterans-taking-advantage.html?rh=1#storylink=cpy.

[908] Prudential Financial, Inc., *Veterans' Employment Challenges: Perceptions And Experiences Of Transitioning From Military To Civilian Life*, May 2012.

[909] Information provided by Veterans Benefits, Administration, conference call with MCRMC staff, November 17, 2014.

[910] Government Accountability Office, *Transitioning Veterans: Improved Oversight Needed to Enhance Oversight of Transition Assistance Program*, GAO-14-144, 2 (2014), accessed January 7, 2015, http://www.gao.gov/products/GAO-14-144.

Veterans may benefit from an additional focus within One-Stop Career Centers. With the exception of Texas, states administer JVSG programs, which provide staff funding for One-Stop Career Centers, through their departments of labor or their equivalent.[911] Texas does this differently, by coordinating administration of its JSVG program through the Texas Veterans Commission.[912] Of the 10 states with the highest veteran populations,[913] Texas has one of the lowest veterans' unemployment rates.[914] Though state departments of labor or their equivalent agencies have the subject matter experts who understand the challenges of the employment market, state departments of veterans affairs directors or offices have a better understanding of the challenges veterans face. Rear Admiral W. Clyde Marsh, USN (Ret.), President of the National Association of State Directors of Veterans Affairs, testified before the House and Senate Veterans Affairs' Committees on March 6, 2014. He stated that the JVSG program's effectiveness could be improved with coordination with state Veteran Affairs directors.[915] In fact, several people commented to the Commission that some civilian employers do not fully understand military careers or skills, which increased coordination with state VAs could help address:

> *Civilian employers don't understand military veterans either. On interviews I was actually asked if I had shot at anyone or if I had been shot at. Civilian employers told me I didn't have the skills they needed to work in accounting even though I had worked in accounting and budget in the military my entire career.*[916]

> *When our service members retire from the military, they do so having been out of the civilian work force for twenty years—their peers are already established and will likely be our retirees' bosses. Veteran unemployment is high, and the age of the average retiree makes many companies reluctant to hire them at a competitive wage. Many will go into second careers, such as teaching, where they will start at the bottom of the pay scale in an already-underpaid job.*[917]

Veterans' unemployment may be reduced by increasing face-to-face connections between veterans and employees from the One-Stop Career Centers. Currently, One-Stop Career Center employees are not required to attend Transition GPS workshops.[918] Their participation in veteran-focused jobs fairs is not monitored or reported.[919] This lack of a face-to-face introduction impairs the connection these two groups require to best ensure a strong working relationship once the Service member has been separated.

---

[911] Employees' Benefits, 20 CFR 1001.101.
[912] Kyle Mitchell, Deputy Executive Director, Texas Veterans Commission, witness testimony to the U.S. Congress Joint Economic Committee, July 10, 2013, accessed on September 30, 2014, http://www.jec.senate.gov/public//index.cfm?a=Files.Serve&File_id=bea3dd52-9403-4fa7-b720-94c19db526d3.
[913] Texas Workforce Investment Council, *Veterans in Texas: A Demographic Study,* December 2012, 6, access September 30, 2014, http://governor.state.tx.us/files/twic/Veterans_in_Texas.pdf.
[914] Joint Economic Committee Democratic Staff, *Post-9/11 and Total Veterans' Unemployment Rates by State, 2013 Annual Averages,* accessed September 30, 2014, http://www.jec.senate.gov/public//index.cfm?a=Files.Serve&File_id=21290f66-e2bf-4af1-855d-33ad4ce95445.
[915] Rear Admiral W. Clyde Marsh, USN (Ret.), President, National Association of State Directors of Veterans Affairs, testimony to Joint Hearing of the House and Senate Veterans' Affairs Committees, March 6, 2014.
[916] MCRMC letter writer, comment form submitted via MCRMC website, DATE
[917] MCRMC letter writer, comment form submitted via MCRMC website, DATE
[918] Implementation of Mandatory Transition Assistance Program Participation for Eligible Service Members, DTM-12-007, 5, 6, and 11 (2014).
[919] Ibid.

Conclusions:
Unemployment is a major challenge facing recently separated Service members, and existing programs are not yet sufficient to meet their needs. Service members would benefit from a greater understanding of the education benefits available to them. The existing Transition GPS program can be strengthened by improving Service members' networking skills and identifying existing barriers to private-sector companies seeking to hire veterans. DoD, VA, DOL, and SBA have put forward great effort in implementing Transition GPS. A joint review of the program would ensure the most relevant information is provided to transitioning Service members. The JSVG program and One-Stop Career Centers can be improved to better assist veterans seeking employment. States should have their departments of labor and departments of veterans affairs (or equivalents) work together to implement the JVSGs to ensure they are being put to the best use possible. One-Stop Career Center employees should attend the Transition GPS program whenever possible to encourage separating Service members to access services at the One-Stop Career Centers. One-Stop Career Center employees should report the number of job fairs they attend and the number of veterans they contact at each fair.

Recommendations:

- DoD should require mandatory participation in the Transition GPS education track for those planning to attend school after separation or those who have transferred their Post-9/11 GI Bill benefits. This track is currently an optional portion of the program. DoD should ensure these classes provide vital information regarding education benefits for Service members during the education track such as information regarding types of institutions of higher learning, tuition and fees, admission requirements, accreditation, transferability of credits, credit for qualifying military training, time required to complete a degree, and retention and job placement rates; information that addresses important questions that veterans should consider when choosing an institution of higher learning; and information about the Postsecondary Education Complaint System.[920]

- The Congress should require DoD, VA, and DOL to review and report on the core curriculum for Transition GPS to reevaluate if the current curriculum most accurately addresses the needs of transitioning Service members. This report should include review of the current curriculum; the roles and responsibilities of each Department and whether they are adequately aligned; and the distribution of time between the three departments in the core curriculum and whether it is adequate to provide all information regarding important benefits that can assist transitioning Service members. This review should indicate whether any of the information in the three optional tracks should be addressed

[920] In January 2014, agency partners including the departments of Veterans Affairs, Education and Defense launched online feedback tools that provide a centralized system for filing student complaints. Military and veteran students and their family members are able to submit feedback on their experiences with education institutions. The online complaint system empowers students to be more active in fulfilling their own education goals and positively influencing the decision of others looking for an institution to attend in the future. Students are encouraged to report on their experiences regarding the quality of instruction, recruiting practices, and post-graduation employment placement. "Postsecondary Education Complaint System Launches—January, 2014," Military One Source, accessed December 22, 2014, http://www.militaryonesource.mil/voluntary-education?content_id=272426. For more information regarding the Postsecondary Education Complaint System please visit: "Post Secondary Education Complaint System," Military One Source, accessed December 22, 2014, http://www.militaryonesource.mil/voluntary-education?content_id=274604.

instead in mandatory tracks. It should also include a standard implementation plan of long-term outcome measures for a comprehensive system of metrics. This review should identify any areas of concern regarding the program and recommendations for addressing those concerns.

- The Congress should amend the relevant statutes to permit state departments of labor or their equivalent agencies to work directly with state Veterans Affairs directors or offices to coordinate implementation of the JVSG program.

- The Congress should encourage One-Stop Career Centers to have employees attend Transition GPS classes, to ensure personal connections between veterans and One-Stop Career Centers. The Congress should require DOL to track when and where its employees attend Transition GPS classes, and the number of veterans they interact with and follow up with after separation. This information should be included in DOL's annual report to the Congress.

- DOL should require One-Stop Career Centers to track the number of job fairs their employees participate in and the number of veterans they connect with at each job fair. This information should be included in each state's annual report to the DOL, and provided to the Congress.

- The Congress should require a one-time joint report from DoD, VA, and DOL to the Senate and House Committees on Armed Services and Veterans' Affairs regarding the challenges employers face when seeking to hire veterans. The report should identify the barriers employers face gaining information identifying veterans seeking jobs. It should also include recommendations addressing barriers for employers and improving information sharing between Federal agencies that serve veterans and separating Service members, so they may more easily connect employers and veterans. The report should also review the Transition GPS career preparation core curriculum and recommend any improvements that can be made to better prepare Service members trying to obtain private-sector employment.

Implementation:

- 29 U.S.C. Chapter 30 governs workplace investment systems, including the One-Stop Career Centers. 29 U.S.C. § 2871 should be amended to require each state to include, in its report to DOL, information on the number of job fairs attended by One-Stop Career Center employees at which they contacted veterans in the previous year, and the number of veterans they contacted at each fair.

- 38 U.S.C. Chapter 41 governs job counseling, training, and placement services for veterans. 38 U.S.C. § 4103 should be amended to require that the director for veterans' employment and training for a state coordinate his or her activities with both the state's department of labor, or its equivalent, and the state's department of veterans affairs, or its equivalent.

- The Congress should require DoD, VA, and DOL to review and report on the core curriculum for Transition GPS to reevaluate if the current curriculum most accurately addresses the needs of transitioning Service members. This report should include review of the current curriculum; the roles and responsibilities of each Department and whether they are adequately aligned; and the

distribution of time between the three departments in the core curriculum and whether it is adequate to provide all information regarding important benefits that can assist transitioning Service members. This review should indicate whether any of the information in the three optional tracks should be addressed instead in mandatory tracks. It should also include a standard implementation plan of long-term outcome measures for a comprehensive system of metrics. This review should identify any areas of concern regarding the program and recommendations for addressing those concerns.

- The Congress should require a one-time joint report from DoD, VA, and DOL to the Senate Committees and House on Armed Services and Veterans' Affairs regarding the challenges employers face when seeking to hire veterans. The report should identify the barriers employers face gaining information identifying veterans seeking jobs. It should also include recommendations addressing barriers for employers and improving information sharing between Federal agencies that serve veterans and separating Service members, so they may more easily connect employers and veterans. The report should also review the Transition GPS career preparation core curriculum and recommend any improvements that can be made to better prepare Service members trying to obtain private-sector employment.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed. Such as the following:

  - DoD DTM-12-007 should be changed to provide more information about education assistance available to separating Service members, and to make the education track of Transition GPS mandatory for those planning to attend school after separation or those who have transferred their Post-9/11 GI Bill benefits.

RECOMMENDATION 13: ENSURE SERVICE MEMBERS RECEIVE FINANCIAL ASSISTANCE TO COVER NUTRITIONAL NEEDS BY PROVIDING THEM COST-EFFECTIVE SUPPLEMENTAL BENEFITS.

Background:
Family Subsistence Supplemental Allowance (FSSA) is a voluntary benefits program that increases participating Service members' incomes above the threshold of eligibility for the U.S. Department of Agriculture's (USDA) Supplemental Nutrition Assistance Program (SNAP),[921] formerly called the Food Stamp Program.[922] FSSA and SNAP have the same Congressional mandate and overarching goal of providing nutritional assistance to eligible beneficiaries.[923] FSSA does this by raising a Service member's household income to 130 percent of the Federal poverty level through an increase in Basic Allowance for Subsistence (BAS). SNAP provides money on Electronic Benefit Transfer (EBT) cards, bringing household monthly food spending up to the maximum allotment for the household size, assuming 30 percent of net household income is spent on food.[924]

Service members applying for SNAP are required to pass through two eligibility gates, while FSSA applicants are required to pass only through the first gate. SNAP and FSSA eligibility requirements are summarized in Table 17.[925]

[921] Pay and Allowances of the Uniformed Services, 37 U.S.C. § 402a(a)(1).
[922] *See* U.S. Department of Agriculture, Food and Nutrition Service, *Supplemental Nutrition Assistance Program (SNAP), A Short History of SNAP*, accessed May 1, 2014, http://www.fns.usda.gov/snap/short-history-snap.
[923] Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, 2 (2008). Agriculture, 7 U.S.C. § 2013.
[924] Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, 3 (2008). Agriculture, 7 U.S.C. § 2014. As an example, if a one-person household has net income of $200 per month and maximum SNAP allotment is $194, the monthly SNAP benefit would be $134, which is calculated by multiplying net income by 0.3 and subtracting that amount ($60) from $194. *See also* U.S. Department of Agriculture, Food and Nutrition Service, *Supplemental Nutrition Assistance Program (SNAP) Eligibility*, accessed November 6, 2014, http://www.fns.usda.gov/snap/eligibility.
[925] Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, 3 (2008). Agriculture, 7 U.S.C. § 2014. Military personnel stationed in foreign countries and applying for FSSA are subject to Alaska's income eligibility standard. Also it should be noted some States have raised their SNAP gross income limit above 130 percent of poverty (up to a maximum of 200 percent) through broad-based categorical eligibility. See Agriculture, 7 CFR 273.2(j). *See also* U.S. Department of Agriculture, Food and Nutrition Service, *Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2012,* accessed September 19, 2014, www.fns.usda.gov/characteristics-supplemental-nutrition-assistance-program-households-fiscal-year-2012.

Table 17. SNAP and FSSA Eligibility Requirements

Program	GATE 1 Gross Monthly Income Eligibility	GATE 2 Net Monthly Income Eligibility
SNAP	Household monthly gross income must be less than 130 percent of the Federal poverty level, based on household size.[926] • Households with an elderly (60 years or older) or disabled individual bypass this gate.[927] • 43 states use broad-based categorical eligibility to increase the gate from 130% to as high as 200%. More than half of these set gross income requirements above 185 percent of the Federal poverty level.[928] • BAH is counted as income when paid to the Service member, but not when living in Government-owned "in-kind" housing.[929] • Loans, grants, and scholarships for a variety of educational programs are not counted as income.[930]	Monthly net income must be less than 100 percent of the Federal poverty level, based on household size (*net income = gross income – the deductions listed below*).[931] Deductions include: • 20% of earned income for all household members. • A standard deduction based on household size. • A dependent care deduction when needed for work, training, or education. • Medical expenses for elderly or disabled members exceeding $35 per month, if they are not paid by insurance or a third party. • Legally owed or court directed child support payments. • Cost of shelter, if shelter accounts for more than half of household's income after the other deductions. Allowable costs include the cost of fuel to heat and cook with, electricity, water, the basic fee for one telephone, rent or mortgage payments and taxes on the home. (Some States allow a set amount for utility costs instead of actual costs.) Shelter deduction cannot be more than $490 unless a person in the household is elderly or disabled. (Higher limits in AK, HI, and Guam.)
FSSA	Household monthly gross income must be less than 130 percent of the Federal poverty level, based on household size.[932] • BAH and Government-owned "in-kind" housing are counted as income.[933] • Loans, grants, and scholarships for post-secondary students are not counted as income.[934]	Not applicable.

[926] Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, 3 (2008). Agriculture, 7 U.S.C. § 2014. Military personnel stationed in foreign countries and applying for FSSA are subject to Alaska's income eligibility standard. Also it should be noted some States have raised their SNAP gross income limit above 130 percent of poverty (up to a maximum of 200 percent) through broad-based categorical eligibility. See Agriculture, 7 CFR 273.2(j). *See also* U.S. Department of Agriculture, Food and Nutrition Service, *Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2012*, accessed September 19, 2014, www.fns.usda.gov/characteristics-supplemental-nutrition-assistance-program-households-fiscal-year-2012.
[927] Agriculture, 7 U.S.C. § 2014(c).
[928] *See* Agriculture, 7 CFR 273.2(j). *See also* U.S. Department of Agriculture, Food and Nutrition Service, *Broad-Based Categorical Eligibility*, accessed November 6, 2014, http://www.fns.usda.gov/sites/default/files/snap/BBCE.pdf. *See also* Congressional Research Service, *The Supplemental Nutrition Assistance Program (SNAP): Categorical Eligibility*, July 22, 2014, http://nationalaglawcenter.org/wp-content/uploads/assets/crs/R42054.pdf.
[929] Agriculture, 7 U.S.C. §2014(d)(1).
[930] Agriculture, 7 U.S.C. § 2014(d)(3).
[931] *See* Agriculture, 7 U.S.C. § 2014. *See also* U.S. Department of Agriculture, Food and Nutrition Service, *Supplemental Nutrition Assistance Program*, accessed November 6, 2014, http://www.fns.usda.gov/snap/eligibility.
[932] Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, 3 (2008). Agriculture, 7 U.S.C. § 2014. Military personnel stationed in foreign countries and applying for FSSA are subject to Alaska's income eligibility standard. Also it should be noted some States have raised their SNAP gross income limit above 130 percent of poverty (up to a maximum of 200 percent) through broad-based categorical eligibility. See

Gross monthly household income eligibility standards for FY 2015 are summarized in Table 18. This table is used to determine household eligibility for both FSSA and SNAP (Gate 1). As an example, a Service member with a spouse and three children stationed in the lower 48 states must have total gross household income less than $3,024 to qualify for FSSA or to pass through the first eligibility gate for SNAP. Exceptions in SNAP include households with elderly or disabled members, who automatically bypass this gate, and households in states using broad-based categorical eligibility to increase this gate to as high as 200 percent of the Federal poverty level.

Table 18. Gross Monthly Household Income Eligibility Standards for FSSA and SNAP (130 percent of poverty level), FY 2015[935]

Household Size	Lower 48 States*	Alaska	Hawaii
1	$1,265	$1,580	$1,454
2	$1,705	$2,130	$1,960
3	$2,144	$2,681	$2,466
4	$2,584	$3,231	$2,972
5	$3,024	$3,781	$3,478
6	$3,464	$4,332	$3,984
7	$3,904	$4,882	$4,490
8	$4,344	$5,432	$4,996
Each Additional Member	$440	$551	$506

*Includes District of Columbia, Guam, and the Virgin Islands

FSSA is available to Service members stationed in the United States and overseas.[936] SNAP is only available to Service members in the United States, D.C., Guam, and the U.S. Virgin Islands.[937] As indicated in Table 17, SNAP eligibility also depends on meeting requirements for net monthly household income (Gate 2). Net income thresholds in SNAP, along with associated standard income deductions, vary by household size.

The maximum FSSA benefit is capped at $1,100 per month.[938] FSSA is distributed as a cash payment without purchasing restrictions.[939] SNAP sets maximum payments based on

Agriculture, 7 CFR 273.2(j). *See also* U.S. Department of Agriculture, Food and Nutrition Service, *Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2012,* accessed September 19, 2014, www.fns.usda.gov/characteristics-supplemental-nutrition-assistance-program-households-fiscal-year-2012.
[933] Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, Enclosure 2, 11 (2008).
[934] Pay and Allowances of the Uniformed Services, 37 U.S.C. § 402a(b). *See also* Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, Enclosure 2, 10 (2008).
[935] United States Department of Agriculture FY 2015 Income Eligibility Standards, accessed November 20, 2014, http://www.fns.usda.gov/sites/default/files/FY15_Income_Standards.pdf and Information provided by USDA through Director of Military Compensation, Office of Personnel and Readiness, e-mail to MCRMC, October 7, 2014.
[936] Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, 4 (2008), http://dtic.mil/whs/directives/corres/pdf/134111p.pdf, accessed November 13, 2014.
[937] United States Department of Agriculture, *Memorandum on SNAP – Fiscal Year 2015 Cost-of-Living Adjustments dated August 1, 2014,* accessed November 20, 2014, http://www.fns.usda.gov/sites/default/files/snap/SNAP_%20FY_2015_Cost_of_Living_Adjustments.pdf. *See also* Agriculture, 7 U.S.C. § 2014.
[938] Pay and Allowances of the Uniformed Services, 37 U.S.C. § 402a(a).
[939] Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11, 3 (2008).

household size.[940] A household's monthly benefit level is calculated by subtracting 30 percent of the household's net income from the maximum allotment for the household size as summarized in Table 19.[941] Monthly SNAP benefits can only be used to purchase nutritional food items for the household[942] or to purchase plants and seeds to grow food.[943]

Table 19. Maximum Monthly Allotments for SNAP, FY 2015[944]

Household Size	Lower 48 States	Alaska*	Hawaii	Guam	Virgin Islands
1	$194	$227/$290/$353	$332	$287	$250
2	$357	$417/$532/$648	$609	$526	$459
3	$511	$598/$762/$928	$872	$753	$657
4	$649	$759/$968/$1,178	$1,107	$957	$835
5	$771	$902/$1,150/$1,399	$1,315	$1,136	$991
6	$925	$1,082/$1,380/$1,679	$1,578	$1,364	$1,189
7	$1,022	$1,196/$1,525/$1,856	$1,744	$1,507	$1,315
8	$1,169	$1,367/$1,743/$2,109	$1,994	$1,723	$1,503
Each Additional Member	$146	$171/$218/$265	$249	$215	$188

*Urban/Rural 1/Rural 2

Service members are also eligible to receive supplemental nutritional assistance through USDA's Women, Infants and Children (WIC) program. WIC provides support for low-income; nutritionally at risk pregnant women; breastfeeding women; nonbreastfeeding, postpartum women; infants until they reach 1-year of age, and children until they reach their fifth birthday.[945] Participants receive supplemental nutritious foods, nutrition education, and counseling, as well as screening and referrals to other welfare, health, and social services.[946] There are USDA-sponsored WIC program offices on a number of military installations that provide support to Service member families as well as others with installation access.[947] The overseas WIC program for Service members is provided by DoD,[948] and includes support for Service members, civilian employees, DoD contractors and family members.[949] Although Service members may receive WIC support in addition to SNAP or FSSA,

[940] Information provided by USDA through Director of Military Compensation, Office of Personnel and Readiness, e-mail to MCRMC, October 7, 2014. *See also* Department of Agriculture, Food and Nutrition Service, *Supplemental Nutrition Assistance Program*, accessed November 6, 2014, http://www.fns.usda.gov/snap/eligibility.
[941] Information provided by USDA through Director of Military Compensation, Office of Personnel and Readiness, e-mail to MCRMC, October 7, 2014. *See also* Department of Agriculture, Food and Nutrition Service, *Supplemental Nutrition Assistance Program*, accessed November 6, 2014, http://www.fns.usda.gov/snap/eligibility. Agriculture, 7 U.S.C. § 2017.
[942] *See* U.S. Department of Agriculture, Food and Nutrition Service, *Supplemental Nutrition Assistance Program*, accessed November 6, 2014, http://www.fns.usda.gov/snap/eligibility.
[943] Agriculture, 7 U.S.C. § 2012(k).
[944] United States Department of Agriculture FY 2015 Allotments and Deduction Information, accessed November 20, 2014, http://www.fns.usda.gov/sites/default/files/FY15_Allot_Deduct.pdf. *See also*, United States Department of Agriculture FY 2015 Maximum Allotment Amounts for Alaska, Hawaii, Guam and U.S. Virgin Islands, accessed November 20, 2014, http://www.fns.usda.gov/sites/default/files/FY15_Allot_Deduct_AKHIGUVI.pdf.
[945] The Public Health and Welfare, 42 U.S.C. § 1786. "About WIC - WIC at a Glance," United States Department of Agriculture, http://www.fns.usda.gov/wic/about-wic-wic-glance, accessed November 13, 2014.
[946] Ibid.
[947] "Special Programs: Women, Infants, and Children Overseas Program," Defense Health Agency, accessed January 12, 2015, http://www.tricare.mil.wic.
[948] Ibid.
[949] Ibid.

increased BAS payments associated with FSSA may raise household income above the WIC threshold.

For additional information on FSSA, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 5.1.5).*

Findings:
In many circumstances, it is easier to qualify for SNAP than it is for FSSA. FSSA provides enough supplementary benefits to raise Service member's household income to 130 percent of the Federal poverty level. Most states, however, have increased the gross income eligibility threshold above this 130 percent standard.[950] For example, residents of Texas pass the first eligibility gate of SNAP if their monthly household gross income is below 165 percent of the Federal poverty line.[951] Of the 8,486 FSSA applications nationwide in FY 2013, 96.6 percent were denied.[952] Yet because of differences in the evaluation of gross income and SNAP deductions associated with net income, Service members who are denied FSSA may qualify for SNAP.[953]

Furthermore, SNAP may provide more benefits to Service members than FSSA. FSSA payments are enough to fill the gap between Service members' total household income and 130 percent of poverty level. The lower a Service member's income, the more additional pay they receive, up to the $1,100 per month cap. SNAP pays a set amount for a given household size, subtracting 30 percent of net income. As a result, for a given household size, Service members with very low income levels can receive more money under FSSA and those with a higher income, just low enough to qualify, can receive more money from SNAP. Table 20 provides an example of FSSA and SNAP benefits that would be received by an E4 with 2 years of service with a spouse and four children located at Fort Leonard Wood, Missouri.

[950] *See* Agriculture, 7 CFR 273.2(j). *See also* Department of Agriculture, Food and Nutrition Service, *Broad-Based Categorical Eligibility,* accessed November 6, 2014, http://www.fns.usda.gov/sites/default/files/snap/BBCE.pdf. *See also* Congressional Research Service report on The Supplemental Nutrition Assistance Program (SNAP): Categorical Eligibility, July 22, 2014, http://nationalaglawcenter.org/wp-content/uploads/assets/crs/R42054.pdf.
[951] *See* Agriculture, 7 CFR 273.2(j). *See also* Department of Agriculture, Food and Nutrition Service, *Broad-Based Categorical Eligibility,* accessed November 6, 2014, http://www.fns.usda.gov/sites/default/files/snap/BBCE.pdf. *See also* Congressional Research Service report on The Supplemental Nutrition Assistance Program (SNAP): Categorical Eligibility, July 22, 2014, http://nationalaglawcenter.org/wp-content/uploads/assets/crs/R42054.pdf.
[952] Data supplied by Director of Military Compensation, Office of Personnel and Readiness, e-mail to MCRMC, August 13, 2014. It is important to note a Service member can apply multiple times for FSSA; therefore, this number does not directly correlate to the total number of households who applied for the benefit.
[953] Information provided by USDA through Director of Military Compensation, Office of Personnel and Readiness, e-mail to MCRMC, October 7, 2014. *See also* Agriculture, 7 U.S.C. § 2014. *See also* Family Subsistence Supplemental Allowance (FSSA) Program, Instructions and Guidance, DoDI 1341.11 (2008).

Table 20. Example of Financial Support under FSSA and SNAP

FSSA		SNAP*	
		Income (Basic Pay/BAH/BAS)	$3,386.35
		-20% Deduction	$677.27
		-Standard Deduction[954]	$221.00
130% of Poverty	$3,464.00	Net Income	$2,488.08
-Income (Basic Pay/BAH/BAS)	$3,386.35		
Monthly Increase in BAS	**$77.65**	Maximum SNAP Allotment	$925.00
		-30% of Net Income	$746.42
		Monthly Allotment on EBT Card	**$178.58**

*130 percent of poverty test met ($3,464); 100 percent of poverty test met ($2,665); assumes only guaranteed net income deductions

Military recipients of SNAP have no obligation to inform or obtain permission from their Military Service to utilize these benefits unless they are already receiving FSSA.[955] Service members applying for FSSA support may be required to work with their local financial counselors and chain of command.[956] This requirement may stigmatize Service members. Examples of this perspective can be seen in feedback from Service members in a 2014 joint survey by the advocacy group Esposas Militares Hispanas USA Armed Forces and the Military Spouse Advocacy Network.[957] The goal of the survey was to get information on FSSA awareness and utilization. Feedback included these responses:

> *We looked into FSSA when my husband was E3, but was told by his COC that he shouldn't apply for it because his basic pay "should" have been enough.*[958]

> *I think it's more embarrassing than hard to get the signature which is why we decided to just bear with it and see what we could eliminate from our expenses*[959]

For these reasons, many more Service members enroll in SNAP than in FSSA. The FSSA program has very limited participation; only 285 Service members received FSSA benefits in FY 2013.[960] Meanwhile, USDA estimates that between 2,000 and 22,000 AC Service members received SNAP benefits in FY 2012.[961] The lower estimate is based on data from 50,000 random households provided by states to USDA only for the purpose of auditing SNAP payment verification, not for the purpose of estimating active-duty

[954] Department of Agriculture, *FY 2015 Allotments and Deduction Information,* accessed November 20, 2014, http://www.fns.usda.gov/sites/default/files/FY15_Allot_Deduct.pdf.
[955] Family Subsistence Supplemental Allowance (FSSA) Program, DoDI 1341.11 (2008).
[956] Family Subsistence Supplemental Allowance (FSSA) Program, DoDI 1341.11, 4 (2008). For example, the Army, which has 99 percent of FSSA participants, requires applicants to receive military financial counseling before submitting an FSSA application through the chain of command. *See* ALARACT Family Subsistence Supplemental Allowance, dated January 29, 2010, https://www.dmdc.osd.mil/fssa/consent?continueToUrl=%2Ffssa%2Fgetfile.do%3FfileNm%3DArmy%2520ALARACT%2520FSSA%2520Guidance.pdf%26filePathNm%3Dresources%26appId%3D496%26app_key_id%3Dh20n283kfmw2a3.
[957] Information supplied by Esposas Militares Hispanas USA Armed Forces, e-mails to MCRMC, October 3, 2014.
[958] Information supplied by Esposas Militares Hispanas USA Armed Forces, e-mail to MCRMC, August 19, 2014.
[959] Ibid.
[960] Data supplied by Director of Military Compensation, Office of Personnel and Readiness, e-mail to MCRMC, August 13, 2014.
[961] Department of Agriculture, Food and Nutrition Service, *Quick Facts: SNAP Participation Among Members of the Armed Forces,* February 2014, provided by USDA FNS Office of Policy Support, e-mail to MCRMC, June 25, 2014.

households using SNAP.[962] The higher estimate is based on the U.S. Census Bureau's American Community Survey data, which requires randomly selected households to indicate if any person in the household is in the military and if SNAP benefits were received during the last 12 months.[963]

Estimates of SNAP usage by military members vary widely because states that administer these benefits[964] are not required to collect data on the actual number of active-duty Service members in households receiving SNAP.[965] If a state does ask whether the applicant is a Service member, it does not always receive a clear indication as to whether the member is on active duty or in the Reserve Component.

During town halls and other meetings, there was concern expressed over Service members' continued reliance on supplementary benefits, whether FSSA or SNAP. The Commission received numerous website and survey comments related to "food stamps" highlighting the perception that many Service member households rely on SNAP:

> *A majority of young enlisted military families are currently being paid so little that they qualify for Government assistance programs such as WIC and food stamps.*[966]
>
> *Active-duty enlisted military members are often receiving food stamps in order for their families to survive.*[967]
>
> *Many members of our armed services will need to use food stamps.*[968]
>
> *We still have junior enlisted and officers who are able to get food stamps.*[969]
>
> *E1s with a spouse and children in the military can't afford to feed their own family without food stamps.*[970]
>
> *A lot of the military are eligible for food stamps, and other low income programs.*[971]
>
> *The benefits for the family are extremely important to enlisted personnel retention. When the service member is deployed he doesn't want to know his wife is scrapping together money go shopping for their kids.*[972]

---

962 U.S. Department of Agriculture, Food and Nutrition Service, *Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2012,* accessed September 19, 2014, https://www.fns.usda.gov/characteristics-supplemental-nutrition-assistance-program-households-fiscal-year-2012.
963 *See* U.S. Department of Agriculture, Food and Nutrition Service, *Quick Facts: SNAP Participation Among Members of the Armed Forces,* February 2014, provided by USDA FNS Office of Policy Support, e-mail to MCRMC, June 25, 2014. *See also* United States Census Bureau, American Community Survey: Methodology, accessed January 7, 2015, http://www.census.gov/acs/www/methodology/methodology_main/.
964 Agriculture, 7 U.S.C. § 2013.
965 Information supplied by U.S. Department of Agriculture, Food and Nutrition Service officials, meeting with MCRMC, September 5, 2014.
966 MCRMC letterwriter, comment form submitted via MCRMC Website, June 8, 2014.
967 MCRMC letterwriter, comment form submitted via MCRMC Website, July 18, 2014.
968 MCRMC letterwriter, comment form submitted via MCRMC Website, May 8, 2014.
969 MCRMC letterwriter, comment form submitted via MCRMC Website, April 7, 2014.
970 MCRMC letterwriter, comment form submitted via MCRMC Website, December 3, 2013.
971 MCRMC letterwriter, comment form submitted via MCRMC Website, November 28, 2013.

Table 21 presents the minimum number of people that Service members would need in their households to become eligible for FSSA or SNAP, based on the 130 percent gross income threshold (Gate 1). In these estimates, gross monthly income includes basic pay, Basic Allowance for Housing (BAH), and BAS.[973] This table shows that households need at least six members for Service members to be eligible for either program in the lower 48 states. Households can be smaller in Alaska and Hawaii because of increased costs of living.

Table 21. Minimum Household Size Requirements for a Service Member to Qualify for FSSA or SNAP.

					Minimum Household Size**		
Rank	Basic Pay*	Average BAH	BAS	Total	U.S.	Alaska	Hawaii
E1	$1531.50	$1295.00	$357.55	$3184.05	6	4	5
E2	$1716.90	$1295.00	$357.55	$3369.45	6	5	5
E3	$1805.40	$1295.00	$357.55	$3457.95	6	5	5
E4	$1999.50	$1295.00	$357.55	$3652.05	7	5	6
E5	$2181.00	$1408.00	$357.55	$3946.55	8	6	6
O1	$2905.20	$1431.00	$246.24	$4582.44	N/A	7	8
O2	$3347.10	$1614.00	$246.24	$5207.34	N/A	8	N/A
O3	$3873.90	$1831.00	$246.24	$5951.14	N/A	N/A	N/A

*Assumes minimum years of service
**For SNAP, assumes no households in states using broad-based categorical eligibility or with elderly or disabled members

Conclusions:
FSSA is duplicative and, in many cases, less generous than SNAP, which is a much broader Federal program that successfully addresses the same goal of nutritional assistance. In addition, stigmas associated with FSSA may impair the quality of life and careers of Service members and their dependents. For these reasons, FSSA should be sunset in places where SNAP or similar programs[974] are available.

SNAP administrators should capture information to track the number of active-duty Service members who rely upon supplemental nutritional benefits to better inform military compensation decisions.

Recommendations:

- The FSSA program should be retained for Service members in overseas locations where no SNAP assistance is available.

- The FSSA program should be sunset in the United States, Puerto Rico, Guam, and other U.S. territories where SNAP or similar programs exist, thereby reducing the administrative costs of a duplicative program.

---

[972] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[973] Other household income, such as other allowances, special pays, or income from other household members is not included.
[974] An example of a similar program to SNAP is the National Assistance Block Grants program, which provides nutrition assistance similar to SNAP benefits to eligible residents of Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands. These jurisdictions do not have SNAP programs. *See* Agriculture, 7 U.S.C. § 2028. *See also* United States Department of Agriculture, Food and Nutrition Service, *Nutrition Assistance Block Grants: Quick Facts*, accessed January 7, 2015, http://www.fns.usda.gov/sites/default/files/NABGP_Quick_Facts.pdf.

- Based on the unavailability of data on Service member households using SNAP, states and counties should provide this data to DoD on a regular basis. DoD should analyze the data to determine if there are systemic issues related to location or pay that should be rectified to provide for adequate nutrition for Service member households.

Implementation:

- 37 U.S.C. § 402a governs the FSSA program. The section should be amended to restrict eligibility only to Service member households stationed outside the United States, following a 2-year adjustment period to ensure eligible Service members have sufficient time to apply for replacement benefits.

- 7 U.S.C. Chapter 51 governs the SNAP program, including the administrative and data-sharing provisions of the program. 7 U.S.C. § 2020 should be amended to permit states to disclose information, upon request, to DoD on the number of households in the state which receive SNAP benefits and contain one or more active-duty or RC Service member.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

RECOMMENDATION 14: EXPAND SPACE-AVAILABLE TRAVEL TO MORE DEPENDENTS OF SERVICE MEMBERS BY ALLOWING TRAVEL BY DEPENDENTS OF SERVICE MEMBERS DEPLOYED FOR 30 DAYS OR MORE.

Background:
The Secretary of Defense is authorized to provide air travel for Service members, certain retirees, and their family members on a space-available basis.[975] Space Available (Space-A) travel regulations provide eligible passengers access to seats on military air transport flights that would otherwise be empty. Unused seats on DoD-owned or controlled aircraft are only made available to Space-A travelers once space-required (duty) passengers and cargo have been accommodated.[976]

The program classifies passengers into Categories I through VI, by priority of travel, and potential passengers are processed in priority order.[977] Current DoD policy permits unaccompanied dependents to use Category IV Space-A travel, but only when the dependent's sponsor is serving a deployment of at least 120 days.[978]

For additional information on Space-A travel, please see the Report of the Military Compensation and Retirement Modernization Commission: Interim Report *(Section 5.1.12).*

Findings:
Issues of expanding Space-A eligibility for dependents were first raised during a Town Hall at Joint Base Lewis-McChord.[979] The Commission heard accounts of how important Space-A travel benefits can be to Service families, improving access to extended family and other support during periods of deployment.[980] When available, this benefit was able to improve Service families' quality of life by reducing the psychological and financial stresses placed on them by the military obligations of their deployed Service member.[981]

In recent years, frequent deployments have been a reality for many Service members. Since September 11, 2001, 66 percent of Service members have deployed.[982] The average Service member deployed 2.6 times, with many specialties deploying more often.[983] For example, special operations Service members are likely to be sent on frequent, 30- to 60-day deployments.[984] A 2012 analysis of 678,382 active-duty personnel from 2001 to 2006 showed that many deployments as part of Operation ENDURING FREEDOM (OEF) and Operation IRAQI FREEDOM (OIF) were for fewer

[975] Armed Forces, 10 U.S.C. § 2641b.
[976] Armed Forces, 10 U.S.C. § 2641b. Air Transportation Eligibility, DoD 4515.13-R (1994).
[977] Air Transportation Eligibility, DoD 4515.13-R (1994).
[978] Department of Defense, *Policy Memorandum on Space Available (Space-A) Travel for Dependents of Deployed Military Members (Dec. 6, 2007).* Air Transportation Eligibility, DoD 4515.13-R (1994).
[979] Public testimony, MCRMC Town Hall, Joint Base Lewis-McChord, Seattle, WA, December 12, 2013.
[980] Public testimony, MCRMC Town Hall, Joint Base Lewis-McChord, Seattle, WA, December 12, 2013.
[981] Public testimony, MCRMC Town Hall, Joint Base Lewis-McChord, Seattle, WA, December 12, 2013.
[982] Department of Defense, *February 2012 Status of Forces Survey of Active Duty Members,* 146.
[983] Department of Defense, *February 2012 Status of Forces Survey of Active Duty Members,* 148.
[984] Military Family Advisory Network (MFAN), meeting with MCRMC, Alexandria VA, October 25, 2014.

than 120 days making dependents of these deployed Service members ineligible for Space-A travel.[985]

Deployments are a well-documented period of increased stress for military families.[986] In the 2014 Blue Star Families Military Family Lifestyle Survey, deployments and separations were identified as top causes of stress by 69 percent of spouses and 60 percent of Service members.[987] A 2010 study of more than 250,000 spouses of active-duty Army members determined that deployments to OEF/OIF were associated with elevated rates of treatment for, and diagnoses of, depression, sleep problems, anxiety disorders, acute stress reactions, and adjustment disorders.[988] Multiple studies have shown similar effects on military children.[989]

Conclusions:
The increased stress experienced by families of deployed Service members can sometimes be reduced through access to Space-A travel benefits. Current policy allows unaccompanied Space-A travel for military dependents of Service members deployed for 120 days or more, under priority category IV. Shortening the deployment length needed to qualify for this benefit from 120 days to 30 days would expand availability to this group of people who experience challenges resulting from the deployment of a Service member.

Recommendations:
- DoD should allow unaccompanied dependents of Service members deployed for 30 days or more to use Space-A travel, under priority category IV.

Implementation:
- 10 U.S.C. § 2641b governs Space-A travel on DoD aircraft. No change to this governing statute is recommended.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed. Such as the following:

  - DoD should amend the Air Transportation Eligibility Regulation, DoD 4515.13-R (1994) (as modified by the December 6, 2007, memorandum of

---

[985] Yu-Chen Shen, Jeremy Arkes, Thomas V. Williams, "Effects of Iraq/Afghanistan Deployments on Major Depression and Substance Use Disorder: Analysis of Active Duty Personnel in the US Military," *American Journal of Public Health*, 102, Suppl. 1 (2012): S80-S87, abstract accessed November 13, 2014, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3496458. (The researchers used data obtained from DoD's Contingent Tracking System. MCRMC requests to independently obtain Contingent Tracking System data for confirmation were unsuccessful.)
[986] Department of Defense, *Report on the Impacts of Deployment of Deployed Members of the Armed Forces on Their Dependent Children,* October 2010, 1. Blue Star Families, *2014 Military Family Lifestyle Survey, Comprehensive Report,* 78, accessed December 14, 2014, https://www.bluestarfam.org/sites/default/files/media/stuff/bsf_report_comprehensive_reportfinal_single_pages.pdf
[987] Blue Star Families, *2014 Military Family Lifestyle Survey, Comprehensive Report,* 78, accessed December 14, 2014, https://www.bluestarfam.org/sites/default/files/media/stuff/bsf_report_comprehensive_reportfinal_single_pages.pdf.
[988] Alyssa J. Mansfield, Jay S. Kaufman, Stephen W. Marshall, Bradley N. Gaynes, Joseph P. Morrisey, Charles C. Engel, "Deployment and the use of mental health services among U.S. Army wives," *New England Journal of Medicine*, 362, no. 2, (2010): 101-109.
[989] *See* Abigail H. Gewirtz, Christopher R. Erbes, Melissa A. Polusny, Marion S. Forgatch, David S. DeGarmo, "Helping Military Families Through the Deployment Process: Strategies to Support Parenting," *Professional Psychology*, 42, no. 1, (2011): 56-62.

the Deputy Undersecretary of Defense for Logistics and Materiel Readiness, authorizing Space-A travel by spouses and dependent children of Service members deployed for 120 consecutive days or more), to add "dependents of Service members deployed for at least 30 consecutive days" as Item 23, Table C6.T1.

RECOMMENDATION 15: MEASURE HOW THE CHALLENGES OF MILITARY LIFE AFFECT CHILDREN'S SCHOOL WORK BY IMPLEMENTING A NATIONAL MILITARY DEPENDENT STUDENT IDENTIFIER.

Background:
Most elementary and secondary school student registration processes and associated data systems in the Nation do not include an indicator of students who have a military affiliation.[990] For example, the Elementary and Secondary Education Act (ESEA) currently recognizes four subgroups of students: economically disadvantaged students, students from major racial and ethnic groups, students with disabilities, and students with limited English proficiency.[991] The U.S. Department of Education's Impact Aid program does collect data on military dependent students because school districts applying for Impact Aid collect and report their numbers of military-connected students.[992] But not all schools with military dependent students apply for Impact Aid,[993] and Impact Aid data is not included in or correlated to the ESEA academic performance and attendance data submitted for national-level reporting.[994] As a result, national reports on student performance cannot reliably differentiate military dependent students from all others.

Military dependent student identifiers have been implemented or directed in at least 12 states.[995] Alaska,[996] Arkansas,[997] Illinois,[998] Indiana,[999] Nevada,[1000] North Carolina,[1001] Tennessee,[1002] and Texas[1003] have enacted legislation requiring local education authorities to identify and report on military-connected students. The state education departments in Florida,[1004] Maine,[1005] Michigan,[1006] and South Carolina[1007] have adopted identifiers for military-connected students independent of legislative requirements.

Even in the states that have implemented a military dependent student identifier, there are inconsistencies that affect the quality of the data and associated reports.

---

[990] "Issue 9: Assign an identifier for military children in education data systems," USA4Military Families Initiative, accessed September 17, 2014, http://www.usa4militaryfamilies.dod.mil/MOS/f?p=USA4:ISSUE:0::::P2_ISSUE:9.
[991] Education, 20 U.S.C. § 6311.
[992] Education, 20 U.S.C. § 7703b.
[993] Of the more than 14,000 school districts nationwide, 902 received Education Impact Aid payments for federally connected children in fiscal year 2009. Government Accountability Office, *Education of Military Dependent Students, Better Information Needed to Assess Student Performance,* March 2011, GAO-11-231, 5.
[994] "Issue 9: Assign an identifier for military children in education data systems," USA4Military Families Initiative, accessed September 17, 2014, http://www.usa4militaryfamilies.dod.mil/MOS/f?p=USA4:ISSUE:0::::P2_ISSUE:9.
[995] Jennifer Dounay Zinth, Education Commission of the States, *ECS Analysis of Military Student Identifier Policies,* August 2014.
[996] Alaska Stat. § 14.03.120(d) (2014), as amended.
[997] Ark. Code Ann. § 6-18-107 (2014).
[998] 105 Ill. Comp. Stat. 5/22-70 (2014).
[999] Ind. Code § 20-19-3-9.4 (2014), as amended.
[1000] Nev. Rev. Stat. § 386.650(b)(3) (2013), as amended.
[1001] N.C. Gen Stat. § 115c-12(18)(f) (2014), as amended.
[1002] Tenn. Code Ann. § 49-6-5101(b) (2014).
[1003] Tex. Education Code Ann. § 25.006(c) (2013).
[1004] *See* Florida Department of Education, *DOE Information Database Requirements Vol. 1* (2013).
[1005] *See* "Military Families," Maine Department of Education, accessed October 7, 2014, http://maine.gov/doe/special/military.html.
[1006] *See* Michigan Department of Education, *Reporting Military-Connected Children*, accessed September 25, 2014, http://www.michigan.gov/documents/mde/Mil_children_470904_7.pdf.
[1007] *See* South Carolina State Department of Education Office of Research and Data Analysis, *Power School South Carolina State Reporting Specific Fields Manual*, 69, accessed September 25, 2014.

One example is the definition of a military dependent student. In Alaska,[1008] Illinois,[1009] Michigan,[1010] Nevada,[1011] South Carolina,[1012] and Tennessee,[1013] military dependent students are defined as those who have either a parent or guardian who is military-connected. Indiana[1014] and Maine[1015] simply specify a parent and do not mention guardians. The laws of the remaining five states have definitions that vary greatly. Arkansas includes children who reside in the household of a person on active duty or in the Reserve Component (RC).[1016] North Carolina counts any student living in the same household with an active-duty or RC Service member.[1017] Florida refers to the "child of a military family" and includes prekindergartners in data collection.[1018] Texas requires that a student be a "dependent" of a person in the military.[1019]

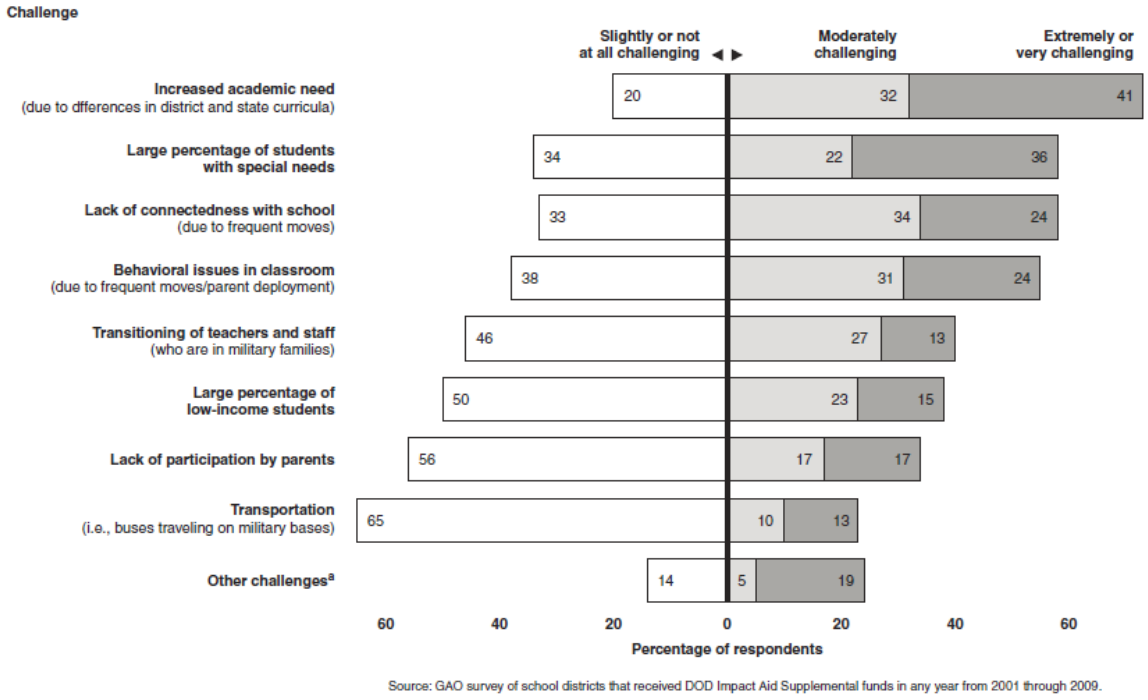
Findings:
A 2011 GAO study found, "There are no national public data on military dependent students' academic progress, attendance, or long-term outcomes, such as college attendance or workplace readiness."[1020] This situation is particularly attributable to the absence of a consistently implemented indicator across all states. The Commission agrees with the GAO that, "without more specific data, educators, base commanders, and community leaders are not able to provide military dependent students with appropriate resources because they do not have information on their specific educational needs or the effectiveness of the schools and programs serving them."[1021]

Military dependent students are often subjected to additional challenges such as family separation and more frequent moves.[1022] A 2010 study by researchers at Johns Hopkins University examined mobility among military families and determined, "Approximately 20 percent of American families move annually, and individuals and families in the military move even more frequently, with approximately 33% relocating each year."[1023] In a survey of local educational activities conducted in 2010, the GAO reported, "Officials at three-quarters of the school districts responding to the survey reported that issues associated with military dependent students' frequent moves to

[1008] Alaska Stat. § 14.03.120(d) (2014), as amended.
[1009] 105 Ill. Comp. Stat. 5/22-70 (2014).
[1010] Michigan's data collection is not required by statute. Instead, the policy was created by the Michigan Department of Education's Office of School Support Services. *See* Michigan Department of Education, *Reporting Military-Connected Children*, accessed September 25, 2014, http://www.michigan.gov/documents/mde/Mil_children_470904_7.pdf.
[1011] Nev. Rev. Stat. § 386.650(b)(3) (2013), as amended.
[1012] South Carolina's data collection is not required by statute. The policy was created by the South Carolina Department of Education alongside the reporting requirements imposed by ESEA. *See* South Carolina State Department of Education Office of Research and Data Analysis, *Power School South Carolina State Reporting Specific Fields Manual*, 69.
[1013] Tenn. Code Ann. § 49-6-5101(b) (2014).
[1014] Ind. Code § 20-19-3-9.4 (2014), as amended.
[1015] Maine's data collection is not required by statute. Instead, Maine's Department of Education has enacted policies conforming to the Military Interstate Children's Compact Commission, of which Maine is a member, though Maine's legislature has not yet formally enacted laws requiring compliance. *See* "Military Families," Maine Department of Education, accessed October 7, 2014, http://maine.gov/doe/special/military.html.
[1016] Ark. Code Ann. § 6-18-107 (2014).
[1017] N.C. Gen Stat. § 115c-12(18)(f) (2014), as amended.
[1018] Florida's data collection is not required by statute. The policy was enacted by the Florida Department of Education in response to Florida's joining the Interstate Compact on Educational Opportunity for Military Children. See Florida Department of Education, DOE Information Database Requirements Vol. 1 (2013).
[1019] Tex. Education Code Ann. § 25.006(c) (2013).
[1020] Government Accountability Office, *Education of Military Dependent Students, Better Information Needed to Assess Student Performance,* March 2011, GAO-11-231, 16.
[1021] Ibid, 17.
[1022] Catherine P. Bradshaw, May Sudhinaraset, Kristin Mmari, Robert W. Blum, "School Transitions Among Military Adolescents: A Qualitative Study of Stress Appraisal and Coping," *School Psychology Review*, 39, no. 1, (2010): 84-105.
[1023] Ibid.

new schools were moderately, very, or extremely challenging. Mobility increased academic needs due to differences in state and district curricula, lack of connectedness with school, and behavioral issues in the classroom. The largest challenge reported by school districts in our survey was the increased academic need of children in military families who transfer to a school with different curricula or academic standards than those in their previous school and thus need additional support."[1024] Figure 23 summarizes challenges encountered in the education of military dependent students as reported in the GAO survey.

Figure 23. School District-Reported Challenges in Educating Military Dependent Students



Source: GAO survey of school districts that received DOD Impact Aid Supplemental funds in any year from 2001 through 2009.

Studies have shown that these children are more likely to experience difficulties and anxieties that can affect how they perform in the classroom.[1025] A study in the journal *Social Forces* found "[h]ighly mobile students tend to report having fewer close friends and are more likely to be on the periphery of peer social networks."[1026] The National Association of School Psychologists published a study titled "School Transitions Among Military Adolescents: A Qualitative Study of Stress Appraisal and Coping," which found, "One-third of school-age military children show psychosocial behaviors

[1024] Government Accountability Office, *Education of Military Dependent Students, Better Information Needed to Assess Student Performance,* March 2011, GAO-11-231, 18.
[1025] Catherine P. Bradshaw, May Sudhinaraset, Kristin Mmari, Robert W. Blum, "School Transitions Among Military Adolescents: A Qualitative Study of Stress Appraisal and Coping," *School Psychology Review*, 39, No. 1, (2010): 84-105. *See also* Eric M. Flake, Beth Ellen Davis, Patti L. Johnson, Laura S. Middleton, "The Psychosocial Effects of Deployment on Military Children," *Journal of Developmental & Behavioral Pediatrics*, 30, no. 4 (2009): 271-278, abstract accessed November 10, 2014, http://journals.lww.com/jrnldbp/Abstract/2009/08000/The_Psychosocial_Effects_of_Deployment_on_Military.1.aspx.
[1026] Dana L. Haynie, Scott J. South, "Residential Mobility and Adolescent Violence," *Social Forces*, 84, no. 1, (2005): 363-376, accessed November 10, 2014, http://sf.oxfordjournals.org/content/84/1/361.

such as being anxious, worrying often, and crying more frequently."[1027] Adolescents who experience school transitions may be particularly vulnerable to experiencing adjustment problems (e.g., academic failure, health risk behaviors, drug use, and complaints about body-related illnesses) following a stressful family event such as relocation.[1028]

Implementation of an identifier would not involve the creation of new information systems. It would merely require the modification of existing processes and systems. According to the Military Child Education Coalition, "97 percent of the school districts (with military students) have existing information systems that could be modified to include a military identifier."[1029]

Conclusions:
Consistent, national-level reporting on the performance and attendance of military dependent students is currently not available. Doing this inhibits efforts to better understand and support these children. Adding a military dependent student identifier to the ESEA datasets submitted annually to the National Center for Educational Statistics would provide the basic information needed to justify, inform, develop, implement, and evaluate policies and programs that specifically address and support military dependent students based on their increased risk of experiencing academic and behavioral challenges at school. National implementation standards are needed to ensure that data are consistent from one location to another. This identifier should be implemented in a way that avoids identification of individual students in aggregated reporting or tracking of individuals from one location to another.

Recommendations:

- A national military dependent student identifier should be implemented by requiring school data systems and processes that serve as sources for ESEA reporting to identify students who have parents or guardians who are active-duty members of the Uniformed Services. This identifier would enable consistent reporting on the attendance and academic performance of military dependent students across the United States, a capability that is not available today. This identifier should create a report-only subgroup in ESEA data sets and should also identify the branch(es) of the Uniformed Services for the active-duty parent(s) or guardian(s) of the military dependent student.

Implementation:

- 20 U.S.C. § 6311 should be amended to add students with at least one parent or guardian who is an active-duty member of the Armed Services (further disaggregated by branch of Service) to the categories of data required for reporting under the Elementary and Secondary Education Act.

[1027] Catherine P. Bradshaw, May Sudhinaraset, Kristin Mmari, Robert W. Blum, "School Transitions Among Military Adolescents: A Qualitative Study of Stress Appraisal and Coping," *School Psychology Review*, 39, no. 1, (2010): 84-105. *See also* Eric M. Flake, Beth Ellen Davis, Patti L. Johnson, Laura S. Middleton, "The Psychosocial Effects of Deployment on Military Children," *Journal of Developmental & Behavioral Pediatrics*, 30, no. 4 (2009): 271-278, abstract accessed November 10, 2014, http://journals.lww.com/jrnldbp/Abstract/2009/08000/The_Psychosocial_Effects_of_Deployment_on_Military.1.aspx.
[1028] Hamilton I. McCubbin, Richard H. Needle, Marc Wilson, "Adolescent Health Risk Behaviors: Family Stress and Adolescent Coping as Critical Factors," *Family Relations*, 34, no. 1, (1985): 51-62, accessed November 10, 2014, http://www.jstor.org/discover/10.2307/583757?uid=3739584&uid=2&uid=4&uid=3739256&sid=21104478986301.
[1029] "Issue 9: Assign an identifier for military children in education data systems," USA4Military Families Initiative, accessed September 17, 2014, http://www.usa4militaryfamilies.dod.mil/MOS/f?p=USA4:ISSUE:0::::P2_ISSUE,P2_STATE:9,DC.

- Any other regulations (including the Code of Federal Regulations, if applicable), instructions, directives, or internal policies necessary to conform to the recommendation described above should be reissued, updated, amended, retracted, or otherwise changed as needed.

4. THE COMMISSION'S PROCESS

With the Congress' mandates and the President's principles as keystones, the Commission has spent its time with a singular focus—developing a modern benefits package that is valued by, and protects the quality of life of, the 21st century force. The Commission's process was divided into three phases of work: the formation of the Commission, information gathering and data analysis, and deliberation and development of the Commission's recommendations. The results of our work are reflected in the June 2014 *Report of the Military Compensation and Retirement Modernization Commission: Interim Report* and in this final report.

Commission Formation

The Military Compensation and Retirement Modernization Commission was established by the Congress in the National Defense Authorization Act for FY 2013.[1] The statute designated a nine-person Commission, with the Commission Chairman appointed by the President of the United States and two Commissioners each appointed by the majority and minority leadership of both chambers of the Congress. In May 2013, President Barack Obama appointed the Hon. Alphonso Maldon, Jr., former Assistant Secretary of Defense for Force Management and Policy and a retired U.S. Army officer, to chair the Commission. Congressional leaders appointed the Hon. Larry L. Pressler, the Hon. Stephen E. Buyer, the Hon. Dov S. Zakheim, Mr. Michael R. Higgins, General Peter W. Chiarelli, USA (ret.), Admiral Edmund P. Giambastiani, Jr., USN (ret.), the Hon. J. Robert (Bob) Kerrey, and the Hon. Christopher P. Carney. These Commissioners represented extensive depth and breadth of relevant experience, including former Senators, former Members of the House of Representatives, former Congressional Staff, Presidential appointees, and career military officers. The Commissioners had more than 14 decades of military service among them. They also collectively had more than 10 decades of military, personnel policy, budget, and legislative experience.

The Commission's staff of 50 personnel included Uniformed Services members, civil servants, and contractors, including eight current Active Component and Reserve Component Service members and nine military retirees. Five staff members were nonretired veterans of military service, and 13 were current or former military dependents. All Military Services except the Coast Guard were represented on staff. Nearly every program examined by the Commission was part of the personal experience of the Commission's staff and those closest to them.

The Commission's establishing documents are found in Appendix A, "Guiding and Enabling Documents." Additional information on the Commissioners, as well as the composition of the Commission staff is found in Appendix B, "MCRMC Composition."

[1] National Defense Authorization Act for FY 2013, Pub. L. No. 112-239, 126 Stat. 1632, 1787 (2013) (as amended by National Defense Authorization Act for FY 2014, Pub. L. No. 113-66, § 1095(b), 127 Stat. 672, 879 (2013)).

PRINCIPLES FOR MODERNIZING THE MILITARY COMPENSATION AND RETIREMENT SYSTEMS

Sections 671-680 of the National Defense Authorization Act for FY 2013 establish the Military Compensation and Retirement Modernization Commission. Section 674(c) requires the President to provide the Commission and the Congress with principles to guide the Commission's review and recommendations.

For over a decade, our men and women in uniform have participated in one of the most extraordinary chapters of service in the history of our Nation. They have served multiple tours of duty in distant, different, and difficult places. They come from all walks of life and all stations; Active, Reserve, and National Guard; serving together to protect our people, while giving others a chance to lead a better life. We owe each and every one of them and their families a tremendous debt of gratitude for their sacrifice, service, and patriotism.

Our Nation requires a strong military for our security and for the defense of American values and principles abroad. While we have successfully transitioned from a conscripted force to an All-Volunteer Force, sustaining this force requires responsive and prudent management, especially given the fiscal challenges we face as a Nation.

In conducting the Commission's review and in developing recommendations, you should ensure that the Commission examines all areas outlined in section 671(b)(1) and considers the full breadth of the military compensation and retirement systems, including health care programs, programs supporting military families, as well as programs of the Federal Government that may influence decisions of current and future members of the military to join and remain in the service of our Nation. The Commission's review should also consider and examine: our Nation's ability to sustain an All-Volunteer Force; the retention of our most experienced and qualified service members and the alignment of compensation and management to achieve this end; our current promotion system and associated force shaping tools; and our responsibilities to the American taxpayers. The review should provide recommendations for sustaining the long-term viability of the All-Volunteer Force in a fiscally responsible manner.

The Commission's recommendations and analysis for reforming and modernizing the military's compensation and retirement systems should be based upon the priorities outlined in sections 671(b)(2) and 674, and upon the longstanding principles of military compensation developed by the 5th Quadrennial Review of Military Compensation, as outlined below. The Commission's recommendations for change must grandfather any currently serving military members and current retirees in the current military retirement systems, but may allow currently serving members and current retirees the choice to change to your proposed retirement system.

The Commission's recommendations should also be guided by the following principles:

1. Manpower and Compensation Interrelationship. Military compensation and retirement systems are an integral part of the military's overall human resource management system and are key tools for recruiting, managing, and retaining the best military personnel. The military compensation and retirement systems should consider differences between service in the Military Services and service in other

Uniformed Services. They should also consider differences between regular and reserve military service and facilitate, as appropriate, the use of reserve service to support regular military forces.

2. Efficiency. The military compensation and retirement systems must attract, retain, and motivate a sufficient quantity of military personnel and those of the highest quality to sustain the All-Volunteer Force. While the military compensation and retirement systems should provide a reasonable standard of living, they should be fiscally sustainable and impose the least burden possible on the American taxpayer, consistent with maintaining a high-quality, All-Volunteer Force.

3. Equity. Military members, whether in the active or reserve components, must be allowed to compete equally for pay and promotion according to their own abilities and should receive equal pay for substantially equal work under the same general working conditions.

    a. To the extent possible, compensation should be comparable with pay in the American economy.

    b. Compensation should be competitive externally with private sector pay. It should also be competitive internally, to incentivize acquiring skills and accepting challenging assignments, to recognize hardships and danger, and to facilitate the distribution and separation of military members at appropriate times.

4. Effectiveness. The military compensation and retirement systems must be effective in times of peace, war, and other levels of conflict. These systems must be robust and assist in expanding and contracting the force as appropriate, including the seamless use of reservists and retirees.

5. Flexibility. The military compensation and retirement systems must be flexible to adjust to changing conditions in the American economy, to changes in the labor markets, and to changes in military force structure requirements. These systems should be capable of rapid and equitable adjustments. They should facilitate the mobility required to employ the force in time of war and in peacetime support the need of force managers to professionally develop future military leaders.

6. Motivation. The military compensation and retirement systems should encourage meritorious performance and the desire to seek and perform in positions of greater responsibility.

7. Fiscal Sustainability. The military compensation and retirement systems should be fiscally sustainable in order to ensure long-term certainty for service members and retirees.

8. Force Management. The military compensation and retirement systems must actively retain the most experienced and qualified service members and align compensation and benefits to achieve this end. Along with the review of compensation the interrelationship of the military's current promotion system should be reviewed, as well as associated force shaping tools.

Together, these principles form a useful foundation to guide the Commission's review and development of recommendations to modernize the military compensation and retirement systems.

Information Gathering and Data Analysis

To gain an understanding of their perceptions, priorities, and concerns regarding Uniformed Services pay and compensation programs, the Commission met with numerous groups of Service members, veterans, retirees, and their family members. It held several public hearings and town hall meetings across the country. The Commission and staff also met with key representatives of each of the Uniformed Services; numerous military and veterans service organizations; academic and research institutions; and private, commercial, and not-for-profit organizations. This comprehensive information gathering and data analysis phase provided important insights for the development of the Commission's recommendations to modernize pay and compensation.

Public Hearings and Town Hall Meetings

The Commission conducted eight public hearings and eight town hall meetings between November 2013 and October 2014 at military installations throughout the United States. These meetings provided local military leadership and community representatives with opportunities to provide testimony on pay and retirement, health benefits, and quality of life programs. Members of the public, including Active Component, Reserve Component, and retired Service members and their spouses, were invited to speak to and ask questions of the Commissioners. The Commission also heard from representatives of advocacy groups and private-sector organizations with specific experience in Uniformed Services compensation issues.

Several public hearings illuminated issues specific to military health benefits. In San Antonio, Texas, the Commission heard from local medical commanders, national private health insurance companies, and a TRICARE regional contractor. In Portsmouth, Virginia, the Commission engaged with representatives of the local military and civilian medical communities. It gained perspective on the issues raised by coordinating DoD, Veterans Affairs, and civilian medical facilities. The Commission also learned about civilian best practices and noted those with relevance to military health care benefits.

Issues related to the daily needs and experiences of Service members and families were also a frequent topic at public hearings and town halls. At public hearings, the Commission heard testimony from representatives of the National Military Family Association, Blue Star Families, the Gold Star Wives of America, the Navy and Marine Corps Relief Society, and representatives of the Services' Morale, Welfare, and Recreation programs among other organizations. This testimony provided insight on aspects of Uniformed Services quality of life.

Transcripts of public hearings and town halls are available for download at www.mcrmc.gov.[2] *Comments provided to the Commission during town halls are incorporated into the summary of public inputs found in Section 4, "Comments to the Commission." A full list of Commission public hearings and town halls is found in Appendix C, "Commission Outreach."*

MILITARY INSTALLATION VISITS AND SENSING SESSIONS

To maximize face-to-face opportunities with Service members and their families, as well as gain a thorough understanding of the effects of compensation and benefit programs, the Commission and staff visited more than 55 military installations around the world. These installations included rural and isolated sites, so the Commissioners could understand the experiences of Service members and families assigned to those locations. The Commission and staff also visited overseas installations and, through various mechanisms, received feedback from deployed Service members and those serving at sea.

During visits to military installations, the Commission and staff met with installation and unit leaders, managers of key installation benefits and services, and groups of Service members and their families. Staff visited more than 10 military recruiting stations around the country to understand the role of military pay and benefits in recruiting efforts. Staff also visited a Military Entrance Processing Station to engage with newly accessed Service members, spoke with cadets from multiple Service academies, and visited U.S. Navy Transient Personnel Units in Virginia and California to gather perspectives on compensation, savings, and retirement programs. The Commission spoke with military recruiters, as well as new and prospective recruits regarding their knowledge of and value placed on various military benefits.

The Commission also visited the Captain James A. Lovell Federal Health Care Center (FHCC) in North Chicago, Illinois. It is the Nation's first FHCC, and a first-of-its-kind partnership between DoD and the Department of Veterans Affairs (VA). The Commission learned about the challenges faced as the separate Naval Hospital Clinic Great Lakes and the North Chicago VA Hospital transitioned to the FHCC. It gained an understanding of differing DoD and VA processes, including the ongoing difficulties with the development and implementation of a common electronic health record. Additional insight into military health care was gained during visits to two Army installations. Sensing sessions with dependent spouses at Fort Bragg, North Carolina provided valuable insight into the perception of health care quality at local military medical facilities and civilian health care providers. Similarly, the Commission's visit to Fort Drum, New York, provided information about the effectiveness of health care at a military base without a military treatment facility.

The Commission paid particular attention to the experiences of Service members and their families assigned to remote installations in service to the Nation. Commissioners and staff visited rural and semi-isolated installations throughout the country and overseas including, for example, Coast Guard Air Station Kodiak in Alaska and Fort Irwin, California (where a trip to the nearest town entails a nearly 80-mile round trip). The experience of personally traveling to such isolated locations gave the Commission

[2] Due to technical issues, the recording from the public hearing at MacDill Air Force Base in Tampa, Florida on May 22, 2014, was not available for transcription.

a valuable understanding of the unique challenges faced by many Service members and families, as well as the role of benefits in improving the quality of life for these populations.

Comments provided to the Commission during installation visits and sensing sessions are incorporated into the summary of public input found in Section 4, "Comments to the Commission."

SERVICE MEMBER SURVEY

The Commission conducted a broad survey of preferences for changes to various compensation programs to gather views directly from Active Component members, Reserve Component members, and retirees. The survey was sent to a random sample of 457,033 active-duty and Reserve Component Service members. The sample was designed so results were statistically representative of key demographic groups of the military populations (such as rank/grade, family status, deployment history, geographic location, etc.). Additionally, the Commission sent surveys to every retired Service member with a current e-mail address on file with the Defense Financial Accounting System—nearly 1.3 million military retirees. In total, the Commission received more than 150,000 completed surveys, substantially exceeding the minimum number required to achieve statistical precision for most subgroups.

The survey included data-gathering, modeling, and simulation to capture, validate, and analyze military compensation preference data. Using these tools and data, the Commission was able to gauge how selected subgroups of each target population valued current and alternative configurations of military compensation. Moreover, the modeling and simulation functions enabled the Commission to identify and compare reconfigured military compensation scenarios that showed promise in terms of perceived value to Service members and cost to the Government.

Comments provided to the Commission during the survey process are incorporated into the summary of public input found in Section 4, "Comments to the Commission." Additional information regarding survey methodology can be found in Section 5 "The Commission's Survey." Additional survey data is available at www.mcrmc.gov.

PUBLIC COMMENT

In addition to surveying current and retired Service members, the Commission wanted to receive as much feedback as possible on the topics of pay and retirement, health benefit, and quality of life programs. Multiple mechanisms were put in place to facilitate a comprehensive collection of public comments. The Commission established a website[3] on which it posted notices of its public hearings, visits to installations around the country, and meetings with public and private organizations. The website contained a mailing address, e-mail address, and a web form via which members of the general public could send comments to the Commission. As of October 2014, more than 2,200 letter, e-mail, or web-form comments were received and read by the Commission. The Commission also took numerous comments by phone.

[3] The Commission's website address is http://www/mcrmc.gov.

Comments provided to the Commission through these mechanisms are incorporated into the summary of public input found in Section 4, "Comments to the Commission."

Government Engagement

The Commission met with representatives from 29 relevant Government agencies to gather their perspectives, data, and other inputs to inform the deliberation and decision-making process. Ongoing dialogue with specific Government agencies, including DoD and VA, facilitated various aspects of the Commission's work in all phases of its process.

In particular, the Commission repeatedly met with the Uniformed Services' chiefs of manpower and personnel affairs, comptrollers, and Reserve Component affairs directors. It also met with each of the Services' and the Joint Staff's Senior Enlisted Advisors on multiple occasions. Through these meetings, the Commissions gained a better understanding of the Services' recruiting and retention requirements. It also had an opportunity to discuss issues related to the implementation of particular benefit programs and to learn from the Services' best practices regarding benefit administration. These meetings also helped the Commission gain an understanding of issues and concerns of enlisted Service members.

The Commissioners engaged directly on multiple occasions with the Surgeons General of the Armed Services to gain an in-depth understanding of the requirements and administration of the military health care system. The Surgeons General and other DoD officials provided important context for the Commission's analysis of the military health care benefit and offered knowledgeable insight into potential courses of action, particularly as they relate to medical readiness. The DoD Office of the Actuary provided valuable information on existing compensation and retirement programs, such as regular and disability retirement and the Survivor Benefit Program. Meetings with the Office of Personnel Management,[4] Federal Retirement Thrift Investment Board, the Pension Benefit Guaranty Corporation, the Consumer Financial Protection Bureau, and the Financial Literacy and Education Commission, among others, provided the Commission opportunities to explore lessons learned and best practices regarding other Government programs.

To best understand issues surrounding the grocery and retail benefit, the Commissioners and staff met on multiple occasions with the directors and senior staff of the Defense Commissary Agency and of the three military exchanges organizations. These meetings allowed the Commission to better understand the varying approaches to providing military retail benefits, such as differences in how each organization serves its respective customers, how they interact with senior leadership of the military services, and how they integrate with the private sector. Representatives of each agency provided perspectives on a variety of proposals to modify their organizations, as well as their cooperative efforts.

A complete list of the Commission's Government engagements is found in Appendix C, "Commission Outreach."

[4] The Office of Personnel Management provided support for the Commission's analysis; however, such support does not represent an endorsement of, or suggest any opinion on, the report, study, or recommendations.

FOREIGN MILITARIES

The Commissioners and staff met with representatives of the British Armed Forces and the Australian Defence Force to discuss several issues related to pay and retirement. The military in the United Kingdom recently introduced a reformed pay and retirement system. Staff discussed the lessons learned from the development and implementation of the new system with British military leadership, noting areas of similarity and differences that could inform the Commission's work. The Commission held similar discussions with officials from the Australian Defense Force regarding financial education and training provided to their members.

Engagements with foreign militaries also offered important insights into issues concerning the military health benefit. Commission staff met with the British Armed Forces to gain an understanding of the lessons learned during the United Kingdom's move from a traditional military medical command and control structure to a Joint Medical Command. The staff also met with the German Bundeswehr Medical Service to discuss Germany's transition to a single medical service, the cultural difficulties involved in such a transition and the resulting structure and responsibilities within the new organization. Officials in both countries explained how their military medical forces maintain critical medical skills and how they interact with their respective civilian health care systems.

A complete list of the Commission's foreign military engagements is found in Appendix C, "Commission Outreach."

MILITARY SERVICE ORGANIZATIONS AND VETERANS SERVICE ORGANIZATIONS

The Commission benefitted from extensive consultation with many military service organizations (MSOs) and veterans service organizations (VSOs). These groups represent the Service members, veterans, retirees, and their families who are directly affected by the work of this Commission. They actively work within legislative and policy circles to preserve and improve the value of military pay and retirement, health care, and quality of life benefits. The assistance of these groups, including their interactions with the groups' own membership, has been invaluable to the Commission. Dialogue with MSOs and VSOs improved the Commission's knowledge of their issues and allowed it to understand the groups' positions and priorities. In particular, Senior Commission staff met individually with the chief executive officers and directors of legislative and government affairs for more than 25 members of the Military Coalition.[5] More than half of the Coalition's members participated in public hearings and executive sessions. Additionally, the Coalition's subcommittees on Pay and Retirement and Health Care engaged directly with Commission staff throughout the life of the Commission. Interactions with MSOs and VSOs allowed the Commission to gather key insight into the issues and concerns most pressing to the Service members, retirees, veterans, and their families. They also provided important feedback

[5] The Military Coalition is "a group of 32 military, veterans, and uniformed services organizations in joint pursuit of [common] goals" related to military recruiting, retention, compensation, and benefits, among others. "Who We Are," The Military Coalition, accessed October 8, 2014, http://www.themilitarycoalition.org/whoweare.htm.

on the aspects of a modernized compensation system that beneficiaries would find most valuable.

A complete list of the Commission's organizational engagements is found in Appendix C, "Commission Outreach."

Private-sector Organizations

The Commission and staff met with representatives of numerous nonprofit and private-sector organizations to gain knowledge of topics under exploration. These meetings were informational in nature, designed to gain necessary context for some programs and benefits in relation to private-sector standards, best practices, and lessons learned. For example, the Commission met with companies such as USAA and Prudential to discuss facets of savings and retirement planning. The Society of Human Resource Management provided insights into current experiences with, and historic trends regarding, employer-sponsored retirement plans in the private sector. Members of the staff also met with individual subject-matter experts on issues relevant to pay and retirement, including personal finance experts, who offered opinions regarding financial literacy education.

The private sector also provided valuable context and perspective for the Commission's examination of the health care benefit. The Commission met with multiple organizations representing collaborative efforts between military and civilian medical communities. These organizations included the Fort Drum Regional Health Planning Organization (RHPO) in New York and the University Medical Center of Southern Nevada in Las Vegas, Nevada. The RHPO is a partnership that enables a synchronized health care system in a military community without a local military treatment facility. In Nevada, military and civilian medical communities have partnered to provide a trauma training environment for military medical personnel. The Commission and staff also met with representatives of the Sacred Heart Health System in Pensacola, Florida, and several private health insurance companies, to gain a deeper understanding of how civilian providers view the provision of health care to military beneficiaries under TRICARE. Additionally, staff met with the Children's National Health System and representatives of the TRICARE for Kids organization to become better acquainted with the needs of military children, how the current system of TRICARE works, and where difficulties and challenges are perceived in relation to health care for military child dependents.

To learn about issues related to military grocery and retail programs, Commission staff met with multiple retail associations including the American Logistics Association, the Armed Forces Marketing Council, and the Military Produce Group. Staff also met with individual vendors such as Procter & Gamble, Coca-Cola, and Kraft. The meetings helped the Commission better understand the perspectives of these types of organizations with respect to the commissary and exchange systems. They also provided valuable information on the ways in which military resale organizations differ from commercial grocers, department stores, and discount outlets.

A complete list of the Commission's private-sector engagements is found in Appendix C, "Commission Outreach."

THINK TANKS AND RESEARCH SUPPORT

The Commission met with more than a dozen policy, research, and academic organizations. Each organization had dedicated substantial time and resources to studying the complexity of the Service's compensation system. Insights gained during these encounters informed multiple Commission efforts, including the development of the Commission survey, and directly contributed to the deliberations of the Commissioners. For example, the Commission and staff visited the Office of Economic and Manpower Analysis at the United States Military Academy at West Point on multiple occasions to discuss issues related to pay and retirement. The Chief Executive Officer of the Institute for Defense Analyses (IDA) spoke to the Commission in a public hearing and an executive session, offering insights on Service compensation policy.

The Commission also contracted with several organizations for research, modeling, and analysis support. The Commission contracted with RAND Corporation (RAND) to use its Dynamic Retention Model (DRM), a proprietary modeling capability designed to support workforce-management policy decision-making. The use of the DRM enabled the Commission to assess potential effects on Service force profiles, including accession and retention, due to alternative changes to pay and retirement. RAND also provided research and cost analysis in support of the Commission's examination of pay and retirement. IDA and CNA Corporation (CNA) prepared multiple briefings to support the Commission's analysis of the military health benefit. IDA delivered a report analyzing aspects of the veterans' disability benefit and another providing a comparison of military and private-sector hospital costs. CNA provided an analysis of military hospital workloads. Additionally, both organizations performed specific research and analysis tasks regarding various health benefit options considered by the Commission.

LEGAL AND POLICY REVIEW

As directed by statute, the Commission performed a thorough review of current Uniformed Services compensation and benefit programs; relevant laws, regulations, and policies; associated appropriated Federal funding; and historical and contextual background for the Uniformed Services' compensation and benefit programs across the Federal Government.[6] The results of our review are found in the *Report of the Military Compensation and Retirement Modernization Commission: Interim Report*. Throughout all phases of our work, the Commissioners and staff received legal guidance and support from the Commission's Office of the General Counsel. This support included review of laws and policies, legal interpretation, and legal review of the Commission's work products, final recommendations, and this final report.

DELIBERATION AND DEVELOPMENT OF RECOMMENDATIONS

The Commission's deliberation and recommendation development process was ongoing and iterative. The Commission held regular executive sessions in Arlington, Virginia, increasing in frequency over the life of the Commission. These executive

[6] National Defense Authorization Act for FY 2013, Pub. L. No. 112-239, 126 Stat. 1632, 1787 (2013) (as amended by National Defense Authorization Act for FY 2014, Pub. L. No. 113-66, § 1095(b), 127 Stat. 672, 879 (2013)).

sessions offered the opportunity for the Commission to hear testimony from and engage in meaningful discussion with many of the stakeholders discussed above, including Government agency officials and members groups representing active-duty, Reserve Component, and retired Service members and their families. The executive sessions allowed for regular face-to-face discussion and deliberation among the Commissioners, including decision-making on final recommendations.

With each piece of information gathered during the Commission's process, the preferences, priorities, and requirements of the 21st century All-Volunteer Force came into sharper relief. The discussions provided the Commission with the necessary insights and information to achieve its mission: developing a Service-member focused compensation package that preserves or improves value for the men and women who serve and have served our Nation, and the families that support them.

THIS PAGE INTENTIONALLY LEFT BLANK

5. THE COMMISSION'S SURVEY

To conduct a comprehensive review of military compensation, the Commission needed to gather opinions directly from current and retired Service members. As described in Section 6 of this report, the Commission gathered comments from town halls, sensing sessions, its website, and other means. Although that input provided valuable insights into the issues of predominant interest to Service members, the Commission wanted to ensure it gathered opinions from a representative cross-section of all Service members. For that reason, the Commission conducted a broad survey to gain feedback on aspects of military compensation from a large, statistically representative sample of current and retired Service members.

Although DoD and the Services maintain an extensive library of survey research on a wide variety of topics, including compensation, those surveys focus on satisfaction with current components of compensation. They do not provide information on whether Service members would prefer compensation programs different than those in the current compensation system. To gather such information, a preference-based survey was required. Preference-based survey methods have been researched extensively for decades[1] and can be used to quantify the incremental value associated with a change in a benefit, as well as the total perceived value for a combination of benefit changes.

Survey Sample Design

The Commission contracted for the design, implementation, and analysis of a preference-based survey.[2] As shown in Table 22, the target populations for the survey consisted of subpopulations for Active Component members, Reserve Component members, and retirees. The sample was further stratified so results were statistically representative of key demographic groups of the military populations (e.g., rank/grade, family status). The Commission chose these stratification variables to provide results that were relevant to its deliberations. The definitions for these variables match those developed and used by the Defense Manpower Data Center (DMDC) in drawing samples for its own use on behalf of DoD clients. The size of each sample was more than sufficient to provide the number of completed surveys required to have a statistically valid sample. DMDC provided e-mail addresses for these sample groups based on particular specifications.

---

[1] Substantial research has been conducted on the subject of preference measurement, including designs for the data collection instruments, choice of analytical methods, and type of software to engage participants in adaptive, interactive sessions. *See, for example,* P.E. Green, A.M. Krieger, and Y. Wind, "Thirty Years of Conjoint Analysis: Reflections and Prospects," *Interfaces*, 31, no. 3, (2001): S56-S73. *See also,* Ryan O. Murphy and Kurt A. Ackermann, *A Review of Measurement Methods for Social Preferences*, accessed April 4, 2014, http://vlab.ethz.ch/svo/SVO_rev_paper.pdf.

[2] National Capital Contracting Ltd. (NCC) served as the prime contractor and project manager; True Choice Solutions Inc. served as a subcontractor to NCC and provided expertise to develop and field a web-enabled interactive survey instrument, along with specialized survey analysis tools; Mathematica Policy Research served as a subcontractor to NCC and supported the development of the sample design and related statistical matters. The consortium of contractors supporting the survey work have published a report that documents in considerable detail the design of the survey samples, including measures of statistical precision used to estimate minimum sample sizes for reporting results representative of the broader military populations.

Table 22. Key Features of the Sample Design for Commission Survey

Target Population Groups	Sampling variables					Target Population Group Size	Total Sample Size to Contact
	Variables used to stratify the samples	# Strata per Variable	Total # of strata	Other variables retained in the samples	# Strata per Variable		
Active duty	Family status Pay group Deployment status Region/duty location	4 6 2 2	96	Service Gender	5 2	1,394,807	180,765
Reserve	Family status Pay group Deployment status	4 6 2	48	Component Gender	4 2	834,621	276,268
Retiree	Family status Age group Rank group Duty status	4 3 2 2	48	Service Gender Retire Type	5 2 2	2,142,189	1,273,337

SURVEY IMPLEMENTATION

The Commission sent the survey to a random sample of 457,033 active-duty and Reserve Service members and to nearly 1.3 million military retirees.[3] In total, the Commission received more than 150,000 completed surveys, substantially exceeding the minimum number required to report results for most subgroups with sufficient statistical precision.

The data collection took place from July through October 2014, allowing about 6 to 8 weeks for each target population group to respond. To maximize response rates, sample members from the Active and Reserve Components were contacted several times with notices prompting them to take the survey. The retired population was contacted only once because the Commission sent the invitation to more than a million e-mail addresses.

Sample members received an e-mail invitation to participate in the survey that directed them to a website hosting the preference-based analytic tool. The survey typically took respondents 20-25 minutes to complete. Unlike more traditional surveys that employ either some form of multiple-choice or Likert-type scale (often 1 to 5) to capture respondent information, this survey employed a web-enabled interactive interface for which respondents moved sliders, shown on their computer screen, to express their preferences for various alternatives presented. Figure 24 shows an example of how a question item is portrayed on the user interface.

[3] The Commission decided to contact all 1.3 million (approximate) military retired with a viable e-mail address and invite them to participate (this is about 60 percent of the 2.2 million on the military retired rolls) because the military retired population is rarely contacted by DOD, VA, or other agencies to gather their views on important topics.

Figure 24. User Interface for Commission Survey

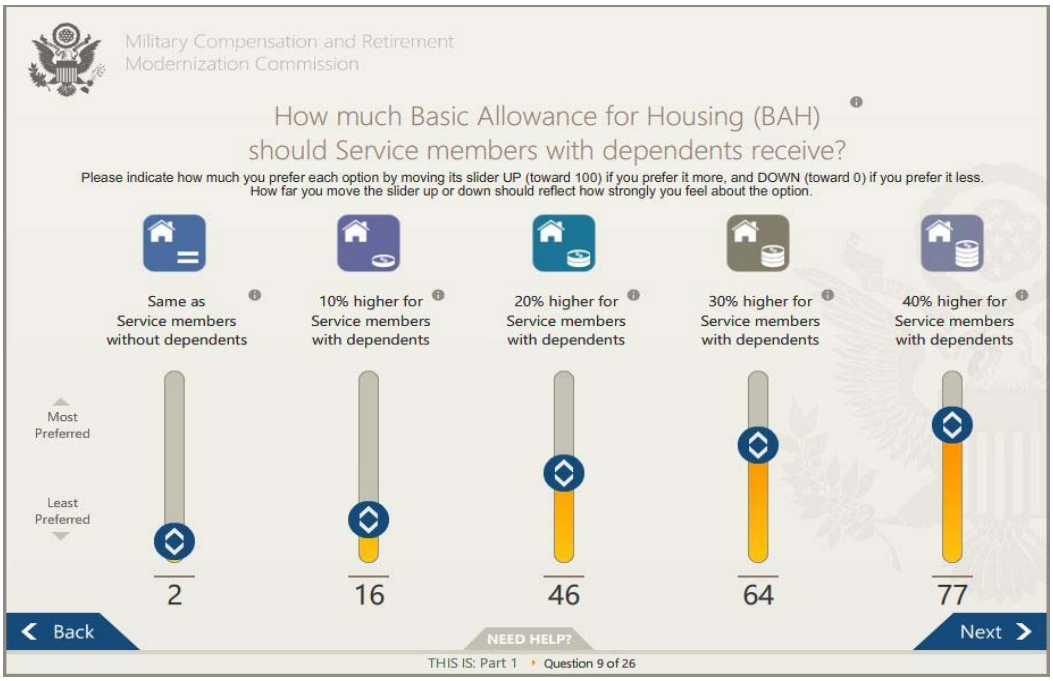


Table 23 shows the compensation topics covered in the survey. The basic survey instrument's content was modified for each of the three Service member populations.

Table 23. Topics Addressed in Commission Survey

Pay and Retirement	Health Care	Quality of Life
• Pay Increases	• Monthly Premiums	• Education
• Retirement	• Copayments	• Commissary
• Allowances	• Provider Arrangements	• Child Care
		• Housing
	• Service Delivery	• Other MWR

NOTE: Question items vary somewhat for Active, Selected Reserve, or retiree surveys

Part one of the survey asked participants to express their degree of preference for each of several alterative levels or features of a particular benefit. In part two of the survey, respondents were asked to rate the importance of these same benefit features. This second step added another layer of information that, together with part one, essentially provided an "importance-weighted preference metric" for each benefit feature in the survey.

Part three presented a series of six to eight screens prompting participants to express their relative preference between two pairs of benefit features. The content captured from this activity in essence provided an internal consistency check on each respondent's choices in parts one and two of the survey. After completing this third step, the survey program can flag responses that contain logically inconsistent results. No survey responses were excluded from the Commission's survey for this reason.

Part four was a standard Likert-type, scaled-satisfaction exercise. It presented each respondent with a series of benefit features based on what was rated as important in the respondent's previous answers. Respondents were asked to rate their satisfaction with the current benefit feature (for example, the BAH with-dependents). This part provided a third layer of detail, and it gave the Commission insight into how satisfied or dissatisfied the respondent was with the benefit feature as currently offered.

Part five captured self-reported information by respondents on six to 10 attributes. This section included some items already known through administrative records provided by DMDC when the sample was drawn such as family status and grade group (officer or enlisted). It also included items such as time to travel to a military facility for services and the type of health benefit plan family members use, data that cannot easily be obtained through administrative record files.

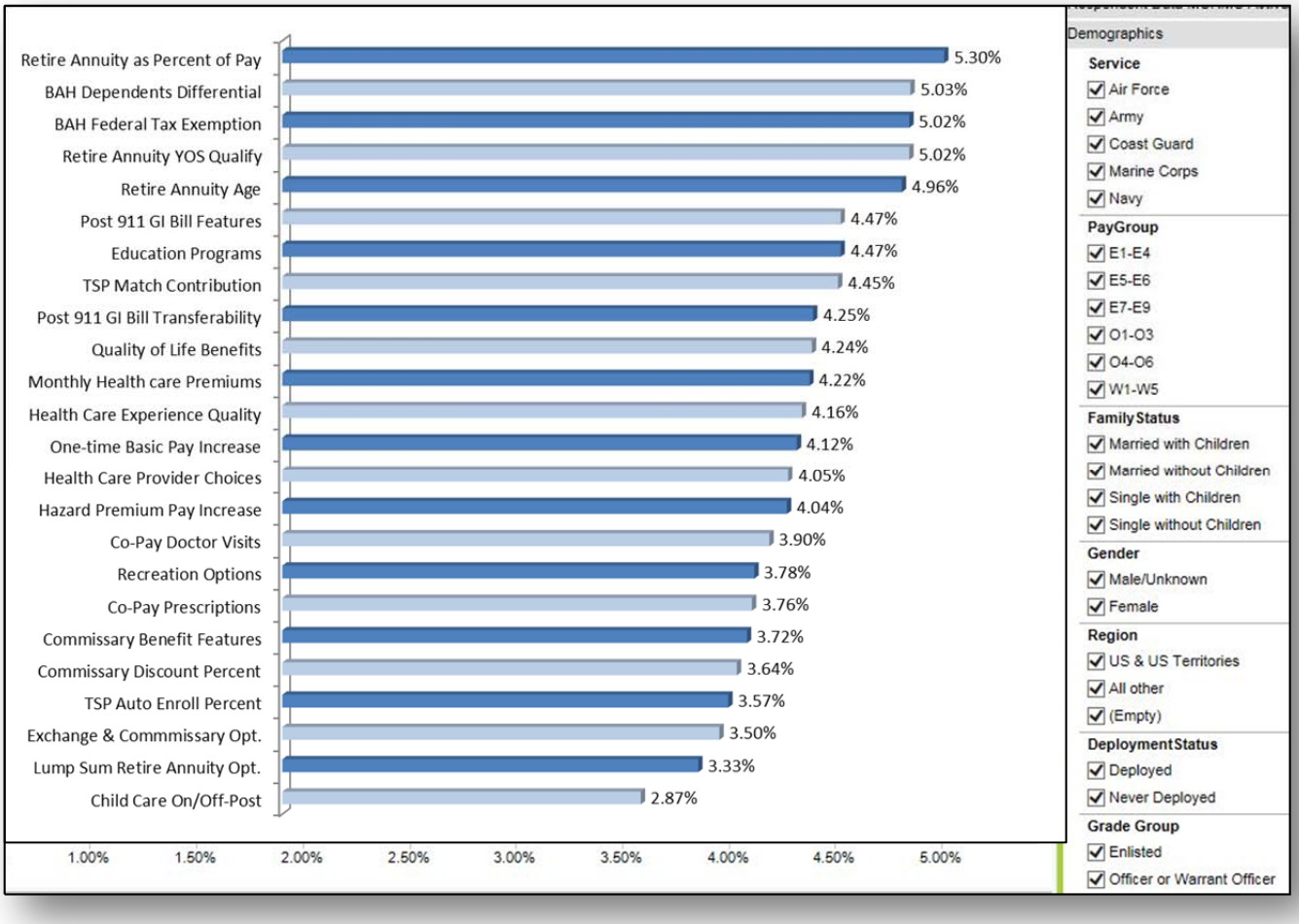
Approximately 20 percent of respondents took the opportunity to offer comments at the end of the survey (part six). More than 32,500 respondents from the three Service member populations surveyed submitted comments. These comments were separately analyzed using qualitative data analysis techniques and the aid of special qualitative data management software (see Section 6).

Survey Analysis and Modeling

The survey process has two major components: the data-gathering (survey) component and a back-end modeling and simulation component. After the data were gathered and weighted, the modeling and simulation functions allowed the Commission to explore and compare reconfigured military compensation scenarios in terms of perceived value and cost for the target populations and their subgroups.

Figure 25 shows elements of the survey analysis dashboard used to examine the collected survey data. The dashboard was available to the Commission and staff for exploring various compensation and benefit alternatives. The panel on the side enables the user to select and display results for various subgroups of the surveyed population. The dashboard then displays the results for the type of analysis chosen. The center panel on Figure 25 illustrates a simple rank ordering by Relative Importance (RI) for benefit features surveyed for the Active Force.

Figure 25. Dashboard Depicting Relative Importance of Various Compensation Features (Sum = 100%)



RELATIVE IMPORTANCE AND PERCEIVED VALUE METRICS

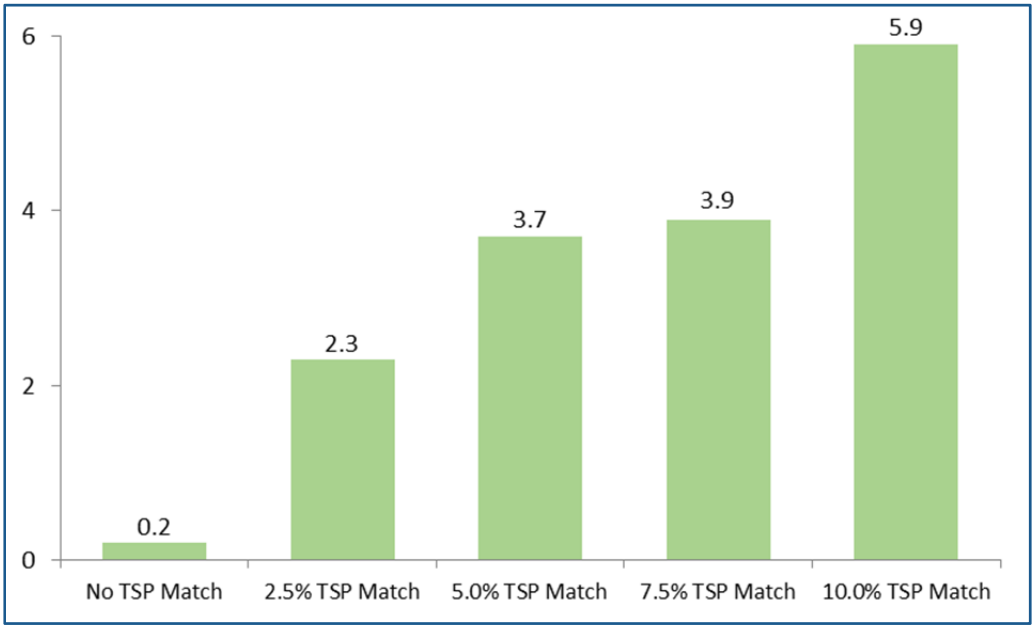
Figures 26 and 27 show examples of results from the survey analysis dashboard. All the question items in the survey show both relative importance and the corresponding perceived value measures.

Relative Importance (RI) Measure

The row of bars depicted in Figure 26 shows how Service members (total AC force) assigned levels of importance to increases in the Thrift Savings Plan (TSP) match if it were offered by DoD. Relative Importance (RI) measures the degree (from 0-10) of importance-weighted preference for each benefit feature in the survey. As depicted in Figure 26, offering a 5 or 10 percent TSP match generates 3.7 and 5.9 RI units (59 percent increase), respectively. Thus, doubling the match from 5 to 10 percent produces a less-than-proportional increase in this RI metric. It appears that Service members attach very little additional importance (from 3.7 to 3.9 in the RI metric) when increasing the DoD match from 5 to 7.5 percent. The implication is that offering a 7.5 percent match—relative to a 5 percent match—is not worth the additional cost

when Service member perceptions are taken into account. This pattern of nondisproportional change in output (such as the 59 percent improvement in RI metric when doubling the TSP match) is a common phenomenon when measuring consumer preferences. Importantly, this standard RI measure enables direct numerical comparisons for alternative levels of a specific benefit feature, as well as comparisons across all 24 benefit features in the survey.

Figure 26. Relative Importance by Active-Duty Service Member: TSP Matching



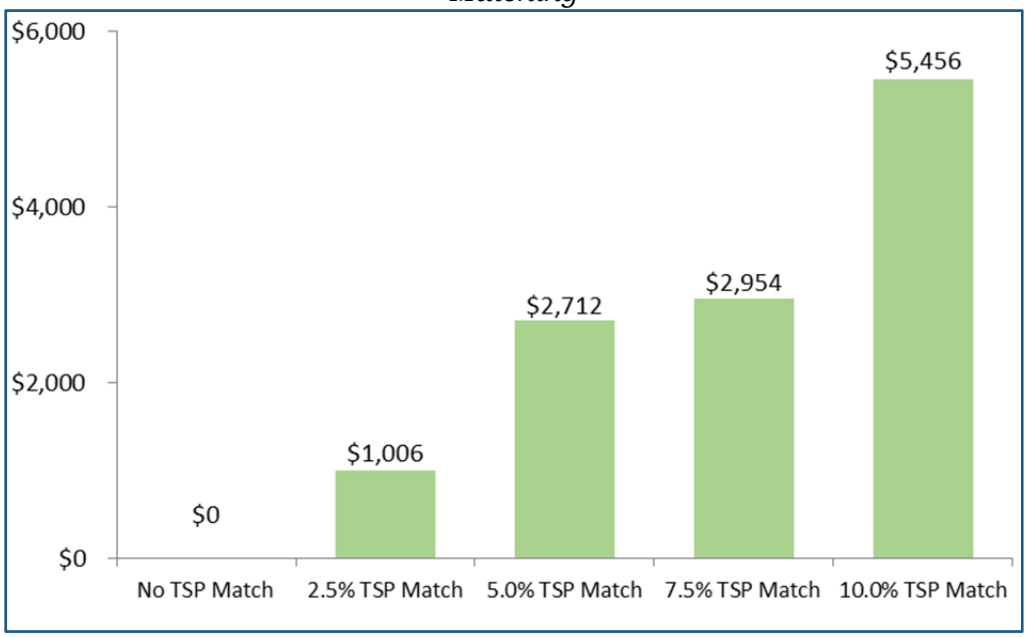
Perceived Value (PV) Measure

The row of bars in Figure 27 provides the equivalent result in terms of Perceived Value (PV). This variable measures how much each alternative benefit (or each level for the benefit) is worth in dollar terms. More specifically, the graphic illustrates how much active-duty Service members value each TSP match percent in the form of an equivalent permanent pay raise.

As this row of bars in Figure 27 shows, a 5 percent TSP match is perceived by active-duty Service members (average across the active force) as worth the equivalent of a $2,712 permanent pay raise. Note, as well, that increasing the TSP match from 5 to 7.5 percent generates only a very modest change in perceived value from $2,712 to $2,954 (equivalent to a permanent pay raise).

An important inference from such findings is that the costs to deliver a benefit can differ markedly from the worth a person perceives it to have. These PV metrics become especially meaningful when the actual (per capita) cost of providing a benefit feature is compared to its value as perceived by Service members.

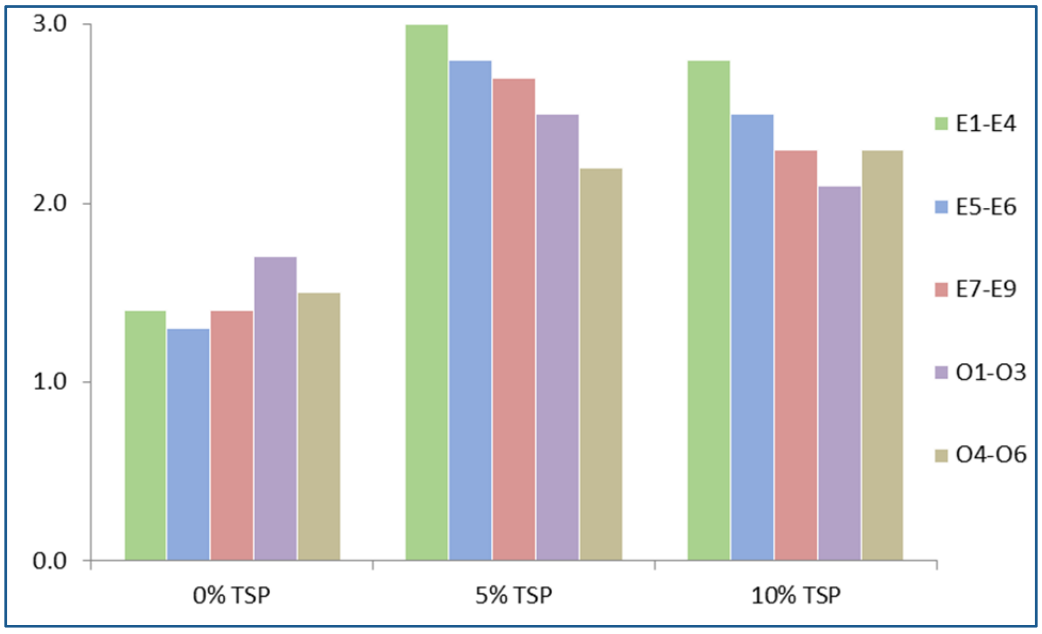
Figure 27. Active-Duty Service Members' Perceived Value: TSP Matching



Comparisons among Subgroups of the Population

The survey results can be examined for a variety of population subgroups. Figure 28 shows results for the question item on how Service members value alternative differentials for the automatic withholding of contributions to TSP.

Figure 28. Relative Importance by Active–Duty Service Members: 0, 5, and 10 percent Automatic TSP Contributions to TSP by Pay Group

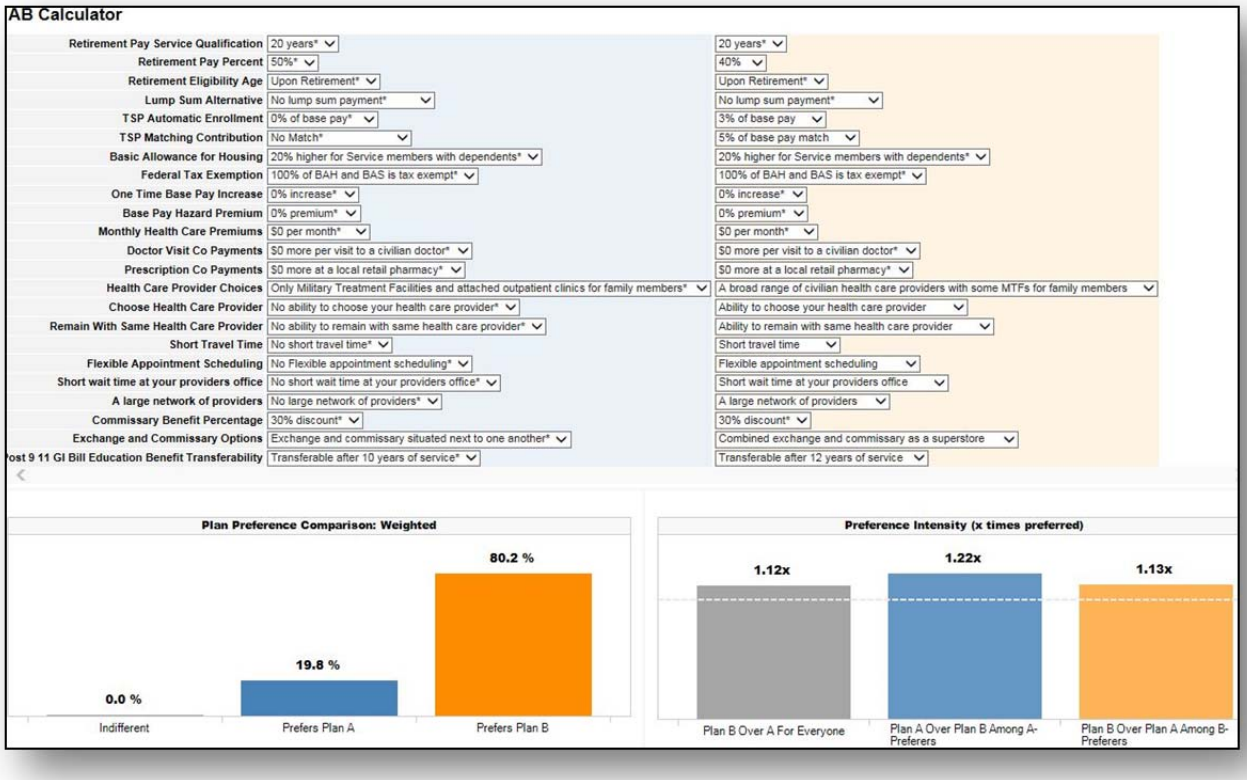


COMPARING ALTERNATIVE COMPENSATION CONFIGURATIONS

In addition to examining benefit features one at a time as shown in the previous sections, the survey analysis dashboard also provides the capability to analyze combinations of benefit features, and then compare one package of benefits against another.

Figure 29 illustrates this capability within the dashboard. The dashboard lets the user work with several benefit features at once to compare the results in terms of Service member preferences for one combination of benefit features compared to another combination. In this example, Plan A (left panel) shows the settings for the current compensation system and Plan B (right panel) shows the settings for the Commission's recommended compensation system.[44]

Figure 29. Illustration of the Compensation Plan Comparison Capability

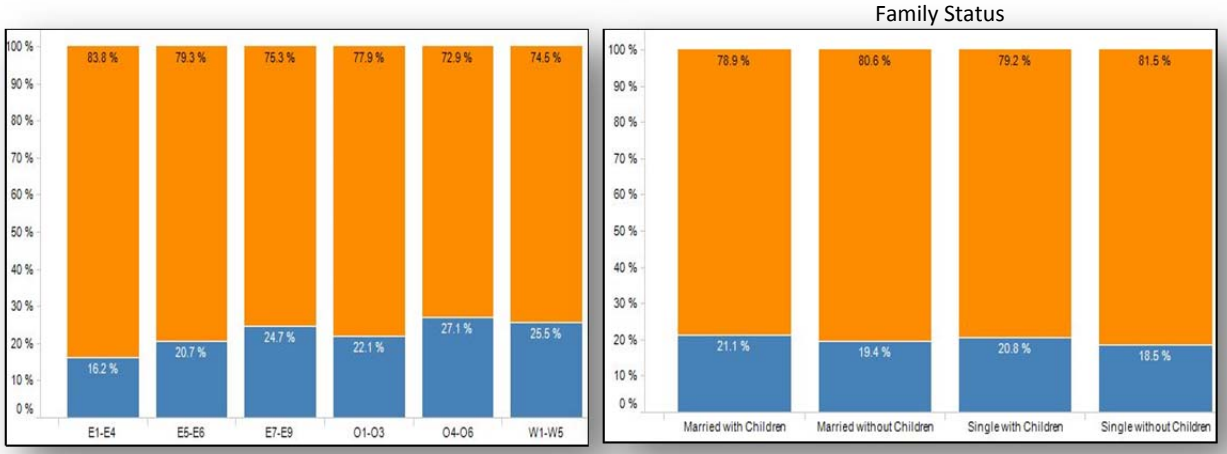


On the bottom half, the leftmost columns show the results in terms of aggregate preference for one plan (A) to another (B). In this example, Plan A (the current compensation system) is preferred by 19.8 percent of the Service-member population and Plan B (the Commission's recommended alternative) by 80.2 percent. The three columns on the far right show a measure of intensity for Service members' preference for the respective plans.

[44] The figure represents a close approximation of the preferences of the Commission's recommendations, because the survey did not address all compensation recommendations of the Commission.

Plan comparisons can also be examined by demographic subgroups. Figure 30 illustrates results of relative preference between these two compensation systems for two subpopulations defined by pay grades and family status.

Figure 30. Active-Duty Service Members' Preferences Between the Current and Recommended Compensation Systems



Blue: Prefers Current Compensation System
Orange: Prefers Recommended Compensation System

This feature enables the user to explore what the effect on preferences may be across key groups within the military populations. In this example, those in pay group E1-E4 exhibit a relatively greater preference for Plan B (orange portion of the columns). Because the E1-E4 subgroup comprises 43 percent of the active force, this difference in preference may be an important consideration.

The Commission considers this preference-based survey approach highly useful in identifying compensation plans that appeal to a broad cross section of Service members and that are fiscally sustainable. This survey, along with the compensation system analysis described in this report, guided the Commission's deliberations.[5]

[5] In the interests of openness and because the data results far exceed what could reasonably be included in this Final Report, the Commission is making the entire data base of survey results available for examination and analysis on the MCRMC website: http://www.mcrmc.gov.

THIS PAGE INTENTIONALLY LEFT BLANK

6. COMMENTS TO THE COMMISSION

All comments to the Commission—including more than 35,000 letters, e-mails, web submissions, town hall comments, and survey free-response comments—were reviewed by Commission staff, with specific areas of concern identified for further consideration in the Commission's deliberation process.[1] In addition, transcripts from town hall meetings and public hearings were thoroughly reviewed by Commission staff. Feedback was regularly reviewed for emerging trends, areas of repeated concern, and general sentiment. All passages and recurrent themes relevant to the work of the Commission were identified and forwarded to the appropriate Commission research teams.

A sampling of comments is included in this chapter. The quotations below have been selected to both represent trends in public feedback to the Commission, as well as the range of sentiment expressed. Other than minor edits for length and to correct typographical or grammatical errors, no changes have been made to the content or substance of any comment.

Overarching Comments and Concerns about Reform

Comments to the Commission overall struck a cautious and, at times, skeptical tone. Respondents from all sectors and across all methods of communication expressed concerns that the process of modernization could unfairly affect current and former Service members and their families or result in a package of pay and benefits that does not adequately compensate members for their service to the Nation.

> *I'm not fully confident that a civilian commission is the best way to determine cost-saving measures in relation to military service. I certainly understand the need to reduce defense spending (and I feel my responses in this very thorough survey will indicate that), but some of the suggested measures don't consider the unique hardships that military members and families must endure when compared to the other 99 percent of the population.*[2]

> *My fear is that this commission is soliciting input in the hopes that current service members, those of the younger, non-long-term-thinking variety, will provide input that asks for more compensation now and puts less emphasis on enduring compensation.*[3]

> *The conversation related to the reduction of pay and services is disturbing. The idea that I place the well-being of myself and my family in the care of*

[1] Section 4 details the Commission's Process and Section 5 discusses the design, methodology, and administration of the survey.
[2] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[3] MCRMC letterwriter, comment form submitted via MCRMC website, June 16, 2014.

> *the Government at the cost of the rights and privileges afforded to civil society requires commitment on both parts. Furthermore, when the right to refuse a directive becomes punishable, the obligation by society at large should be equally burdensome.*[4]
>
> *Service members who have served at least 20 active-duty years, have sacrificed their lives, bodies, families (wife and kids to not being around for parents and grandparents' late years), etc. and should be rewarded with the promised compensation of retirement pay and medical benefits.*[5]
>
> *I would ask that you honor the Government's commitments and promises to those who have served and protect their retirement and medical care entitlements. Many promised benefits have been taken away over the years due to cutting costs.*[6]
>
> *All this talk about "reforming" benefits causes a great deal of stress and uncertainty…I didn't expect to be worrying about stuff like this after serving for 30 years.*[7]

Numerous respondents also expressed satisfaction with some or all aspects of the current compensation system, and many stated a desire to minimize any changes to a system with which they were largely satisfied.

> *Overall my spouse and I are satisfied with the current military benefits provided. The commissary, exchanges, MTFs, and MWR facilities are a very important part of military cohesion and unit readiness and should all remain intact. Only changes should be to enhance or improve upon these services provided to military members.*[8]
>
> *[I am] very happy with my benefits, just wish we could get a raise more often to help with the cost of living adjustments.*[9]
>
> *I do not think the current system is broken. I have been retired for 9 years, have received excellent medical care, and I am very happy with my base access, commissary, and exchange.*[10]
>
> *I am very happy with the medical care I receive at my MTF. I also consider the commissary and exchange benefits to be among the most important for both active-duty military and retirees.*[11]
>
> *[I] am very happy with current benefits. My family made large sacrifices (we endured a 5+ year separation at 25-year point in my 30-year career) to pay off a home near a base and medical treatment facility. We would be*

[4] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[5] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[6] MCRMC letterwriter, comment form submitted via MCRMC website, October 30, 2013.
[7] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[8] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[9] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[10] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[11] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

> *extremely resentful if the value of those sacrifices were eroded due to changes in current benefits.*[12]

Feedback reflected concerns that potential cuts and reductions in compensation and benefits should only happen within the context of a larger conversation about Government spending, and that reductions in Uniformed Services' compensation represent an attempt to resolve larger budgetary concerns disproportionately on the backs of the Services.

> *[Service members and families] are often the most abused when the country finds itself overspending. The Government likes to dip into the accounts of those who served the nation. If you are to cut benefits, it would be very helpful if it included a provision to prevent the Government from using the funds promised to veterans for other purposes.*[13]

> *I am very happy with the benefits as they are. To keep with the promises we were made, our benefits should NOT be eroded. Increases in copays and premiums that match our annual COLA are more than reasonable. Other savings should come from cost cutting in the bloat of other Government spending.*[14]

> *As far as I'm concerned, the Federal Government is guilty of a breach of contract. For the majority of my 24 years in the Air Force, I struggled to make ends meet for me and my family. I fulfilled my portion of the contract, but the same Government that I gave my all to protect is trying to screw me and all the others out of our EARNED benefits.*[15]

> *I feel the major problem is the Governmental DEBT that is presently being solved by severe cuts to the Military.*[16]

> *I am very happy with the current military retirement system, and it worries me that all the talk and budget problems will cause the Government to break faith with current and future retirees.*[17]

> *The fastest way to undermine morale among military personnel is to make a promise that will not be kept.…The military is not a laboratory in which to conduct experiments to find solutions to the problems of a dysfunctional civilian society.*[18]

Some comments from current and former Service members expressed an understanding of the need for reform and modernization of the current compensation and benefits structure, but stated that any reform should be fair and sensitive to the unique concerns of military Service members and their families.

---

[12] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[13] MCRMC letterwriter, comment form submitted via MCRMC website, August 7, 2014.
[14] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[15] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[16] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[17] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[18] MCRMC letterwriter, comment form submitted via MCRMC website, April 7, 2014.

The decisions you have to make are hard and will not be popular, as the system costs so much to maintain, but please be considerate and do your best.…Thank you for your efforts on this very important issue.[19]

I'm very happy with the retirement plan I signed up for, but can see that it is probably not a sustainable option for the future, so I'm happy that you are looking into options for future retirees (as long as they get the retirement benefit that they sign up for).[20]

Although I think everyone would like to have more entitlements, we must balance that with the overall cost. I risked my life in war and now feel the Army promises were lived up to the maximum extent. I am very happy with the current system.[21]

I just want a fair and comparable compensation package [commensurate] to the civilian sector, the number of hours I work, along with the sacrifice me and my family make on a daily basis.[22]

COMMENTS REGARDING PAY AND RETIREMENT

Feedback to the Commission encompassed the full breadth of pay and retirement, offering diverse comments from all perspectives, including that of active, Reserve Component, veteran, and retired Service members.

When facing 20-plus years of relocating, and extended periods of isolation from family, it takes a significant group of benefits to compensate for the loss of stability a military career brings. When every day you voluntarily place your life on the line, your compensation cannot be compared to the average office or retail worker who goes home to the same house for years on end. The promise of lifetime medical coverage and a retirement check helps to compensate for inequities suffered by the average military person.…I cherish my experiences in my 23-year career, but had the promise of the retirement pay, medical coverage, and other benefits such as the commissary not been there, my decision to continue after 4 or 6 years would have been much harder and probably would have been different.[23]

Retirement is the most important thing. If you take away retirement, then you are going to get rid of the most valuable people in the military, quickly.[24]

Above all else, if my retirement is changed, I will get out as soon as possible with no second thoughts.[25]

[19] MCRMC letterwriter, comment form submitted via MCRMC website, August 7, 2014.
[20] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[21] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[22] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[23] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[24] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[25] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

> *I don't think that we should change anything for retirement. A significant portion of the reason that I have decided to stay in is the option to retire after only 20 years of work while I am still young enough to enjoy the childhood of my (future) children. If I had to wait until age 65, had to receive a lump sum and then wait until age 65, or had to work longer before I could retire, then I would have gotten out of the Army a lot sooner.*[26]

> *Reducing in any way the retirement pay or benefits of those who have served with honor and retired is a breach of faith. Doing it to military retirees is still immoral and unethical [and] reducing or changing retirement plans for active-duty members, particularly those in initial obligated service, is morally [unreasonable]…any reduction in compensation or change in compensation structure will alter the willingness of our best and brightest to commit to careers.*[27]

Many of the comments regarding potential changes to compensation supported retirement savings for those who do not serve the 20 years required for retirement benefits eligibility under the current system.

> *There is no reason that 85 percent of the military separates with nothing to show for it when you could do a standard retirement system with increasing contributions the more senior you get.*[28]

> *There should be some type of retirement or IRA for those individuals who leave the military before 20 years. Twenty years is the gold standard for service to receive a retirement benefit. In a 20-year career you can expect a combat deployment, peace keeping mission, or unaccompanied tour. The toll is enough that after 20 years you should be able to enjoy the financial stability that a retirement pension would offer.*[29]

> *What needs to be addressed is personnel who either voluntarily, or otherwise, are separated. They should have a matching TSP/401(k) because walking away with nothing after 10 years of service is wrong…I know of no company that doesn't let you leave with your 401(k) contributions and vesting after 5 years.*[30]

Other comments noted the value of retirement savings programs—and encouraged potential DoD matching of retirement contributions—as an additional savings tool, regardless of whether Service members pursue a traditional retirement track.

> *Mandatory TSP enrollment is a good idea, with matching Government contributions, but the military retirement system should not be changed.*[31]

[26] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[27] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[28] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[29] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[30] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[31] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

> *There was no Thrift Savings when I served, and I did not save! In my USG jobs I participated in TSP fully and saved a lot in 18 years. Young soldiers need the push of a required percentage contribution to TSP, and a substantial match will, over a 20-year career, make all the difference. The required contribution should be the same as the match.*[32]

> *I think that the current military retirement system is broken and unsustainable. The Army needs to adopt some kind of TSP matching that encourages Soldiers to make responsible saving decisions with their own money…[and with] proper financial counseling. The system sets people without financial literacy up for failure.*[33]

Some feedback regarding pay and retirement addressed more specific concerns and suggestions for modernizing the current compensation structure.

> *I am pleased with my military retirement structure as it stands today; however, I also see the need for a restructure….I feel strongly that 50 percent should be a minimum, but with more individuals retiring at a "working age," I could see a small lump sum, with reduced annuities, and full restoration at 65 as a viable alternative. Although the retirement is not a "living wage," the retirement pay, specifically when combined with the medical coverage, offers the flexibility to seek employment, without the worry that a marginal employment situation (far too common in today's workforce) and the cost of health care will leave a family destitute.*[34]

> *Bottom line is that some of the changes to the military can be done, but we need higher pay. For the lower-ranking individuals (the meat and potatoes of the military), they earn significantly less than your officers and high-ranking enlisted members. Military members should never qualify for extra Government assistance because they don't make enough money.*[35]

> *Our payment structure should be based upon rank, qualifications/ education, and hardship/deployment activities. A solution might be to have a base pay 75 percent equal to what we have now and offer an extra money per month for those with degrees, certifications, and specialized skills. Each skill, language, degree would add additional dollar amounts depending on what the Navy, COs, and mission needed (members could seek out training and schools with their own money if they knew they would be paid more).*[36]

> *Equalize and standardize Active versus RC retirement. If Active can collect checks immediately upon retirement after 20 good years, why can't RC do the same? Why does RC have to wait until age 60 to collect? Make AC wait until age 60 to collect retirement checks also and save the*

[32] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[33] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[34] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[35] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[36] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

Government billions of dollars! Help them transition to civilian careers or to RC and keep growing their retirement.[37]

The increases in military retired pay each year should be tied to the same rates as with the active duty. I am very happy with my retired pay, but felt very slighted that once I retired, active-duty pay scales have skyrocketed, while the retired pay scale has inched its way up about 1 percent per year.[38]

Traditional pay scale for retirement is a significant benefit; however, if we HAD TO, I could see a two-step scale, with a lower percentage from retirement date until 55 or 60, then full payment per current scale thereafter.[39]

SBP and DIC are two separate programs and should not be offset. Retirees can get concurrent receipt. Widows should get what the Military promised and spouses paid [for] with their lives. I read that only 3 percent of all veterans that have ever served actually retire. The widows deserve what is promised for their sacrifice.[40]

The SBP-DIC offset takes thousands of dollars out of those families' pockets that really need it. I am asking that the SBP-DIC offset be eliminated. I know this has been an ongoing issue, but it is time to do the right thing.[41]

Several respondents emphasized that issues of Uniformed Services pay and retirement should not be viewed through the lens of civilian society because the choice to commit to serve places limits on the amount Service members and their families can earn and save for retirement.

Military professionals now have a lot of comparative professions in the community, and when a service member makes that decision of going into the military they may be foregoing something out in the civilian community. They should be compensated similarly.[42]

The life of a Service member greatly impacts the ability of the service member's spouse to gain employment, build a career, generate income, and save retirement funds. Regardless of branch or specialty, active-duty Service members move frequently…This proves extremely difficult for many spouses regardless of profession or education level. Spouses may need to acquire new certificates and licenses from state to state, which takes time and money. Many employers avoid hiring military spouses because they are seen as temporary workers. Even if a military spouse finds employment he/she most likely will not work long enough at that company

[37] MCRMC letter writer, comment form submitted via MCRMC website, June 13, 2014.
[38] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[39] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[40] MCRMC letterwriter, comment form submitted via MCRMC web site, April 8, 2014.
[41] MCRMC letterwriter, comment form submitted via MCRMC website, November 4, 2013.
[42] Audience member, comment made at MCRMC town hall meeting, Joint Base Lewis-McChord, Tacoma, Washington, December 12, 2013, http://www.mcrmc.gov/public/docs/meetings/20131212/JBLM_Town_Hall_20131212.pdf.

> *[to] earn promotions or build retirement benefits with the company. Serving in the military is truly a sacrifice for the entire family. Today's American families often depend on dual income spouses to pay the bills and save for retirement. When one spouse serves as an active-duty service member, dual income is often not possible.*[43]

COMMENTS REGARDING HEALTH BENEFITS

Health care was an important concern expressed across all demographics and generated passionate responses. Feedback focused primarily on health care quality, access, and cost. For many respondents, especially retirees, the primary concern was continued access to military health benefits. Many perceived the provision of health benefits to be a "promise" made by the military to those retired from Service and expressed concern about an erosion or elimination of health care benefits.

> *The medical benefits of retiring from the military and being able to count on reliable, cost effective, and timely health care will be important for me when I do retire. If I put in the time and endure the sacrifices that go along with being deployed and serving 20 years, the light at the end of the tunnel is retiring and having the comfort of having good health care after I do retire.*[44]

> *Copays and TRICARE fees are not the free health care we were promised. Forced enrollment in Medicare-B at 65 is not free health care. This country should keep the promises it made. God knows we kept our promises to serve at risk of life and limb.*[45]

> *[I was] overall very happy serving 22 years in the Navy. Had a great time; wish I was still active. My only concern is during my entire career I was told, "do a career and the Navy will take care of you with medical care for life." [I] did not find out this was not true until my preretirement class.*[46]

Though many Service members and retirees felt that increases in costs erode the health care benefit they believe they were promised, some respondents indicated a limited support for modest increases in costs to preserve or improve the quality of the health benefit.

> *I'm one of those promised free lifetime medical care by my recruiter. I already think the Government broke a promise by making us pay for TRICARE. But I'm still willing to pay a little more as long as benefits remain essentially the same.*[47]

> *[I am] very happy with current medical care (TRICARE Prime); I recognize that the premiums are unreasonably low. [I] would not be averse to a one-time significant raise in premiums (say to $1,000 per year) with inflation*

[43] MCRMC letterwriter, comment form submitted via MCRMC web site, July 14, 2014.
[44] MCRMC letterwriter, comment form submitted via MCRMC web site, August 17, 2014.
[45] MCRMC letterwriter, comment form submitted via MCRMC website, July 31, 2014.
[46] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[47] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

adjustment in the future in order to retain quality of service provided by TRICARE Prime. But I need assurance it would not be the first step to many more significant raises.[48]

I would be happy to pay a copay if my family and I had access to quality insurance….TRICARE Prime means we can't see good doctors, we have to waste our time jumping through hoops to ever be seen by a specialist or get preventive tests or screening. My family doesn't meet the "criteria" for any quality screening like genetic cancer predisposition, so we are forced to spend our meager savings for mammograms, blood tests, chiropractors, and quality health care that the military won't allow us to see.[49]

Paying minimal cost for health care is very important and I think the most underrated military benefit. However, I think we need more freedom to choose civilian providers especially with children with special needs.[50]

Some respondents expressed support for the current TRICARE and military treatment facility (MTF) systems and concern about potential changes to those systems.

I have only the greatest appreciation for all of my military benefits. In general, all medical services provided seem to be done with both care and competence. Delays in medical services seem to occur everywhere—in both the civilian and military worlds—as so many (too many?) people seek them out. [51]

I am very happy with my pay and TRICARE. I worried at the many changes I hear of and see coming down the pike. I feel sorry for soldiers now serving because they are "not" being taken care of as I was. I believe they will lose more benefits and TRICARE will be watered down or eliminated.[52]

I am sold on my MTF. It takes approximately 50 minutes to get to it because I live in the country. I have tried using civilian doctors, but they are not as organized and fluid as my MTF. When necessary, the MTF has always provided great doctors outside the MTF. I am very happy with my current health care. Don't mess with it in a negative manner. Add to it in a positive manner.[53]

A substantial number of comments from Service members and families reflected concerns about access to health care, including a desire for increased choice and flexibility in seeking quality medical care.

Currently I am not allowed to see a civilian provider even if it's 3 minutes away. I have to wait almost 2 months to see a specialist. Current rules state if no appointments are available within 2 months, I can see a civilian;

[48] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[49] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014. (TRICARE does provide coverage for routine mammograms and blood tests.)
[50] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[51] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[52] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[53] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

however the hospitals have found a way around that by not putting out schedules for 2 months and making you continually call back for appointments instead of allowing you to see a civilian.[54]

I live an hour or so from the nearest base….I only access military medical care for overseas travel preparation. Am very happy with my pension and medical care on TRICARE Standard/Extra, [but] it is very important to me to have access to a nearby medical facility since I am single and must get myself there if I am ill.[55]

Quality health care is very limited in this area. Almost all specialists are a minimum of a 90-minute drive one way. The MTF has only two unexperienced doctors and one PA assigned. Quality of care at the MTF is as bad as or worse than what has been reported for the VA.[56]

[I] recommend dependents and retirees be cared for by civilian providers of their choice, paid for by savings from contracting this expensive service out to civilian sector.[57]

My family and I made an informed decision to purchase health care. If we need a specialist, we can see a specialist without going through countless appointments at the MTF before a referral to a specialist is provided. It is a cost we have knowingly absorbed to have access to quality health care.

The military would perhaps be best served if we integrated our military medical services with the civilian services so that we would not have military hospitals with only one surgeon, limited internists, and few specialists. I feel that our civilian medical services could only benefit if our military medical officers were required to be credentialed at civilian facilities, and were in fact entitled to practice, and even required to practice, at these civilian facilities.[58]

COMMENTS REGARDING QUALITY OF LIFE BENEFITS

The Commission received a substantial number of comments regarding the many quality of life programs across the Services. Feedback illuminated the importance of these programs that are, in many cases, beloved by Service members, retirees, and their families. They are often perceived as central to the positive experience of Service life. The quality of life benefit the Commission heard most about was the commissary. Though some respondents expressed ambivalence about the commissary benefit or concern about its cost, many expressed a desire for preservation of the benefit, both as a means of providing discounted retail offerings and as a unique experience that brings the military community together. Similar opinions were often expressed about military exchanges.

[54] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[55] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[56] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[57] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[58] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

If you want to keep an all-volunteer military, you must keep the benefits that are in place as of today and for the future. All that are serving and have served depend on the commissary and exchange for low-cost goods. If the Commission does not recommend a pay increase, all benefits are extremely needed.[59]

Commissary (I earned it, don't mess with it!) Exchanges (I earned it, don't mess with it!)[60]

I am very happy to have a small commissary within a 30-minute drive—not just because of the savings, but because it's there just for U, and I enjoy seeing the military members, retirees, and their families taking advantage of the benefit.[61]

I love the commissary benefit and think it would be horrible to remove it. The benefit goes further than grocery savings, the jobs it provides to spouses and retirees (bagging) and the great sense of community when you walk through there.[62]

Many respondents noted lower-paid Service members, retirees on fixed budgets, and their families disproportionately rely on the savings provided by the commissaries and exchanges.

We depend on the commissary to survive the high prices on the outside. We [can't] afford to eat on what our financial status allows. We can't do without it!!!! Please keep it open!!!!!!![63]

The commissary for your people who—I'm talking about your young people who are E4 and below, with families—and everybody else—it's much cheaper for them to buy stuff at the commissary. And if you walk up and down the aisles, it is so prevalent that people are getting WIC…it's labeled what items are available for WIC at the commissary.

Where we live there is only one commissary to serve the lower half of the state. At and just after the first of the month (and at case lot sales) the commissary is filled with retirees (some who travel great distances) taking advantage of the discounts afforded by this valuable benefit. In our area, access to the commissary provides my family with a savings of 30 percent over local stores. While there are some items that may be found at a lower individual price on the economy, the total combined savings remains constant. In closing, while we generally understand the funding constraints, it is unfathomable that the DoD and the services would acquiesce to plans that seriously degrade our hard earned benefits.[64]

[59] MCRMC letterwriter, comment form submitted via MCRMC web site, June 18, 2014.
[60] MCRMC letterwriter, comment form submitted via MCRMC web site, November 13, 2013.
[61] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[62] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[63] MCRMC letterwriter, comment form submitted via MCRMC web site, June 20, 2014.
[64] MCRMC letterwriter, comment form submitted via MCRMC web site, April 8, 2014.

Some who offered feedback observed that exchange profits fund Morale, Welfare, and Recreation (MWR) services, which benefit Service members and families, and they expressed concern that a cut to retail services may adversely affect MWR services.

> *[Exchanges are] also providing a dividend back to MWR every year, which is then recycled into bowling centers and sailor Liberty centers. I'm reinvesting into my facilities. So, I would offer to you that if you only have limited dollars then if you've got a…Government funded program that's giving you a [return] on your tax-payer dollar, then I think you're getting high leverage.*[65]

> *They do provide something good to the post—or to the base, whichever service you may be in. And the morale fund, there's a lot of that feedback. And if that goes, who's gonna be supporting the teen centers and the swimming pools for the families that can use it?*[66]

Some feedback did, however, suggest closing commissaries to reduce military spending. Alternatively, some respondents suggested giving Service members permanent raises in lieu of a commissary benefit.

> *The commissary is a waste of Government money stateside. The whole agency should be reduced to only support OCONUS bases—then it would not have to be its own agency either. Wrap it up under DLA.*[67]

> *Eliminate the commissary and pay people slightly more (2.5-5 percent) [instead] and you would eliminate all the overhead of running a grocery store.*[68]

The Commission also heard substantial feedback regarding education programs and benefits, including dependent education, tuition assistance, and the GI Bill.

> *Sir, I'll give you an example that's been a great retention tool for individuals that have children, and that is the GI Bill and the ability to gift that to either their spouse or to their children.*[69]

> *A lot of people coming in already have an undergraduate degree. There are very few graduate level programs for your enlisted. A lot of the programs are only for officers. But I was meeting people straight out of boot camp who had undergraduate degrees, and they were E3s….because a lot of your Force coming in now, because there [are not] any jobs, are very well educated.*[70]

---

[65] RADM Robert Bianchi, testimony given at MCRMC public hearing 3, Naval Base Norfolk, Norfolk, VA, December 13, 2013, http://www.mcrmc.gov/index.php/schedule?id=60.
[66] Audience member, comment made at MCRMC town hall meeting, Joint Base San Antonio, San Antonio, Texas, January 7, 2014, http://www.mcrmc.gov/public/docs/meetings/20140107/JBSA_Town_Hall_20140107.pdf.
[67] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[68] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[69] Col. Kevin McMahan, testimony made at MCRMC public hearing, Joint Base Lewis-McChord, Tacoma, Washington, December 13, 2013, http://www.mcrmc.gov/public/docs/meetings/20131213/MCRMC_JBLM_13_Dec_13_AM.pdf.
[70] Audience member, comment made at MCRMC town hall meeting, BASE, Naval Station Norfolk, Norfolk, Virginia, January 7, 2014, http://www.mcrmc.gov/public/docs/meetings/20131202/MCRMC-Norfolk-Dec02-Panel3-20131202.pdf.

Programs and assistance for Service members transitioning to the civilian workforce were a key concern of those who communicated with the Commission.

> *Transition centers and plans from military to civilian life are poorly set-up and do little to actually help the transitioning service member. [The] program needs to get fixed! Job placement should be the focus.*[71]

> *Prepare the service member throughout their career [for transition].*[72]

> *We need to develop partnerships and get students out of the classroom, start the conversation. Networking is an art form.*[73]

> *I never received any retirement transition program information.*[74]

> *Military commanders need to be held accountable for not allowing Service members to properly schedule appointments for and complete the Army Career and Alumni Program/ Transition Assistance Program.*[75]

> *I think a good step toward a real fix would be to make the VA and DoD to work together [on military transition]. Have both under the same roof and same office. When a service member in transition—like retirement, both normal and medical—their records are not looked at after the service member leaves service, but before. Make it a part of the out processing. No Service member should be released from service until it is done and appeals are exhausted. I have seen many Service members retire only to face months or even years waiting on backlogs, and unable to work.*[76]

Dependent programs, especially DoD schools and the Exceptional Family Member Program (EFMP), were praised as key to the quality of life of Service families. Others, such as child care services, were identified as in need of improvement.

> *DoD schools provide a wonderful service. They're popular with the families that use them. They're popular with the commands at the installation where they're located. And they're also popular in the communities where they're located.*[77]

> *Respite care and the programs through EFMP that offer assistance to those with special needs family members are great.*[78]

> *Regarding child care, the Child Development Centers on base are wonderful and the staff are very loving and nurturing toward the children. My complaint is that at bases with 24-hour operations, there are no 24-hour child care facilities, limited local options, and no Family Child Care*

[71] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.
[72] Summary report, MCRMC sensing sessions, North Carolina, South Carolina, Georgia, August 18-20, 2014.
[73] Summary report, MCRMC sensing sessions, North Carolina, South Carolina, Georgia, August 18-20, 2014.
[74] Summary report, MCRMC sensing sessions, North Carolina, South Carolina, Georgia, August 18-20, 2014.
[75] Summary report, MCRMC sensing sessions, North Carolina, South Carolina, Georgia, August 18-20, 2014.
[76] MCRMC letterwriter, comment form submitted via MCRMC web site, March 20, 2014.
[77] Audience member, comment made at MCRMC town hall meeting, Fort Belvoir, Alexandria, Virginia, November 4, 2013, http://www.mcrmc.gov/public/docs/meetings/20131104/Transcript_Nov_4_13_Town_Hall.pdf.
[78] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

> *homes willing to care for children on nights, weekends, or overnight when active-duty parents have to work. Military parents who are shift workers have to find nannies or some form of alternative care for their children, which is a huge additional expense that is not factored in and a huge stressor.*[79]

Together, the letters, e-mails, testimony, and survey comments painted a deeply personal picture of the experiences regarding pay and benefits of our Service members, current and retired, and their families. These personal observations and suggestions helped the Commission develop avenues of inquiry, informed our discussions and deliberations, and directly contributed to the recommendations put forth in this report. The Commission thanks each person who provided comments and helped make the recommendations in this report better.

[79] Survey respondent, comment submitted via MCRMC survey, July 1, 2014 to October 10, 2014.

APPENDIX A: GUIDING AND ENABLING DOCUMENTS

National Defense Authorization Act (NDAA) for Fiscal Year 2013

[112th Congress, Public Law 112-239, Section 671, 126 Stat. 1632, 1787 (2013)]

SEC. 671. PURPOSE, SCOPE, AND DEFINITIONS.

(a) PURPOSE.—The purpose of this subtitle is to establish the Military Compensation and Retirement Modernization Commission to conduct a review of the military compensation and retirement systems and to make recommendations to modernize such systems in order to—

(1) ensure the long-term viability of the All-Volunteer Force by sustaining the required human resources of that force during all levels of conflict and economic conditions;

(2) enable the quality of life for members of the Armed Forces and the other uniformed services and their families in a manner that fosters successful recruitment, retention, and careers for members of the Armed Forces and the other uniformed services; and

(3) modernize and achieve fiscal sustainability for the compensation and retirement systems for the Armed Forces and the other uniformed services for the 21st century.

(b) SCOPE OF REVIEW.—

(1) REQUIRED ELEMENTS OF REVIEW.—In order to provide the fullest understanding of the matters required to balance the primary purpose of the review specified in subsection (a), the Commission shall make its recommendations for changes to the military compensation and retirement systems only after—

(A) examining all laws, policies, and practices of the Federal Government that result in any direct payment of authorized or appropriated funds to—

(i) current and former members (veteran and retired) of the uniformed services, including the reserve components of those services; and

(ii) the spouses, family members, children, survivors, and other persons authorized to receive such payments as a result of their connection to the members of the uniformed services named in clause (i);

(B) examining all laws, policies, and practices of the Federal Government that result in any expenditure of authorized or appropriated funds to support the persons named in subparagraph (A) and their quality of life, including—

(i) health, disability, survivor, education, and dependent support programs of the Department of Defense and the Department of Veterans Affairs, including outlays from the various Federal trust funds supporting those programs;

(ii) Department of Education impact aid;

(iii) support or funding provided to States, territories, colleges and universities;

(iv) Department of Defense morale, recreation, and welfare programs, the resale programs (military exchanges and commissaries), and dependent school system;

(v) the tax treatment of military compensation and benefits; and

(vi) military family housing; and

(C) such other matters as the Commission considers appropriate.

(2) PRIORITIES.—In weighing its recommendations on those matters necessary to sustain the human resources of the All-Volunteer Force, the Commission shall—

(A) pay particular attention to the interrelationships and interplay of impact between and among the various programs of the Federal Government, especially as those programs influence decisions of persons about joining the uniformed services and of members of the uniformed services about remaining in the those services; and

(B) closely weigh its recommendations regarding the web of interrelated programs supporting spouses and families of members of the uniformed services, so that changes in such programs do not adversely impact decisions to remain in the uniformed services.

(3) EXCEPTION.—The Commission shall not examine any program that uses appropriated funding for initial entry training or unit training of members of the uniformed services.

(c) DEFINITIONS.—In this subtitle:

(1) The term "Armed Forces" has the meaning given the term "armed forces" in section 101(a)(4) of title 10, United States Code.

(2) The term "Commission" means the Military Compensation and Retirement Modernization Commission established by section 672.

(3) The term "Commission establishment date" means the first day of the first month beginning on or after the date of the enactment of this Act.

(4) The term "military compensation and retirement systems" means the military compensation system and the military retirement system.

(5) The term "military compensation system" means provisions of law providing eligibility for and the computation of military compensation, including regular military compensation, special and incentive pays and allowances, medical and dental care, educational assistance and related benefits, and commissary and exchange benefits and related benefits and activities.

(6) The term "military retirement system" means retirement benefits, including retired pay based upon service in the uniformed services and survivor annuities based upon such service.

(7) The term "Secretary" means the Secretary of Defense.

(8) The term "uniformed services" has the meaning given that term in section 101(a)(5) of title 10, United States Code.

(9) The terms "veterans service organization" and "military related advocacy group or association" mean an organization whose primary purpose is to advocate for veterans, military personnel, military retirees, or military families.

SEC. 672. MILITARY COMPENSATION AND RETIREMENT MODERNIZATION COMMISSION.

(a) ESTABLISHMENT.—There is established in the executive branch an independent commission to be known as the Military Compensation and Retirement Modernization Commission. The Commission shall be considered an independent establishment of the Federal Government as defined by section 104 of title 5, United States Code, and a temporary organization under section 3161 of such title.

(b) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of nine members appointed as follows:

(A) The President shall appoint one member.

(B) The Majority Leader of the Senate, in consultation with the Chairman of the Committee on Armed Services of the Senate, shall appoint two members.

(C) The Minority Leader of the Senate, in consultation with the Ranking Member of the Committee on Armed Services of the Senate, shall appoint two members.

(D) The Speaker of the House of Representatives, in consultation with the Chairman of the Committee on Armed Services of the House of Representatives, shall appoint two members.

(E) The Minority Leader of the House of Representatives, in consultation with the Ranking Member of the Committee on Armed Services of the House of Representatives, shall appoint two members.

(2) DEADLINE FOR APPOINTMENT.—Members shall be appointed to the Commission under paragraph (1) not later than four months after the Commission establishment date.

(3) QUALIFICATIONS OF INDIVIDUALS APPOINTED.—In appointing members of the Commission, the President and Members of Congress specified in paragraph (1) shall ensure that, collectively, there are members with significant expertise regarding the matters described in section 671. The types of specific expertise and experience to be considered include the following:

(A) Federal civilian employee compensation and retirement.

(B) Military compensation and retirement.

(C) Private-sector compensation, retirement, or human resource systems.

(D) Active-duty service in a regular component of the uniformed services.

(E) Service in a reserve component.

(F) Experience as a spouse of a member of the uniformed services.

(G) Service as an enlisted member of the uniformed services.

(H) Military family policy development and implementation.

(I) Department of Veterans Affairs benefit programs.

(J) Actuarial science.

(4) LIMITATION.—An individual who, within the preceding year, has been employed by a veterans service organization or military-related advocacy group or association may not be appointed to the Commission.

(c) CHAIR.—The President shall designate one of the members of the Commission to be Chair of the Commission. The individual designated as Chair of the Commission shall be a person who has expertise in the military compensation and retirement systems. The Chair, or the designee of the Chair, shall preside over meetings of the Commission and be responsible for establishing the agenda of Commission meetings and hearings.

(d) TERMS.—Members shall be appointed for the life of the Commission. A vacancy in the Commission shall not affect its powers, and shall be filled in the same manner as the original appointment was made.

(e) STATUS AS FEDERAL EMPLOYEES.—Notwithstanding the requirements of section 2105 of title 5, United States Code, including the required supervision under subsection (a)(3) of such section, the members of the Commission shall be deemed to be Federal employees.

(f) PAY FOR MEMBERS OF THE COMMISSION.—

(1) IN GENERAL.—Each member, other than the Chair, of the Commission shall be paid at a rate equal to the daily equivalent of the annual rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission.

(2) CHAIR.—The Chair of the Commission shall be paid at a rate equal to the daily equivalent of the annual rate of basic pay payable for level III of the Executive Schedule under section 5314, of title 5, United States Code, for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission.

SEC. 673. COMMISSION HEARINGS AND MEETINGS.

(a) IN GENERAL.—The Commission shall conduct hearings on the recommendations it is taking under consideration. Any such hearing, except a hearing in which classified information is to be considered, shall be open to the public. Any hearing open to the public shall be announced on a Federal website at least 14 days in advance. For all hearings open to the public, the Commission shall release an agenda and a listing of materials relevant to the topics to be discussed.

(b) MEETINGS.—

(1) INITIAL MEETING.—The Commission shall hold its initial meeting not later than 30 days after the date as of which all members have been appointed.

(2) SUBSEQUENT MEETINGS.—After its initial meeting, the Commission shall meet upon the call of the Chair or a majority of its members.

(3) PUBLIC MEETINGS.—Each meeting of the Commission shall be held in public unless any member objects.

(c) QUORUM.—Five members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(d) PUBLIC COMMENTS.—

(1) SOLICITATION.—The Commission shall seek written comments from the general public and interested parties on measures to modernize the military compensation and retirement systems. Comments shall be requested through a solicitation in the Federal Register and announcement on the Internet website of the Commission.

(2) PERIOD FOR SUBMITTAL.—The period for the submittal of comments pursuant to the solicitation under paragraph (1) shall end not earlier than 30 days after the date of the solicitation and shall end on or before the date on which the Secretary transmits the recommendations of the Secretary to the Commission under section 674(b).

(3) USE BY COMMISSION.—The Commission shall consider the comments submitted under this subsection when developing its recommendations.

(e) SPACE FOR USE OF COMMISSION.—Not later than 90 days after the date of the enactment of this Act, the Administrator of General Services, in consultation with the Secretary, shall identify and make available suitable excess space within the Federal space inventory to house the operations of the Commission. If the Administrator is not able to make such suitable excess space available within such 90-day period, the Commission may lease space to the extent the funds are available.

(f) CONTRACTING AUTHORITY.—The Commission may acquire administrative supplies and equipment for Commission use to the extent funds are available.

SEC. 674. PRINCIPLES AND PROCEDURE FOR COMMISSION RECOMMENDATIONS.

(a) CONTEXT OF COMMISSION REVIEW.—The Commission shall conduct a review of the matters described in section 671, including current military compensation and retirement systems, force management objectives, and changes in life expectancy and the labor force.

(b) DEVELOPMENT OF COMMISSION RECOMMENDATIONS.—

(1) CONSISTENCY WITH PRESIDENTIAL PRINCIPLES.—Subject to paragraph (2), the Commission shall develop recommendations that are consistent with the principles established by the President under subsection (c) and section 671.

(2) GRANDFATHERING OF RETIRED PAY.—

(A) CONDITIONS.—In developing its recommendations, the Commission shall comply with the following conditions with regard to the treatment of retired pay for members and retired members of the uniformed services who joined a uniformed service before the date of the enactment of an Act to modernize the military compensation and retirement systems:

(i) For members of the uniformed services as of such date, who became members before the enactment of such an Act, the monthly amount of their retired pay may not be less than they would have received under the current military compensation and retirement system, nor may the date at which they are eligible to receive their military retired pay be adjusted to the financial detriment of the member.

(ii) For members of the uniformed services retired as of such date, the eligibility for and receipt of their retired pay may not be adjusted pursuant to any change made by the enactment of such an Act.

(B) VOLUNTARY ELECTION EXCEPTION.—Nothing in subparagraph (A) prevents a member described in such subparagraph from voluntarily electing to be covered under the provisions of an Act to modernize the military compensation and retirement systems.

(c) PRESIDENTIAL PRINCIPLES.—Not later than five months after the Commission establishment date, the President shall establish and transmit to the Commission and Congress principles for modernizing the military compensation and retirement systems. The principles established by the President shall address the following:

(1) Maintaining recruitment and retention of the best military personnel.

(2) Modernizing the regular and reserve military compensation and retirement systems.

(3) Differentiating between regular and reserve military service.

(4) Differentiating between service in the Armed Forces and service in the other uniformed services.

(5) Assisting with force management.

(6) Ensuring the fiscal sustainability of the military compensation and retirement systems.

(7) Compliance with the purpose and scope of the review prescribed in section 671.

(d) SECRETARY OF DEFENSE RECOMMENDATIONS.—

(1) DEADLINE.—Not later than nine months after the Commission establishment date, the Secretary shall transmit to the Commission the recommendations of the Secretary for modernization of the military compensation and retirement systems. The Secretary shall concurrently transmit the recommendations to Congress.

(2) DEVELOPMENT OF RECOMMENDATIONS.—The Secretary shall develop the recommendations of the Secretary under paragraph (1)—

(A) on the basis of the principles established by the President pursuant to subsection (c);

(B) in consultation with the Secretary of Homeland Security, with respect to recommendations concerning members of the Coast Guard;

(C) in consultation with the Secretary of Health and Human Services, with respect to recommendations concerning members of the Public Health Service;

(D) in consultation with the Secretary of Commerce, with respect to recommendations concerning members of the National Oceanic and Atmospheric Administration; and

(E) in consultation with the Director of the Office of Management and Budget.

(3) JUSTIFICATION.—The Secretary shall include with the recommendations under paragraph (1) the justification of the Secretary for each recommendation.

(4) AVAILABILITY OF INFORMATION.—The Secretary shall make available to the Commission and to Congress the information used by the Secretary to prepare the recommendations of the Secretary under paragraph (1).

(e) COMMISSION HEARINGS ON RECOMMENDATIONS OF SECRETARY.—After receiving from the Secretary the recommendations of the Secretary for modernization of the military compensation and retirement systems under subsection (d), the Commission shall conduct public hearings on the recommendations.

(f) COMMISSION REPORT AND RECOMMENDATIONS.—

(1) REPORT.—Not later than 15 months after the Commission establishment date, the Commission shall transmit to the President a report containing the findings and conclusions of the Commission, together with the recommendations of the Commission for the modernization of the military compensation and retirement systems. The Commission shall include in the report legislative language to implement the recommendations of the Commission. The findings and conclusions in the report shall be based on the review and analysis by the Commission of the recommendations made by the Secretary under subsection (d).

(2) REQUIREMENT FOR APPROVAL.—The recommendations of the Commission must be approved by at least five members of the Commission before the recommendations may be transmitted to the President under paragraph (1).

(3) PROCEDURES FOR CHANGING RECOMMENDATIONS OF SECRETARY.—The Commission may make a change described in paragraph (4) in the recommendations made by the Secretary only if the Commission—

(A) determines that the change is consistent with the principles established by the President under subsection (c);

(B) publishes a notice of the proposed change not less than 45 days before transmitting its recommendations to the President pursuant to paragraph (1); and

(C) conducts a public hearing on the proposed change.

(4) COVERED CHANGES.—Paragraph (3) applies to a change by the Commission in the recommendations of the Secretary that would—

(A) add a new recommendation;

(B) delete a recommendation; or

(C) substantially change a recommendation.

(5) EXPLANATION AND JUSTIFICATION FOR CHANGES.—The Commission shall explain and justify in its report submitted to the President under paragraph (1) any recommendation made by the Commission that is different from the recommendations made by the Secretary under subsection (d).

(6) TRANSMITTAL TO CONGRESS.—The Commission shall transmit a copy of its report to Congress on the same date on which it transmits its report to the President under paragraph (1).

SEC. 675. CONSIDERATION OF COMMISSION RECOMMENDATIONS BY THE PRESIDENT.

(a) REPORT OF PRESIDENTIAL APPROVAL OR DISAPPROVAL.—Not later than 60 days after the date on which the Commission transmits its report to the President under section 674, the President shall transmit to the Commission and to Congress a report containing the approval or disapproval by the President of the recommendations of the Commission in the report.

(b) PRESIDENTIAL APPROVAL.—If in the report under subsection (a) the President approves all the recommendations of the Commission, the President shall include with the report the following:

(1) A copy of the recommendations of the Commission.

(2) The certification by the President of the approval of the President of each recommendation.

(3) The legislative language transmitted by the Commission to the President as part of the report of the Commission.

(c) PRESIDENTIAL DISAPPROVAL.—

(1) REASONS FOR DISAPPROVAL.—If in the report under subsection (a) the President disapproves the recommendations of the Commission, in whole or in part, the President shall include in the report the reasons for that disapproval.

(2) REVISED RECOMMENDATIONS FROM COMMISSION.—Not later than one month after the date of the report of the President under subsection (a) disapproving the recommendations of the Commission, the Commission shall transmit to the President revised recommendations for the modernization of the military compensation and retirement systems, together with revised legislative language to implement the revised recommendations of the Commission.

(3) ACTION ON REVISED RECOMMENDATIONS.—If the President approves all of the revised recommendations of the Commission transmitted pursuant to paragraph (2), the President shall transmit to Congress, not later than one month after receiving the revised recommendations, the following:

(A) A copy of the revised recommendations.

(B) The certification by the President of the approval of the President of each recommendation as so revised.

(C) The revised legislative language transmitted to the President.

(d) TERMINATION OF COMMISSION.—If the President does not transmit to Congress an approval and certification described in subsection (b) or (c)(3) in accordance with the applicable deadline under such subsection, the Commission shall be terminated not later than one month after the expiration of the period for transmittal of a report under subsection (c)(3).

SEC. 676. EXECUTIVE DIRECTOR.

(a) APPOINTMENT.—The Commission shall appoint and fix the rate of basic pay for an Executive Director in accordance with section 3161 of title 5, United States Code.

(b) LIMITATIONS.—The Executive Director may not have served on active duty in the Armed Forces or as a civilian employee of the Department of Defense during the one-year period preceding the date of such appointment and may not have been employed by a veterans service organization or a military-related advocacy group or association during that one-year period.

SEC. 677. STAFF.

(a) IN GENERAL.—Subject to subsections (b) and (c), the Executive Director, with the approval of the Commission, may appoint and fix the rate of basic pay for additional personnel as staff of the Commission in accordance with section 3161 of title 5, United States Code.

(b) LIMITATIONS ON STAFF.—

(1) NUMBER OF DETAILEES FROM EXECUTIVE DEPARTMENT.—Not more than one-third of the personnel employed by or detailed to the Commission may be on detail from the Department of Defense and other executive branch departments.

(2) PRIOR DUTIES WITHIN EXECUTIVE BRANCH.—A person may not be detailed from the Department of Defense or other executive branch department to the Commission if, in the year before the detail is to begin, that person participated personally and substantially in any matter concerning the preparation of recommendations for military compensation and retirement modernization.

(3) NUMBER OF DETAILEES ELIGIBLE FOR MILITARY RETIRED PAY.—Not more than one-fourth of the personnel employed by or detailed to the Commission may be persons eligible for or receiving military retired pay.

(4) PRIOR EMPLOYMENT WITH CERTAIN ORGANIZATIONS.—A person may not be employed by or detailed to the Commission if, in the year before the employment or detail is to begin, that person was employed by a veterans service organization or a military-related advocacy group or association.

(c) LIMITATIONS ON PERFORMANCE REVIEWS.—No member of the uniformed services, and no officer or employee of the Department of Defense or other executive branch department, may—

(1) prepare any report concerning the effectiveness, fitness, or efficiency of the performance of the staff of the Commission or any person detailed to that staff;

(2) review the preparation of such a report; or

(3) approve or disapprove such a report.

SEC. 678. JUDICIAL REVIEW PRECLUDED.

The following shall not be subject to judicial review:

(1) Actions of the President, the Secretary, and the Commission under section 674.

(2) Actions of the President under section 675.

SEC. 679. TERMINATION. Except as otherwise provided in this title, the Commission shall terminate not later than 26 months after the Commission establishment date.

SEC. 680. FUNDING. Of the amounts authorized to be appropriated by this Act for the Department of Defense for fiscal year 2013, up to $10,000,000 shall be made available to the Commission to carry out its duties under this subtitle. Funds made available to the Commission under the preceding sentence shall remain available until expended.

NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FOR FISCAL YEAR 2014

[113th Congress, Public Law 113-66, Section 1095(b), 127 Stat. 672, 879 (2013)]

(b) MILITARY COMPENSATION AND RETIREMENT MODERNIZATION COMMISSION.—

(1) SCOPE OF MILITARY COMPENSATION SYSTEM.—Section 671(c)(5) of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112–239; 126 Stat. 1788) is amended by inserting before the period the following ", and includes any other laws, policies, or practices of the Federal Government that result in any direct payment of authorized or appropriated funds to the persons specified in subsection (b)(1)(A)".

(2) COMMISSION AUTHORITIES.—Section 673 of such Act (126 Stat. 1790) is amended by adding at the end the following new subsections:

"(g) USE OF GOVERNMENT INFORMATION.—The Commission may secure directly from any department or agency of the Federal Government such information as the Commission considers necessary to carry out its duties. Upon such request of the Chair of the Commission, the head of such department or agency shall furnish such information to the Commission.

"(h) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

"(i) AUTHORITY TO ACCEPT GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services, goods, and property from non-Federal entities for the purposes of aiding and facilitating the work of the Commission. The authority in this subsection does not extend to gifts of money.

"(j) PERSONAL SERVICES.—

"(1) AUTHORITY TO PROCURE.—The Commission may—

"(A) procure the services of experts or consultants (or of organizations of experts or consultants) in accordance with the provisions of section 3109 of title 5, United States Code; and

"(B) pay in connection with such services travel expenses of individuals, including transportation and per diem in lieu of subsistence, while such individuals are traveling from their homes or places of business to duty stations.

"(2) LIMITATION.—The total number of experts or consultants procured pursuant to paragraph (1) may not exceed five experts or consultants.

"(3) MAXIMUM DAILY PAY RATES.—The daily rate paid an expert or consultant procured pursuant to paragraph (1) may not exceed the daily rate paid a person occupying a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.".

(3) COMMISSION REPORT AND RECOMMENDATIONS.—Section 674(f) of such Act (126 Stat. 1792) is amended—

(A) in paragraph (1)—

(i) by striking "15 months" and inserting "24 months"; and

(ii) by inserting "and recommendations for administrative actions" after "legislative language"; and

(B) in paragraph (6), by inserting ", and shall publish a copy of that report on an Internet website available to the public," after "its report to Congress".

(4) PRESIDENTIAL CONSIDERATION OF COMMISSION RECOMMENDATIONS.—Section 675 of such Act (126 Stat. 1793) is amended by striking subsection (d).

(5) COMMISSION STAFF.—

(A) DETAILEES RECEIVING MILITARY RETIRED PAY.—Subsection (b)(3) of section 677 of such Act (126 Stat. 1794) is amended—

(i) in the paragraph heading, by striking "ELIGIBLE FOR" and inserting "RECEIVING"; and

(ii) by striking "eligible for or receiving military retired pay" and inserting "who are receiving military retired pay or who, but for being under the eligibility age applicable under section 12731 of title 10, United States Code, would be eligible to receive retired pay".

(B) PERFORMANCE REVIEWS.—Subsection (c) of such section is amended—

(i) in the matter preceding paragraph (1), by inserting "other than a member of the uniformed services or officer or employee who is detailed to the Commission," after "executive branch department,"; and

(ii) in paragraph (2), by inserting "(other than for administrative accuracy)" before the semicolon.

(6) TERMINATION OF COMMISSION.—Section 679 of such Act (126 Stat. 1795) is amended by striking "26 months" and inserting "35 months".

(7) FUNDING.—Section 680 of such Act (126 Stat. 1795) is amended—

(A) by striking "$10,000,000" and inserting "$15,000,000"; and

(B) by adding at the end the following new sentence: "Amounts made available under this section after the date of the enactment of the National Defense Authorization Act for Fiscal Year 2014 shall be derived from fiscal year 2013 balances that remain available for obligation on that date."

APPENDIX B: COMMISSION STAFF COMPOSITION

Executive Director

Robert B. Daigle

Deputy Executive Director

Nancy C. Crisman

Pay and Retirement Portfolio

Moira N. Flanders, Associate Director
Lyle J. Hogue, Deputy
Cheryl Blackstone, Col, USMCR
Edna Falk Curtin
Steven C. Cylke
Ronald Garner, Maj, USMCR
Matthew G. Reardon, CAPT, USNR
Albert J. Smith, Maj, USMCR
Derek Vestal, CDR, USN
Jeni Tasken, Intern

Health Benefits Portfolio

Christopher T. Meyer, Associate Director
Alexis Lasselle Ross, Deputy
Deidra Briggs-Anthony, LTC, USA
Trupti N. Brahmbhatt, PhD, CAPT, USN
Gretchen S. Dietrich, Lt Col, USAF

Quality of Life Portfolio

Susan E. Schleigh, Associate Director
Mark A. Murphy, Deputy
Jennifer R. Knowles
John R. O'Hara
Pamela K. Tomlinson

Administration and Operations

Christopher Nuneviller, Associate Director
Claire Zipf Giambastiani, Deputy
Alicia Kuhar
Tywana Sutton
Denise L. Thompson
Molly Ferguson, Intern

General Counsel

Elizabeth DiVecchio Berrigan

Office of the General Counsel

Allison C. George, Deputy General Counsel
Mark Koster, Legislative Counsel
Brandon Ford
Mariam Gillis
Collin Mickle
Patrick Gunson, Legal Administrator Intern

Special Advisors to the Commission

Daniel F. Huck
Frank Thorp IV

Public Relations and Outreach

James Graybeal, Associate Director
Shawn Woodbridge, Deputy

Legislative Affairs

Jennifer R. Knowles

Modeling

Garrett Summers, Lead
Jacqueline DePaulitte, Deputy
Wiley Rittenhouse, LTC, USA

Writing, Editing, and Report Production

Benjamin Bryant, Lead
Jennifer E. McKinney, Deputy
Donald J. Cicotte
Wendy J. LaRue, PhD
Christy Samuels

Web & Technical Operations

Thomas J. Zamberlan, Lead
Alex Estep
Christin Keophila Kenny, Intern

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX C: COMMISSION OUTREACH

The Commission has conducted extensive outreach efforts with diverse stakeholders to gain their input and a better understanding of perceptions, concerns, and priorities regarding military pay and compensation programs. In particular, the Commission has met with numerous groups of Service members, veterans, retirees, and their family members to discuss the pay and benefits that support the All-Volunteer Force. In addition, the Commission has conducted outreach efforts through public hearings, town hall meetings, and conversations with representatives from Government Agencies, Uniformed Services, military and veterans service organizations, research institutions, and other commercial and not-for-profit organizations, as listed below.

These interactions have helped create a foundation of information from which the Commission developed recommendations to modernize pay and compensation programs to do the following

- *ensure the long-term viability of the All-Volunteer Force by sustaining the required human resources of that force during all levels of conflict and economic conditions*
- *enable the quality of life for members of the Armed Forces and the other Uniformed Services and their families in a manner that fosters successful recruitment, retention, and careers for members of the Armed Forces and the other Uniformed Services*
- *modernize and achieve fiscal sustainability for the compensation and retirement systems for the Armed Forces and the other Uniformed Services for the 21st century*[1]

Public Hearings and Town Hall Meetings

Date	Location
November 4, 2013	Public Hearing – Fort Belvoir, Virginia
November 4, 2013	Town Hall Meeting – Fort Belvoir, Virginia
November 5, 2013	Public Hearing – Arlington, Virginia
November 13, 2013	Public Hearing – Arlington, Virginia
December 2, 2013	Town Hall Meeting – Norfolk, Virginia
December 2-3, 2013	Public Hearings – Norfolk, Virginia
December 11, 2013	Town Hall Meeting – Seattle, Washington
December 11-12, 2013	Public Hearings – Seattle, Washington
January 6, 2014	Town Hall Meeting – San Antonio, Texas
January 6-7, 2014	Public Hearings – San Antonio, Texas
March 25, 2014	Town Hall Meeting – Carlsbad, California
March 26, 2014	Public Hearings – San Diego, California

[1] National Defense Authorization Act for FY 2013, Pub. L. No. 112-239, 126 Stat. 1632, 1787 (2013) (as amended by National Defense Authorization Act for FY 2014, Pub. L. No. 113-66, § 1095(b), 127 Stat. 672, 879 (2013)).

May 22, 2014	Town Hall – Tampa, Florida
June 25, 2014	Public Hearing – Fayetteville, North Carolina
June 25, 2014	Town Hall – Fayetteville, North Carolina
October 16, 2014	Town Hall – Killeen, Texas

Military Installations Visited

- Beale Air Force Base, California
- Camp Atterbury, Indiana
- Camp Casey, South Korea
- Commander Fleet Activities Yokosuka, Japan
- Creech Air Force Base, Nevada
- Defense Language Institute Foreign Language Center, California
- Edwards Air Force Base, California
- Eglin Air Force Base, Florida
- Fleet Anti-Submarine Warfare Training Center, California
- Fort Belvoir, Virginia
- Fort Benning, Georgia
- Fort Bragg, North Carolina
- Fort Campbell, Kentucky
- Fort Drum, New York
- Fort Hood, Texas
- Fort Hunter Liggett, California
- Fort Indiantown Gap National Guard Training Center, Pennsylvania
- Fort Irwin, National Training Center, California
- Fort Rucker, Alabama
- Fort Stewart, Georgia
- Fort Wainwright, Alaska
- Hunter Army Airfield, Georgia
- Joint Base Charleston, South Carolina
- Joint Base Elmendorf-Richardson, Alaska
- Joint Base Lewis-McChord, Washington
- Joint Base San Antonio-Fort Sam Houston, Texas
- Joint Force Headquarters, California National Guard, California
- Landstuhl Regional Medical Center, Germany
- Marine Corps Air Ground Combat Center Twenty-Nine Palms, California
- Marine Corps Base Camp Lejeune, North Carolina
- Marine Corps Base Camp Pendleton, California
- Marine Corps Base Kaneohe, Hawaii
- Marine Corps Base Quantico, Virginia
- Marine Corps Recruit Depot Parris Island, South Carolina
- Marine Corps Recruiting Station
  - Chesapeake, Virginia
- Army Recruiting Station
  - Chesapeake, Virginia
  - Hampton Roads, Virginia
  - San Antonio, Texas
  - Tampa, Florida
- MacDill Air Force Base, Florida
- Military Entrance Processing Station, Brooklyn, New York
- Naval Air Station Pensacola, Florida

- Naval Base Point Loma, California
- Naval Base San Diego, California
- Naval Postgraduate School, California
- Naval Recruiting Station
  - Chesapeake, Virginia
  - Hampton Roads, Virginia
  - San Antonio, Texas
  - San Diego, California
  - Seattle, Washington
  - Tampa, Florida
- Naval Station Mayport, Florida
- Naval Station Norfolk, Virginia
- Naval Support Activity Mid-South, Tennessee
- Nellis Air Force Base, Nevada
- Osan Air Base, South Korea
- Texas Army National Guard, 2/149th General Support Aviation Battalion, Texas
- Travis Air Force Base, California
- U.S. Army Garrison Stuttgart (Patch Barracks), Germany
- U.S. Coast Guard Station Kodiak, Alaska
- U.S. Coast Guard Station Portsmouth, Virginia
- United States Military Academy, West Point, New York
- United States Naval Academy, Annapolis, Maryland
- United States Pacific Fleet, Pearl Harbor Naval Base, Hawaii
- Wright-Patterson Air Force Base, Ohio
- Yakota Air Base, Japan
- Yongsan Garrison, Korea

United States Government Engagement

Executive Agencies and Offices

- Executive Office of the President
  - Office of Management and Budget
- Department of the Treasury
- Department of Defense
  - Office of the Secretary of Defense
  - Office of the Joint Chiefs of Staff
  - U.S. Army
  - U.S. Marine Corps
  - U.S. Navy
  - U.S. Air Force
  - National Guard Bureau
- Department of Agriculture
- Department of Commerce
  - National Oceanic and Atmospheric Administration
- Department of Labor
- Department of Health and Human Services
  - Centers for Medicare & Medicaid Services
  - U.S. Public Health Service
- Department of Education
- Department of Veterans Affairs

  - National Cemetery Administration
  - Veterans Benefits Administration
  - Veterans Health Administration
    - Captain James A Lovell Federal Health Care Center, North Chicago, Illinois
    - Gulf Coast Veterans Health Care System-Joint Ambulatory Care Center, Pensacola, Florida
    - Veterans Affairs Southern Nevada Healthcare System, North Las Vegas, Nevada
    - Hampton VA Medical Center, Hampton, Virginia
    - South Texas Veterans Health Care System, San Antonio, Texas
    - VA San Diego Health Care System, San Diego, California
- Department of Homeland Security
  - United States Coast Guard
- U.S. Maritime Administration
  - United States Merchant Marine Academy
- Office of Personnel Management
- Pension Benefit Guaranty Corporation
- Federal Retirement Thrift Investment Board
- Quadrennial Defense Review Independent Panel

Legislative Bodies and Offices

- U.S. Senate
- U.S. House of Representatives
- Congressional Budget Office
- U.S. Government Accountability Office
- Congressional Research Service

FOREIGN MILITARIES

- Australian Defence Force
- Bundeswehr Zentraler Sanitätsdienst (Joint Medical Service), Federal Republic of Germany
- United Kingdom Ministry of Defence
  - Armed Forces' Pay Review Body
  - Joint Forces Command, Defense Medical Services, Surgeon General
  - Office of the Director General of the Army Medical Services

OTHER ORGANIZATIONS

- Acosta Sales and Marketing
- Air Force Aid Society
- Air Force Association
- Air Force Sergeants Association
- American Academy of Actuaries
- American Enterprise Institute
- The American Legion
- American Logistics Association
- America's Health Insurance Plans
- Armed Forces Marketing Council
- Army Emergency Relief

- Army Wife Network
- Association of the United States Army
- Association of the United States Navy
- Blinded Veterans Association
- Blue Cross and Blue Shield of Texas
- Blue Cross Blue Shield Association
- Blue Star Families
- Business Executives for National Security
- Carthage Area Hospital, Carthage, New York
- Center for a New American Security
- Center for Strategic and Budgetary Assessments
- Center for Strategic and International Studies
- Chief Warrant and Warrant Officers Association, United States Coast Guard
- Children's National Medical Center
- Cigna-HealthSpring
- Clear Channel Communications
- ClearPoint Credit Counseling Solutions
- CNA Corporation
- The Coalition to Save our Military Shopping Benefits
- The Coca-Cola Company
- Commissioned Officers Association of the United States Public Health Service
- Concerned Veterans for America
- Consumer Financial Protection Bureau
- Consumers' Checkbook
- Disabled American Veterans
- Doorways to Dreams
- Employee Benefits Research Institute
- Enlisted Association of the National Guard of the United States
- EverFi
- Fairfax County Retirement Administration Office
- FINRA Investor Education Foundation
- Fisher House Foundation
- Fleet Reserve Association
- Fort Drum Regional Health Planning Organization, New York
- George Mason University
- George Washington University
- Gold Star Wives of America
- Health Net
- Health Care Integrators
- Humana
- Huron Healthcare
- Institute for Defense Analyses
- Iraq and Afghanistan Veterans of America
- JP Morgan Chase & Company
- Kaiser Family Foundation
- Kaiser Permanente
- KeepYourPromise Alliance
- Kraft Foods Group, Inc.
- Lend Lease Group
- Lewin Group
- Lowe Campbell Ewald

- Macho Spouse
- Marine Corps League
- Marine Corps Reserve Association
- MAZON: A Jewish Response to Hunger
- Military Chaplains Association-United States of America
- Military Child Education Coalition
- Military Family Advisory Network
- Military Officers Association of America
- Military Order of the Purple Heart
- The Military Produce Group/The Vectre Corporation
- Military Saves
- Military Spouse Magazine
- Military.com
- MITRE
- National Academy of Public Administration
- National Association for Uniformed Services
- National Association of Chain Drug Stores
- National Association of Counties
- National Association of Federally Impacted Schools
- National Guard Association of the United States
- National Military Family Association
- National Veterans Transition Services, Inc.
- Naval Enlisted Reserve Association
- Navy-Marine Corps Relief Society
- Non-Commissioned Officers Association
- Office of Economic and Manpower Analysis
- Pacific Medical Centers
- Procter & Gamble
- Project Hope
- Prudential Insurance
- RAND
- Red Sox Foundation and Massachusetts General Hospital Home Base Program
- Reserve Officers Association
- The Retired Enlisted Association
- River Hospital, Inc., Watertown, New York
- Sacred Heart Health System
- Sacred Heart Hospital, Pensacola, Florida
- Samaritan Medical Center, Watertown, New York
- Scott & White Health Plan
- Sentara Healthcare
- SNAP administering agencies in 25 states
- Society for Human Resources Management
- The Spectrum Group
- Stimson Center
- Student Veterans of America
- Suzi Orman Media, Inc.
- Tampa General Hospital, Tampa, Florida
- TRICARE for Kids Initiative
- Troops to Engineers, San Diego State University
- United Healthcare
- United Services Automobile Association

- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- University Medical Center of Southern Nevada, Las Vegas Nevada
- University of San Diego
- US Family Health Plan Alliance
- USAA Federal Savings Bank
- USMC Life
- Veterans of Foreign Wars
- WEBCO General Partnership
- WIC administering agencies on four military installations
- Wounded Warrior Project
- Zeiders Enterprises

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX D: COST DATA

The Commission estimates that its modernization recommendations would reduce DoD budgetary costs, in FY 2016 constant dollars,[1] by $31.8 billion during FY 2016–FY 2020 and result in annual steady-state savings of $8.7 billion by FY 2046. Federal outlays would decrease by $11.0 billion during FY 2016–FY 2020 and by $12.6 billion annually starting in FY 2053. In then-year (current) dollars, Federal outlays would decline by $12.0 billion during FY2016-FY 2020 and by $40 billion in FY 2055. Overall results are shown in the following summary table, which presents expected costs to implement the Commission's recommendations, costs or savings (presented as negative dollars shown in parentheses) within the budgets of affected Federal agencies, and increases or decreases in both constant and then-year Federal outlays. All costs and savings are presented net of implementation costs.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	348	218	111	120	89	-	-	-
DoD Budget	(4,789)	(4,895)	(7,113)	(7,367)	(7,608)	(8,677)	(8,677)	(8,677)
VA Budget	120	(2,126)	(4,667)	(4,478)	(4,542)	(4,757)	(4,757)	(4,757)
USDA Budget	-	1	1	1	1	1	1	1
Federal Outlays	961	(160)	(3,850)	(3,858)	(4,100)	(12,609)	(12,609)	(12,609)
Federal Outlays (Then-Year $)	961	(175)	(4,073)	(4,199)	(4,553)	(37,564)	(38,748)	(39,972)

For each of the Commission's recommendations, this appendix presents cost estimates and key assumptions related to those estimates. For example, current Service members and retirees are grandfathered in to the existing retirement system,[2] but may opt in to the modernized retirement system. The cost estimate for the Commission's retirement recommendation therefore estimates the percentage of current Service members who will opt in to the new retirement system.

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

The Commission estimates that its retirement recommendation would reduce DoD budgetary costs by $6.1 billion during FY 2016–FY 2020 and result in annual steady-state savings of $1.9 billion by FY 2046. Federal outlays would increase by $7.2 billion during FY 2016–FY 2020, but decrease by $4.7 billion annually starting in FY 2053. In this estimate, DoD budgetary reductions are the net result of decreases in DoD's normal cost payments (NCPs) into the Military Retirement Fund (MRF), increases in automatic and matching contributions for the Service members' Thrift Savings Plan (TSP) accounts, increases in Continuation Pay (CP) for midcareer retention bonuses, and minor funding effects from associated changes in the disability retirement system. Reductions in Government outlays are the net result of changes in payments from the MRF to retired Service members for defined benefit (DB) annuities and increases in

[1] Unless otherwise noted, all costs and savings are presented in FY 2016 constant dollars, which do not account for expected inflation. Each costing table in this appendix includes a line for Federal outlays in then-year (current) dollars, which do include expected inflation to better compare to estimates of National debt.
[2] National Defense Authorization Act for FY 2013, Pub. L. No. 112-239, § 674(b)(2), 126 Stat. 1632, 1791 (2013).

TSP contributions and CP. Outlays are higher in the near years because Government contributions to Service members' TSP accounts begin immediately upon implementation of the blended retirement system, yet reductions in DB payments are realized over time as Service members retire under the blended retirement system.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	154	-	-	-	-	-	-	-
DoD Budget	(990)	(1,185)	(1,238)	(1,297)	(1,357)	(1,894)	(1,894)	(1,894)
Federal Outlays	522	1,564	1,645	1,719	1,792	(4,666)	(4,666)	(4,666)
Federal Outlays (Then-Year $)	522	1,579	1,684	1,791	1,934	(14,853)	(15,346)	(15,855)

Assumptions

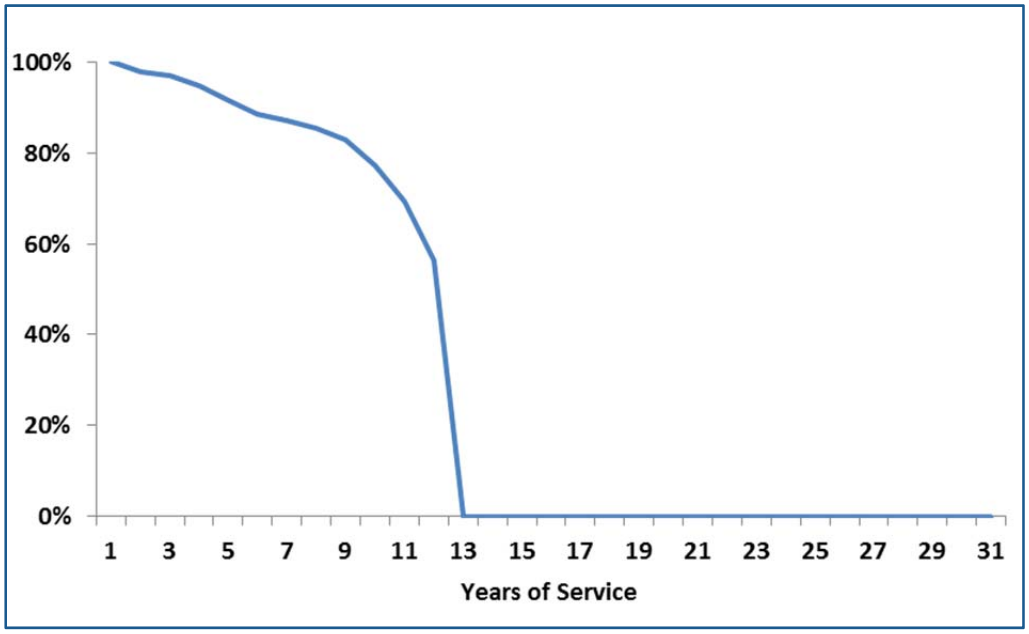
- TSP (defined contribution): The Government automatically contributes 1 percent to Service members' TSP accounts upon entry through 20 years of service (YOS). Service members are automatically enrolled to contribute 3 percent of basic pay upon entry in to service. Service members continue to contribute 3 percent of basic pay annually throughout their service. The Government matches Service member contributions of 3 percent of basic pay from YOS 3-20. Service members are vested into TSP beginning at YOS 3 (for matching and automatic contributions from DoD).

- DB: The defined benefit retirement multiplier is established at 2.0 and is paid to Active Component (AC) and Reserve Component (RC) members who serve at least 20 years of qualifying service. Service members have the flexibility to receive DB annuities prior to full Social Security retirement age as monthly payments, full lump sums, or partial lump sums with partial monthly payments.

- CP: Basic CP is paid to Service members at 12 YOS. AC members receive 2.5 times their monthly basic pay as Basic CP and RC members receive 0.5 times the monthly basic pay of an AC Service member of the same rank and YOS as Basic CP. Additional CP is paid to Service members consistent with projections of the CP necessary to maintain the Services' current force profiles (see Figure 31).

- Current AC members opt in to the blended retirement system according to the following figure. No current RC members opt in.

Figure 31. Assumed percent of Service Member Who Opt in to Blended Retirement[3]



- Implementation costs include training sessions for all AC and RC Service members on the Commission's recommendations,[4] as well as development of the necessary processes to record Service member opt-in decisions and TSP investment choices. The cost is estimated at $25 for each Service member.[5] Using the FY 2013 total force end-strength population of 2,272,410,[6] total cost is $113.6 million.

- For the high-cost (low-savings) estimate, all Service members contribute 5 percent of basic pay into their TSP accounts, the Government matches all 5 percent of these TSP contributions, and nobody elects a lump sum DB option. For the low-cost (high-savings) estimate, no Service members contribute to their TSP accounts, there are therefore no Government matching contributions, and all Service members elect the full lump-sum DB option.

Validation

Current contributions to and future payments from the MRF are actuarially determined.[7] The Commission therefore procured the services of RAND to assist with

[3] RAND Corporation, *Analysis of Retirement Reform in Support of the Military Compensation and Retirement Modernization Commission Progress Report*, November 2014 (RAND performed this analysis pursuant to a contract with the Commission).
[4] It is expected that these training events will provide Service members with information on the Commission's other recommendations, including health benefit changes.
[5] The Department of the Army estimated that effective one-time personal financial management training could be delivered for $22 per soldier. Office of Economic and Manpower Analysis, Department of Social Sciences, United States Military Academy, *Assessing Financial Education: Evidence from a Personal Financial Management Course,* December 10, 2013.
[6] End Strength Data, Military Compensation & Retirement Modernization Commission Interim Report, June 2014, 6.
[7] NCPs are based on economic assumptions including annual rates of interest used to discount future cash flows; retirement cost of living adjustments; future across-the-board salary increases; withdrawal and retirement assumptions; and retiree death and "other loss" rates. Estimated NCPs related to the Commission's recommendations

developing estimates of NCP changes, in conjunction with DoD's Office of the Actuary (OACT). RAND also estimated CP that would be necessary to maintain the Services' current force profiles using its Dynamic Retention Model.[8] RAND further assisted the Commission by estimating the percentage of existing Service members who would opt in to the blended retirement system, as well as the number of DB annuities that would be chosen as full or partial lump-sum payments. These methods were similar to those used in DoD's March, 2014 white paper on military retirement.[9]

Recommendation 2: Provide more options for Service members to protect their pay for their survivors by offering new Survivor Benefit Plan coverage without Dependency and Indemnity Compensation offset.

The Commission estimates that its recommendation related to the Survivor Benefit Plan would reduce DoD budgetary costs by $382 million during FY 2016–FY 2020 and result in annual steady-state savings of $160 million by FY 2042. Federal outlays would increase by $8 million during FY 2016–FY 2020, but be unaffected thereafter.[10] In this estimate, DoD budgetary reductions are the net result of decreases in DoD's NCPs into the MRF, as well as increases from new receipts from retirees opting into the new SBP option and therefore paying greater premiums.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	4	4	-	-	-	-	-	-
DoD Budget	(66)	(66)	(80)	(80)	(90)	(160)	(160)	(160)
Federal Outlays	4	4	-	-	-	-	-	-
Federal Outlays (Then-Year $)	4	4	-	-	-	-	-	-

Assumptions

- DB: SBP payments depend upon retired Service member's DB annuity payments, which are consistent with the assumptions of Recommendation 1.
- Current SBP plan: Service members' premiums and survivors' benefits (e.g., premium of 6.5 percent of retired pay for benefits of 55 percent of retired pay) remain the same. SBP benefits under the current SBP continue to be offset by Department of Veterans Affairs (VA) Dependency and Indemnity Compensation (DIC) payments.
- SBP option: Service members fully fund SBP coverage with greater premiums (e.g., 11.25 percent of retired pay for benefits of 55 percent of retired pay).[11]

---

are relative to baseline NCPs that were calculated using the most recent methods, assumptions, and law that underlay the September 30, 2014, Military Retirement Fund actuarial valuation and FY 2016 NCPs, which were approved by the DoD Board of Actuaries at their July, 2014, meeting. Department of Defense, Office of the Actuary, Statistical Report of the Military Retirement System, Fiscal Year 2013, May 2014, accessed November 22, 2014, http://actuary.defense.gov/Portals/15/Documents/statbook13.pdf.

[8] RAND's Dynamic Retention Model, (DRM) involves simulations of the impact of compensation and retirement policy changes on active and reserve retention as well as on cost and outlays, in the steady state as well as in the transition to the steady state.

[9] Department of Defense, *Concepts For Modernizing Military Retirement,* http:// www.mcrmc.gov/public/docs/report/pr/Concepts_for_Modernizing_Military_Retirement_SBP_FN_15_16_27.pdf.

[10] SBP payments are partly based on the DB retirement multiplier. Changes in Federal outlays associated with SBP payments that result from establishing the DB retirement multiplier at 2.0 are included in the costs and savings of Recommendation 1.

[11] Annual premiums for the recommended SBP options will be established annually by DoD's Office of the Actuary. For FY 2013, the premium to fully fund SBP payments would have been 11.25 percent of retired pay.

SBP benefits under this option are not offset by DIC payments. Approximately 16 percent of retiring Service members choose the new SBP option.

- Implementation costs include communication of the new SBP option to retiring Service members, retirees, and their families. For retiring Service members, communication is achieved during the mandatory transition assistance program. For current retirees, a mail campaign is initiated to inform them of the open season opportunity to choose the SBP option.

- For the high-cost (low-savings) estimate, no Service member elects the lump sum DB option. For the low-cost (high-savings) estimate, every Service member elects the full lump-sum DB annuity payment option. Service members who choose the lump sum DB annuity payment option have their lump-sum payment amount reduced by the total amount (for 360 months) of their SBP premium cost.

Validation

Current contributions to and future payments from the MRF are actuarially determined. The Commission therefore developed estimates of NCP changes in conjunction with the OACT and RAND. RAND further assisted the Commission by estimating the percentage of existing Service members who would opt in to the SBP option. These methods were similar to those used in DoD's March, 2014 white paper on military retirement.[12]

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

The Commission estimates that its recommendation related to financial literacy would increase DoD budgetary costs and Federal outlays by $400 million during FY 2016–FY 2020 and result in annual steady-state cost increases of $75 million by FY 2019. In this estimate, increased costs fund a substantial enhancement in the financial training provided to Service members and their families, including training by professional certified financial advisors and an online budget planner that is linked electronically to Service members' restructured Leave and Earnings Statements (LESs). Costs are estimated by multiplying costs per training event by the number of Service members to be trained.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	10	10	5	-	-	-	-	-
DoD Budget	85	85	80	75	75	75	75	75
Federal Outlays	85	85	80	75	75	75	75	75
Federal Outlays (Then-Year $)	85	87	83	80	81	156	159	162

Assumptions

- Training is provided, on average, to each Service member annually. This training includes initial-entry training for all new entrants and for all personnel ranked E4/O3 and below upon arrival at each duty station, all members at the

[12]Department of Defense, *Concepts For Modernizing Military Retirement,* http://www.mcrmc.gov/public/docs/report/pr/Concepts_for_Modernizing_Military_Retirement_SBP_FN_15_16_27.pdf.

vesting point for the TSP program, on dates of promotion (up to pay grades E5 and O4), for major life events, during leadership and pre- and postdeployment training, at transition, and upon the request of Service members. Using the FY 2013 total force end-strength population, there are 2,272,410 training events annually.

- The cost per training is $33 per Service member.
- DoD estimates enhanced financial literacy training would reduce the number of Service members involuntarily separated due to financial problems, thereby saving $13 million to $137 million annually.[13] These estimates are not included in the Commission's cost estimates.
- Implementation costs include development of training curriculum, procurement of professional trainers services, and development of an online budget planner linked to Service members' LESs.
- For the high-cost (low-savings) estimate, the cost per training event is $44 (twice the Army's estimate). For the low-cost (high-savings) estimate, the cost per training event is $22 (equal to the Army's estimate).

Validation

The Department of the Army estimated that effective one-time personal financial management training could be delivered for $22 per soldier.[14] Because the Commission's recommendation includes professional training, the Army's estimate is increased by 50 percent.

Recommendation 4: Increase efficiency within the Reserve Component by consolidating 30 Reserve Component duty statuses into 6 broader statuses.

The Commission estimates that its recommendation related to RC duty statuses would reduce annual DoD budgetary costs and Federal outlays by streamlining paperwork and other processes related to mobilizations of RC Service members. These savings are expected to be minimal and are not included in the Commission's cost estimates.

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

The Commission estimates that its recommendation related to medical readiness would increase DoD budgetary costs and Federal outlays by $1.1 billion during FY 2016–FY 2020 and result in annual steady-state cost increases of $298 million by FY 2018. In this estimate, these costs result from increases in operating expenses associated with establishing a new four-star Joint Readiness Command (JRC).

---

[13] 79 Fed. Reg. 58601 (September 29, 2014). *See also* "Shielding troops from high interest rates may help DoD," *Military Times,* accessed October 8, 2014, http://www.militarytimes.com/article/20141008/NEWS/310080053/Shielding-troops-from-high-interest-rates-mayhelp-DoD.

[14] Office of Economic and Manpower Analysis, Department of Social Sciences, United States Military Academy, *Assessing Financial Education: Evidence from a Personal Financial Management Course,* December 10, 2013.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	20	10	-	-	-	-	-	-
DoD Budget	20	159	298	298	298	298	298	298
Federal Outlays	20	159	298	298	298	298	298	298
Federal Outlays (Then-Year $)	20	162	310	316	322	619	631	644

Assumptions

- Annual JRC operating costs equal the average operating costs of the existing Combatant Commands,[15] excluding U.S. Transportation Command (TRANSCOM) and U.S. Special Operations Command (SOCOM) because of their unique funding situations.[16] Although actual costs may be less, because some functions may be transferred to the JRC from existing DoD organizations (e.g., the Joint Staff), estimates of such transfers are not included in this cost estimate.

Table 24. Annual Combatant Command Funding Level[17]

	FY13	FY16
USAFRICOM	$285,022,000	$299,805,477
USCENTCOM	$179,266,000	$188,564,141
USEUCOM	$119,267,000	$125,453,122
USNORTHCOM	$200,114,000	$210,493,482
USPACOM	$300,097,000	$315,662,385
USSOUTHCOM	$206,342,000	$217,044,515
USSTRATCOM	$689,821,000	$725,600,529
Average	$282,847,000	$297,517,664

- Implementation costs represent 10 percent of the baseline steady-state cost estimate to fund detailed planning for JRC establishment.

- For the high-cost (low-savings) estimate, JRC operating costs are set at the highest cost of a Combatant Command, excluding TRANSCOM and SOCOM. For the low-cost (high-savings) estimate, JRC operating costs are set at the lowest cost of a Combatant Command, excluding TRANSCOM and SOCOM.

Validation

Costs are based on internal Commission assessments of existing Combatant Command funding.

Recommendation 6: Increase access, choice, and value of health care for active-duty family members, Reserve Component members, and retirees by allowing beneficiaries to choose from a selection of commercial insurance plans offered through a Department of Defense health benefit program.

The Commission estimates that its health benefit recommendation would reduce DoD budgetary costs by $26.5 billion during FY 2016–FY 2020 and result in annual steady-

[15] Feickert, Andrew, "The Unified Command Plan and Combatant Commands: Background and Issues for Congress," Congressional Research Service, January 3, 2013, 12.
[16] Ibid. TRANSCOM is predominantly funded through customer orders and SOCOM receives operational funding.
[17] Ibid. FY 2016 costs extended from 2013 by using DoD Comptroller inflation rates from the National Defense Budget Estimates for 2015, Table 5-2, 52.

state savings of $6.7 billion by FY 2033. Federal outlays would decrease by $3.9 billion during FY 2016–FY 2020 and $3.2 billion annually starting in FY 2033. In this estimate, these reductions are the net result of decreases in costs for providing the health care benefits, decreased cost shares for some beneficiaries, and increased cost shares for other beneficiaries. The decline in DoD budgetary costs also results from accrual funding non-Medicare-eligible retiree health benefit costs. In developing this estimate, the Commission worked closely with the Office of Personnel Management (OPM); procured the services of the Institute for Defense Analyses (IDA) to conduct health benefit pricing analyses; and relied upon data from OPM related to beneficiary demographics, choices, and health care plans in the Federal Employees Health Benefit Program (FEHBP).[18]

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	100	100	-	-	-	-	-	-
DoD Budget	(3,900)	(3,900)	(6,173)	(6,234)	(6,292)	(6,666)	(6,666)	(6,666)
Federal Outlays	100	100	(1,242)	(1,374)	(1,507)	(3,229)	(3,229)	(3,229)
Federal Outlays (Then-Year $)	100	104	(1,341)	(1,541)	(1,756)	(13,295)	(13,813)	(14,352)

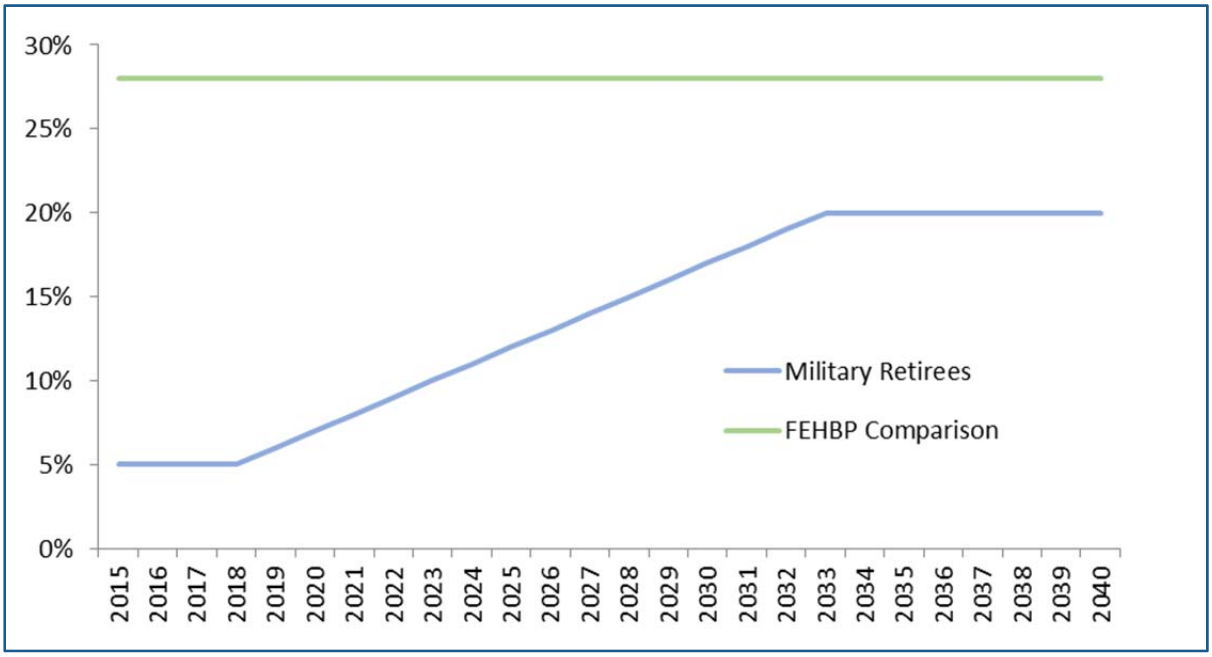
Assumptions

Assumptions used in this estimate are detailed in IDA's report titled "Analyses of Military Healthcare Benefit Design and Delivery: Study in Support of the Military Compensation and Retirement Modernization Commission."[19] Key assumptions include the following:

- The commercial health insurance plan choices of Federal civilians of similar age, income, and state are a proxy for the choices of DoD military beneficiaries.
- The plans offered to DoD military beneficiaries are managed separately (i.e., a separate risk pool) from Federal civilians with their own plan types, coverage requirements, and pricing.
- Each AC Service member with at least one dependent receives a Basic Allowance for Health Care (BAHC) that covers the median health insurance plan premium and average copayments in the dependent's location.
- AC Service members pay 28 percent of the premium for their families' health insurance plan (covered by BAHC), retirees pay 20 percent of their plan premiums, and all beneficiaries pay copayments (covered by BAHC for AC family members).
- Retiree cost shares increase to 20 percent of plan premiums according to the ramp shown in Figure 32.

[18] The Office of Personnel Management provided support for the Commission's analysis, however such support does not represent an endorsement of, or suggest any opinion on, the report, study, or recommendations.
[19] Horowitz, S., P. Lurie, and S. Burns, "Analyses of Military Healthcare Benefit Design and Delivery: Study in Support of the Military Compensation and Retirement Modernization Commission," Institute for Defense Analyses, November, 2014, http://www.mcrmc.gov.

Figure 32. Gradual Ramp of Retiree Cost Shares (1 percent annually)[20]



- The percentage of eligible beneficiaries who do not use TRICARE health benefits remains constant.

- Approximately one-fifth of non-Medicare-eligible retirees and a very small number of AC family members do not use TRICARE.[21] These beneficiaries have historically been referred to as "ghosts" because they are not visible in the TRICARE system, but could return and become active users in the future. Although IDA's baseline estimate holds these nonuse rates constant, the Commission's recommendation improves the quality of the health benefit (choice, access, etc.) and raises cost shares for beneficiaries. Improving quality could increase the number of users; higher costs shares could reduce the number of users. IDA estimated that increasing the number of users with higher quality benefits would reduce annual cost savings by $1 billion.[22] Conversely, decreasing the number of users because of greater cost share would increase annual savings by $1 billion.[23] These reductions and increases to annual savings form the basis for the Commission's high and low cost estimates.

- IDA analyzed a wide range of other excursions to test its cost estimates, including sensitivity to plan-choice behavior, effects of demographic changes on plan prices, and ways in which different beneficiary incentives may affect plan choices. The results of these excursions are described in detail in the IDA report.

[20] The FEHBP premium cost share can vary with the plan selected, 28 percent is used here for illustrative purposes.
[21] Horowitz, S., P. Lurie, and S. Burns, "Analyses of Military Healthcare Benefit Design and Delivery: Study in Support of the Military Compensation and Retirement Modernization Commission," Institute for Defense Analyses, November, 2014.
[22] Ibid.
[23] Ibid.

Validation

The Commission validated the results of this cost estimate with several high-level estimation methods. For example, the estimate is consistent with testimony received by the Commission, as well as DoD reporting on health care costs, and may understate likely savings from modernizing the health care benefit:

- Outside Experts: The Commission received testimony that moving to a commercial insurance program could reduce health care costs by 24 percent,[24] which equates to approximately $5 billion annual reduction to Federal outlays. This is greater than IDA's baseline estimate of health care cost reductions,[25] in part because IDA assumes some potential savings will be reinvested to provide health benefit improvements (i.e., better health care plans with more access, choice of providers, etc.).

- DoD Proposals: Testimony to the Commission from health care experts also indicated that slightly more than half of health care savings would result from increased cost shares for beneficiaries, with the remainder resulting from nonprice tools used by civilian health insurers.[26] DoD has estimated that increasing cost shares within the current TRICARE system, which does not use nonprice tools, would save approximately $2 billion annually.[27] DoD's estimated savings are somewhat more than half of IDA's estimate, which is consistent with the expert testimony received by the Commission.[28]

- Congressional Budget Office (CBO) Proposals: CBO's 2014 report on TRICARE reform options provides two validations of IDA's estimate.[29] First, CBO reports that current annual per-person costs to provide health benefits to TRICARE Prime enrollees and Standard/Extra users are $4,800 and $3,900, respectively.[30] These values imply the total cost of health benefits for the relevant DoD military beneficiary population is similar to IDA's estimate. Second, CBO estimates annual savings from only changes in beneficiary cost shares to be approximately $2 billion.[31] Like DoD estimates, CBO's proposals are consistent with IDA's estimate for a reform that combines both price and nonprice reform tools.

- DoD Reporting to the Congress: On March 5, 2014, DoD provided to the Congress a comparison of the costs of TRICARE beneficiaries to demographically similar civilians.[32] Multiplying the savings identified in the

[24] Testimony of Dr. Gail Wilensky, Project Hope, to the Commission on April 9, 2014.
[25] Horowitz, S., P. Lurie, and S. Burns, "Analyses of Military Healthcare Benefit Design and Delivery: Study in Support of the Military Compensation and Retirement Modernization Commission," Institute for Defense Analyses, November, 2014, 8.
[26] Testimony of Dr. Gail Wilensky, Project Hope, to the Commission on April 9, 2014.
[27] Department of Defense, Fiscal Year 2015 Budget Request, Overview, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/fy2015_Budget_Request_Overview_Book.pdf, p. 5-13.
[28] Testimony of Dr. Gail Wilensky, Project Hope, to the Commission on April 9, 2014.
[29] Congressional Budget Office, Approaches to Reducing Federal Spending on Military Health Care, 8, January 2014, http://www.cbo.gov/sites/default/files/44993-MilitaryHealthcare.pdf.
[30] Ibid.
[31] Ibid, 28.
[32] Department of Defense, *The Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report*, 91 & 93, accessed January 12, 2015, http://www.health.mil/~/media/MHS/Report%20Files/TRICARE2014_02_25_14v5%201.ashx.

report by the number of affected military beneficiaries suggests annual savings of approximately $5 billion in Federal outlays, which is very similar to the expert testimony described above and greater than IDA's savings estimate.

- Review of Previous Comparisons: The Commission also reviewed available previous studies of health benefit costs under TRICARE and civilian health insurance. These studies compared proposals that differ from the Commission's recommendation (e.g., placing DoD beneficiaries in the FEHBP).[33] For example, these studies generally assumed that the DoD beneficiary population was demographically similar to the Federal civilian workforce, implying similar health risk, plan choices, and premium costs.[34] As IDA's report demonstrates, DoD's military beneficiary population is substantially younger than the Federal civilian workforce, resides in different locations, and has different income levels.[35] Each of these factors affects health care costs, commercial insurance plan premiums, and therefore, estimated costs savings. For these reasons, the Commission found IDA's estimate to be more realistic than previous studies.

Out-of-Pocket (OOP) Costs

The Commission's recommendation balances two competing factors: the desire to preserve low-cost health benefits (particularly for active-duty family members (ADFMs)) and the need to give beneficiaries "skin in the game" to incentivize more efficient health care utilization. The introduction of BAHC enables the use of a common and well understood compensation tool (an allowance) to bring an important innovation from civilian health care (first-dollar responsibility for routine health care). Allowing beneficiaries to keep BAHC amounts not spent on health care provides appropriate incentives to use health benefits efficiently. To determine appropriate BAHC levels, out-of-pocket (OOP) costs were compared under the current TRICARE system and the Commission's recommended health benefit. As shown below, annual OOP costs for the average ADFM household that does not currently have an individual enrolled in TRICARE Young Adult would be $500 less under the recommended health benefit.[36] OOP costs would be $2,500 less under the recommended health benefit for the average ADFM household that has an individual currently enrolled in TRICARE Young Adult.

[33] See Congressional Budget Office Cost Estimate, H.R. 1222, Keep Our Promise to America's Military Retirees Act, February 28, 2007, and Department of Defense, T4 Study Group Final Report, January 17, 2012.
[34] Ibid.
[35] Horowitz, S., P. Lurie, and S. Burns, "Analyses of Military Healthcare Benefit Design and Delivery: Study in Support of the Military Compensation and Retirement Modernization Commission," Institute for Defense Analyses, November, 2014.
[36] Actual out-of-pocket costs will depend on the health plan selected by the ADFM household.

Table 25. Comparison of FY 2014 Out-of-Pocket (OOP) Costs for Active-Duty Service Members without TRICARE Young Adult[37]

Current State	Enrolled in Prime	Standard/Extra User	Average
Current OOP Costs	$97	$493	$177
Recommended State	Enrolled in HMO	Enrolled in PPO	Average
OOP w/ Private Insurance	$561	$920	$830
BAHC Payment	$920	$920	$920
Delta of BAHC and Actual Cost	$359	$0	$90
Net Effect on ADFM			
Savings to Family	$457	$493	$464

Table 26. Comparison of FY 2014 Out-of-Pocket (OOP) Costs for Active-Duty Service Members with TRICARE Young Adult[38]

Current State	Enrolled in Prime	Standard/Extra User	Average
Current OOP Costs	$97	$493	$177
TRICARE Young Adult Premium	$2,160	$1,872	$2,102
TRICARE Young Adult OOP Costs	$0	$194	$39
Total ADFM Costs	$2,257	$2,559	$2,318
Recommended State	Enrolled in HMO	Enrolled in PPO	Average
OOP w/ Private Insurance	$561	$920	$830
BAHC Payment	$920	$920	$920
Delta of BAHC and Actual Cost	$359	$0	$90
Net Effect on ADFM			
Savings to Family	$2,617	$2,559	$2,605

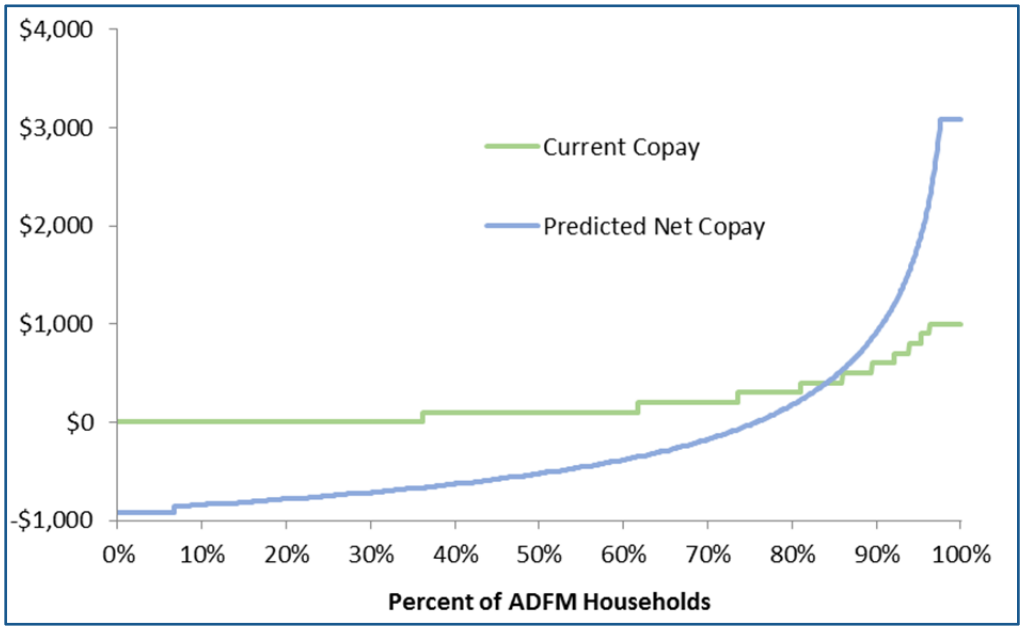
Some families, predominantly those with chronic conditions or a catastrophic illness, have OOP costs that exceed the average. For example, in the United States in 2009, the lowest-cost half of the population accounted for approximately 3 percent of national health care spending, and the highest-cost 5 percent of the population accounted for half of national health care spending.[39] ADFM households that were

[37] In the following tables and figure, "copay" is used to represent all nonpremium out-of-pocket costs. MCRMC calculations based on data from pages 90 and 92 of Department of Defense, *The Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report,* accessed January 11, 2015, http://www.health.mil/~/media/MHS/Report%20Files/TRICARE2014_02_25_14v5%201.ashx.
[38] MCRMC calculations based on data from pages 90 and 92 of Department of Defense, *The Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report,* accessed January 11, 2015, http://www.health.mil/~/media/MHS/Report%20Files/TRICARE2014_02_25_14v5%201.ashx. "TRICARE Young Adult Costs," TRICARE, accessed January 11, 2015, http://www.tricare.mil/Costs/HealthPlanCosts/TYA.aspx.
[39] National Institute for Health Care Management, "The Concentration of Health Care Spending," July 2012, accessed December 8, 2014, http://www.nihcm.org/pdf/DataBrief3%20Final.pdf.

enrolled in TRICARE Prime in FY 2013 had a similar cost distribution.[40] The lowest-cost half of the ADFM households accounted for 9 percent of the costs of ADFM households in TRICARE Prime, and the highest-cost 5 percent of households accounted for 34 percent of the total cost.[41]

To mitigate the financial risks of chronic and catastrophic illnesses to ADFM households, the Commission recommends establishing a program to provide these households with additional support for OOP expenses. The following chart displays a comparison of net current ADFM household OOP costs to estimated OOP costs under the recommended health benefit. The comparison assumes that ADFM households would receive $920 of BAHC to cover OOP costs; the total effect of the recommended health benefit is the combination of this BAHC and commercial insurance copayments and deductibles. When a household experiences a catastrophic illness or has a member who is diagnosed with a high-cost chronic condition, the Service member will be able to apply to this program for additional funding to cover OOP expenses. Based on the analysis below, funding this program with $50 million annually would allow for the complete coverage of excess net medical expenses greater than $2,000 per year for all ADFM households that find themselves in such a situation. This estimate was created by taking the estimated OOP amount for the top 4 percent of the distribution and setting aside the difference between that forecasted expense amount and $2,000 above the BAHC amount.

Figure 33. Comparison of Out-of-Pocket Cost Distributions[42]



[40] Commission calculation based on data from Military Health System Management Analysis and Reporting Tool: Inpatient Admissions (SIDR), Professional Encounters (CAPER), PC Institutional (TED-II), PC Non-Institutional (TED-N). Data for family units, not individuals, was used, making the comparison different.
[41] Ibid.
[42] Ibid.

Based on this analysis, ADFM households can be divided into several categories:

- Approximately 7 percent of ADFM households would have no OOP expenses in a year. The $920 BAHC amount would be equivalent to a $920 pay raise.

- Approximately 70 percent of ADFM households would have some OOP expenses that would be totally covered by the $920 BAHC amount. These households would have some remaining BAHC that would be the equivalent of a pay raise.

- Approximately 8 percent of ADFM households would have OOP expenses in excess of the $920 BAHC amount, but their net OOP expense would still be less than their payment under the current TRICARE program.[43] These households would get the equivalent of a pay raise for the difference between their projected (lower) expenses under the Commission's recommendation and their existing (higher) expenses under the current TRICARE program.[44]

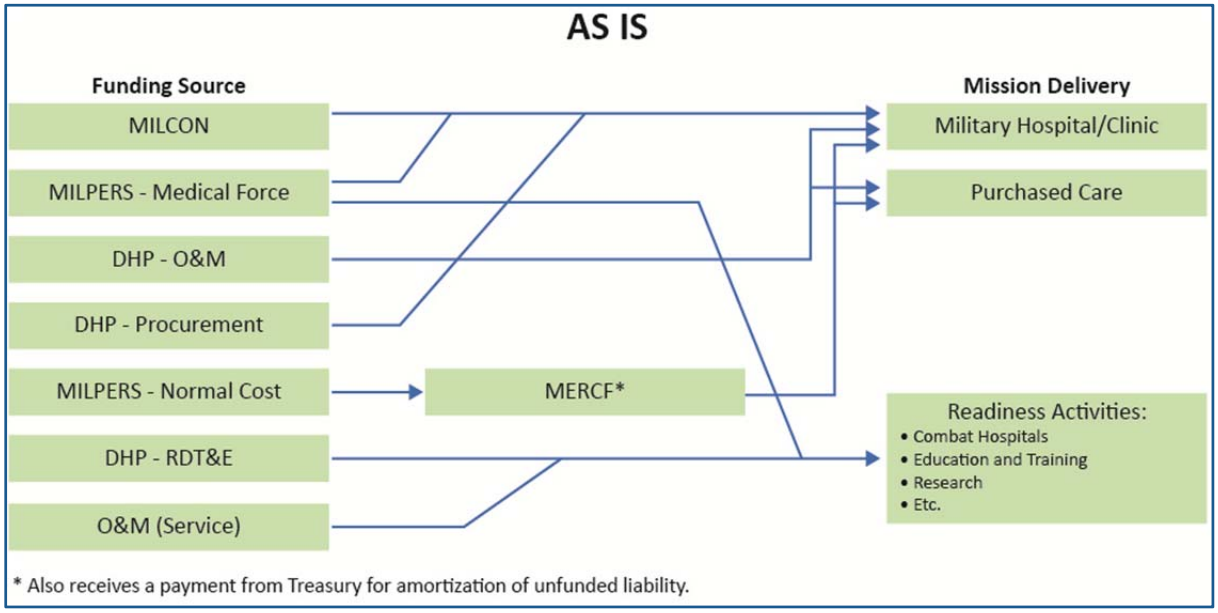
- Approximately 15 percent of ADFM households would have higher OOP expenses under the Commission's recommendation. Approximately one-quarter of these households would experience a substantial increase in their expenses. It is for this category that the Commission recommends a secondary program to assist with OOP costs for chronic or catastrophic illnesses.

Health Care Funding

The Commission's recommendation substantially improves the transparency of funding of the Military Health System (MHS). As shown in the following charts, the MHS is currently resourced by multiple funding categories (operations and maintenance, procurement, military personnel, etc.), rather than supported mission (readiness vs. beneficiary health care). [45]

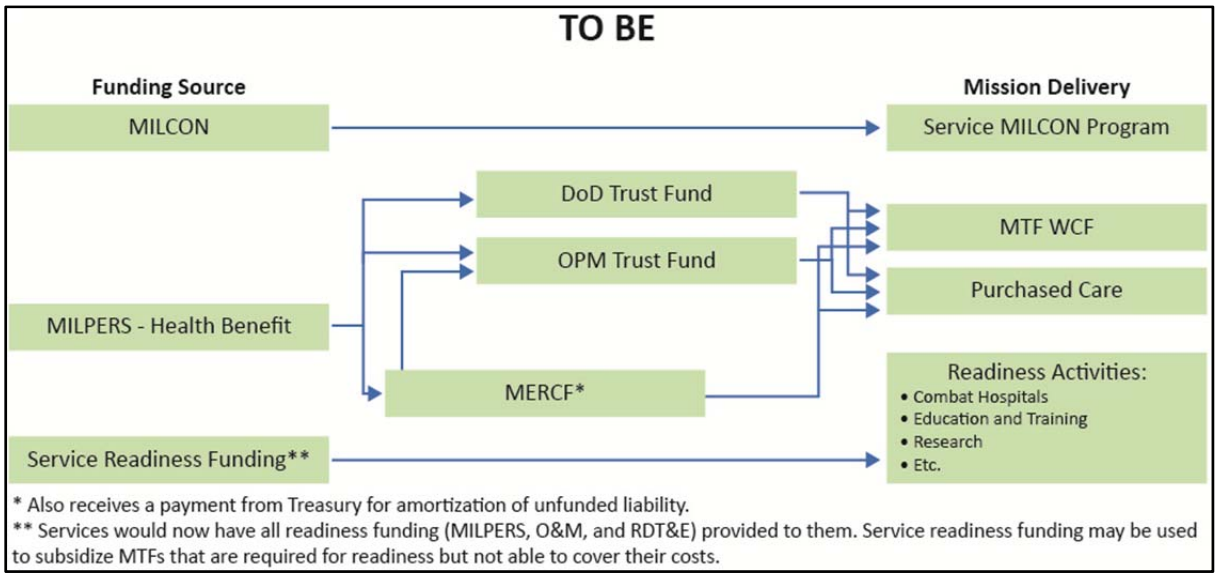
[43] Commission calculation based on data from Military Health System Management Analysis and Reporting Tool: Inpatient Admissions (SIDR), Professional Encounters (CAPER), PC Institutional (TED-II), PC Non-Institutional (TED-N).
[44] Commission calculation based on data from Military Health System Management Analysis and Reporting Tool: Inpatient Admissions (SIDR), Professional Encounters (CAPER), PC Institutional (TED-II), PC Non-Institutional (TED-N).
[45] Department of Defense, *The Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report,* 20, accessed January 11, 2015, http://www.health.mil/~/media/MHS/Report%20Files/TRICARE2014_02_25_14v5%201.ashx. Abbreviations: MILCON = Military Construction, MILPERS = Military Personnel, DHP = Defense Health Program, O&M = Operations and Maintenance, RDT&E = Research, Development, Test, and Evaluation, MERHCF = Medicare-Eligible Retiree Health Care Fund.

Figure 34. Current MHS Resourcing



The Commission recommendations result is a more streamlined, efficient flow of MHS resources, thereby improving MHS transparency, effective management, and the ability to identify and protect readiness funding.

Figure 35. Proposed MHS Resourcing[46]



Under the Commission's recommendation, medical readiness operations would be funded from the Services, with oversight from the JRC. Beneficiary costs would be

[46] Abbreviations: MILCON = Military Construction, MILPERS = Military Personnel, O&M = Operations and Maintenance, RDT&E = Research, Development, Test, and Evaluation, MERHCF = Medicare-Eligible Retiree Health Care Fund, OPM = Office of Personnel Management, MTF = Military Treatment Facility, WCF = Working Capital Fund. The reimbursement rates received by MTFs for the care they deliver to beneficiaries covered by the commercial insurance will contain funding for military construction. That funding would likely be transferred to MILCON accounts for execution.

funded from the Services' Military Personnel (MILPERS) and Military Construction (MILCON) accounts. This approach makes these costs separately identifiable and allows for the direct monitoring of readiness funding. The key flows of funding illustrated in the figure above include the following:

- AC Service member health benefits are funded from MILPERS accounts and transferred to the DoD trust fund for use in paying for health care.
- ADFM health benefits are funded from MILPERS accounts and transferred to the DoD Trust Fund for dental and pharmacy benefits and OPM Trust Fund for commercial health plans.
- Retiree (both Medicare eligible and non-Medicare-eligible) health benefits are funded from MILPERS and paid into the Medicare Eligible Retiree Health Care Fund. Major disbursements from the fund include payments to the OPM Trust Fund for commercial health plans for non-Medicare-eligible retirees and to the Military Treatment Facility revolving fund and purchased care for the pharmacy benefit of non-Medicare-eligible retirees and for all benefits for Medicare-eligible retirees.

Recommendation 7: Improve support for Service members' dependents with special needs by aligning services offered under the Extended Care Health Option to those of state Medicaid waiver programs.

The Commission estimates that its recommendation related to the Extended Care Health Option (ECHO) would increase DoD budgetary costs and Federal outlays by $715 million during FY 2016–FY 2020 and result in annual steady-state cost increases of $190 million by FY 2018. In this estimate, increased costs result from the expansion of services that are covered under the ECHO program, which lead current ECHO participants to use more services and additional eligible Service families to enroll in ECHO. The existing funding cap of $36,000 per fiscal year per dependent remains in place.[47]

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	2	1	-	-	-	-	-	-
DoD Budget	49	96	190	190	190	190	190	190
Federal Outlays	49	96	190	190	190	190	190	190
Federal Outlays (Then-Year $)	49	99	205	213	221	782	813	844

Assumptions

- The average FY 2016 cost per participant for capped services under ECHO increases from $2,490 to $18,748.[48] In 2011, the average per-person cost of services provided by Medicaid Home and Community Based Services (HCBS) program, which offers services similar to those under the proposed ECHO

[47] National Defense, 32 CFR 199.5(f)(3)(i).
[48] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, October 20, 2014 and Department of Defense Annual Report to Congress on Plans for DoD for Support of Military Family Readiness, FY 2013, 45, received from Department of the Army, e-mail to MCRMC, May 22, 2014.

expansion, varied by state from $7,702 to $40,049, with an overall average cost of $17,174 per person.[49]

- ECHO enrollment increases by 25 percent. In FY 2013, 8,094 DoD Exceptional Family Members (EFMs) received ECHO benefits.[50] Under the proposed expansion 10,118 EFMs would receive ECHO benefits.

- Implementation costs include analyzing HCBS waivers across states to determine which services should be added to ECHO, how best to add them, and how to create a model to support consumer-directed care for select services.

- The implementation timeline assumes the current restriction on respite care will be removed and substantially more EFMs will access this benefit in FY 2016. Based on the analysis performed by DoD in FY 2016, new services will be added and accessed in FY 2017, with full implementation by FY 2018.

- For the high-cost (low-savings) estimate, costs are increased by 20 percent to adjust for the uncertainty related to increased ECHO enrollment and average per-person costs. For the low-cost (high-savings) estimate, costs are decreased by 20 percent to adjust for the uncertainty related to increased ECHO enrollment and average per-person costs.

Validation

The Commission validated the expected increase in average cost for ECHO beneficiaries using the current average patient cost reported by the Medicaid HCBS program. Given that this recommendation aligns ECHO benefits with the HCBS program, this should be a strong indicator of the resulting costs. The estimated increase in ECHO program participants was validated through discussions with military family support and advocacy groups. These discussions indicated that increased access to benefits such as respite care is a frequently discussed topic and would clearly motivate additional participation in the ECHO program.

Recommendation 8: Improve collaboration between Department of Defense and Veterans Affairs by enforcing coordination on electronic medical records, a uniform formulary for transitioning Service members, common services, and reimbursements.

The Commission estimates that its recommendation related to collaboration between DoD and VA would reduce annual DoD budgetary costs and Federal outlays by reducing costs for electronic health record development and maintenance, as well as by increasing resource-sharing between the Departments. Costs would increase from expanding VA's drug formulary to ensure continuity of medical care for transitioning Service members. Net funding changes depend upon the collaboration initiatives that are pursued by the Departments and are not included in the Commission's cost estimates.

---

[49] The Henry J. Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2010 Data Update*, 2, accessed January 12, 2015, http://files.kff.org/attachment/report-medicaid-home-and-community-based-services-programs-2011-data-update.

[50] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, October 20, 2014 and Department of Defense Annual Report to Congress on Plans for DoD for Support of Military Family Readiness, FY 2013, 45, received from Department of the Army, e-mail to MCRMC, May 22, 2014.

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

The Commission estimates that its recommendation related to DoD commissaries and exchanges would decrease DoD budgetary costs and Federal outlays by $1.0 billion during FY 2016–FY 2020 and result in annual steady-state savings of $515 million by FY 2021. In this estimate, these reductions result from a series of efficiencies, primarily in consolidating back office functions, logistics systems, and staffing. Numerous studies have projected that both financial savings and nonfinancial benefits can be achieved through a consolidation of the three exchanges.[51] Including the commissaries in such a consolidation increases potential efficiencies. The recommendation proposes a new defense resale executive team that would be responsible for evaluating, selecting, and implementing these potential efficiencies. Realized costs and savings therefore depend upon the set of efficiencies selected for implementation.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	58	93	106	120	89	-	-	-
DoD Budget	17	(78)	(184)	(313)	(426)	(515)	(515)	(515)
Federal Outlays	17	(78)	(184)	(313)	(426)	(515)	(515)	(515)
Federal Outlays (Then-Year $)	17	(79)	(192)	(332)	(461)	(1,071)	(1,092)	(1,114)

Assumptions

- Consolidation of logistics networks: Various studies have estimated the annual savings achievable through a consolidation of logistics networks among the three exchanges.[52] In 2005, the Unified Exchange Task Force (UETF) estimated that $75 million in annual savings was initially available and an additional $75 million to $150 million could be achieved with more aggressive integration. Combining these saving estimates, adjusting for inflation, and applying a 30 percent reduction to account for efficiencies implemented since 2005, annual savings are estimated to be $149 million. Additional savings achieved by including commissaries are not reflected in this estimate.

- Consolidation of staffing: The UETF estimated that 8.9 percent of exchange support staff could be reduced through consolidation of the three exchanges.[53] Applying this percentage to above-store management and support positions of commissaries and exchanges, annual savings are $112 million.

[51] Office of the Assistant Secretary of Defense (Force Management and Personnel), *DoD Study of the Military Exchange System,* September 7, 1990. *See also* Logistics Management Institute, Report PL110R1, *Toward a More Efficient Military Exchange System*, July 1991. *See also* Systems Research and Applications (SRA) International, *Integrated Exchange System Task Force Analysis*, 1996. *See also* PricewaterhouseCoopers, *Joint Exchange Due Diligence*, 1999, *See also* Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services,* August 26, 2005.

[52] Office of the Assistant Secretary of Defense (Force Management and Personnel), *DoD Study of Military Exchanges,* September 7, 1990, 1-7. *See also* Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services,* August 26, 2005, 64.

[53] Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services, Appendix B: Alternative Descriptions,* August 26, 2005, B-61 (based on a reduction from a baseline of 7,690 full-time equivalents to 7,005).

- Consolidation of supplies and services procurement: The cost of operating supplies and services is reduced by jointly procuring these items across commissaries and exchanges. The UETF estimated $37 million in associated annual savings for the exchanges.[54] This cost estimate includes the same annual savings, adjusted for inflation, even though the UETF did not include consolidation of the commissaries. This savings estimate does not include the procurement of goods for resale.

- Consolidation of capital expenditures: Capital expenditures are reduced by collectively planning, negotiating, and executing capital purchases, such as facilities and information technology (IT) systems, for commissaries and exchanges. The UETF analysis estimated $10 million could be saved annually through consolidation of routine procurements of IT equipment.[55] This cost estimate includes the same annual savings, adjusted for inflation, even though the UETF did not incorporate potential savings from common procurement, refresh of major IT systems, or consolidation of the commissaries.[56]

- Consolidation of retail space: In some areas of military concentration, multiple exchanges and commissaries are operated within close proximity. Consolidation of some of these facilities provides annual savings of $8 million.[57]

- Use of the MILITARY STAR® Card at commissaries: The MILITARY STAR® Card is a "private label" credit card provided by AAFES that allows the exchanges to avoid credit card processing fees and to profit from the interest that card holders pay on outstanding balances.[58] Based on data and analysis provided by AAFES, exchange customers, on average, make 20 percent of their purchases using the MILITARY STAR® Card, maintain a balance approximately equal to 15 percent of their purchases, and pay a 10.24 percent financing rate.[59] Expanding use of the MILITARY STAR® Card to 15 percent of commissary purchases yields approximately $11 million in additional annual revenue.

- Reduction of second destination transportation (SDT) costs: In FY 2013, approximately $331 million of appropriated funds (APF) was spent on shipping goods from the United States to overseas commissaries and exchanges.[60] Increased local sourcing reduces annual SDT costs by 10 percent, or $33 million.

---

[54] Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services, Executive Summary,* August 26, 2005.
[55] Ibid, E-1.
[56] Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services, Appendix D: Cost Basis of Estimate,* August 26, 2005.
[57] Based on information provided by DeCA, the average cost of operating a commissary was approximately $4 million in FY 2012, e-mail to MCRMC, May 6, 2014.
[58] Army and Air Force Exchange Service, Memorandum for ASD (R&FM), Army and Air Force Exchange Service (AAFES) Response to Commissary Legislative Proposal, March 17, 2014. Tom Shull, Chief Executive Officer, *Army & Air Force Exchange Service Overview,* briefing to MCRMC, June 10, 2014. AAFES, briefing to discuss AAFES response to Commissary legislative proposals with MCRMC, July 2, 2014.
[59] Ibid.
[60] Commissary SDT data ($152 million for FY 2013) provided by Defense Commissary Agency, e-mail to MCRMC, May 6, 2014. Exchange SDT data ($179 million for FY 2013) provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, November 6, 2014.

- Expansion of commissary sales with variable pricing: Changes to laws and policies, combined with a consolidation of commissaries and exchanges facilitates the commissaries selling new items at a profit, including beer and wine, convenience items (e.g., greeting cards, school supplies, cosmetics), and private-label (store brand) products. Based on an overall increase in the sale of these products by the consolidated organization, annual profits increase by $45 million.

- Conversion of the commissary workforce from APF to nonappropriated fund (NAF) employees: Commissary personnel continue to be funded by APF. Based partially on a 2002 DoD internal study,[61] however, converting the commissary workforce to NAF employees who are funded by APF reduces staffing costs by $110 million. This estimate includes an increase in staffing costs for exchanges associated with adding grocery employees to NAF wage surveys.

- Implementation cost estimates are based, where possible, on estimates provided in source studies. When scaling exchange estimates to apply to commissaries, the relative sizes of their sales, infrastructures, and staffs were considered. Implementation periods are assumed to be between 1 and 5 years, depending on the complexity of the change. Implementation costs are distributed across these years, accounting for time to modify laws and policies and dependencies on other changes. For conversion of commissary staff, 30 percent of the assumed transition-period savings are assumed as transition-period costs.

- High-cost (low-savings), and low-cost (high-savings) estimates, for each efficiency or cost-saving effort, wherever possible, are based on ranges provided in the cited studies. In other cases, cost uncertainty is made using consistent categories: high (+100, -50 percent), medium (+50, -30 percent), and low (+20, -10 percent) uncertainty. Similar categories are for savings: high (+50, -80 percent), medium (+50, -30 percent), and low (+20, -10 percent) uncertainty. These categories were assigned based on the availability of reliable analysis.

Validation

The Commission validated the results of this cost estimate using several high-level estimation methods. For example, the estimate is consistent with testimony received by the Commission, discussions with leadership of the commissaries and exchanges, and multiple studies conducted by DoD. Information drawn from studies was validated, where possible, against similar information in other studies and reports, including the following:

- DoD Study of the Military Commissary System, DoD[62]

- Study of the Military Exchange System, DoD[63]

[61] DeCA Nonappropriated Fund Workforce – Feasibility and Desirability, DASD (MC&FP) and DASD (CPP) In-Progress Review, June 26, 2002.
[62] The Jones Commission, *DoD Study of the Military Commissary System, December 18, 1989,* provided by OSD (P&R) via CD on June 11, 2014.

- Toward a More Efficient Military Exchange System, Logistics Management Institute[64]
- Potential Reductions to the Operation and Maintenance Programs, United States General Accounting Office (GAO)[65]
- DoD Review of GAO Report on Military Commissaries and Exchanges, DoD[66]
- Military Exchange System Study, Systems Research and Applications (SRA) International[67]
- Joint Exchange Due Diligence, PricewaterhouseCoopers[68]
- Briefing on Joint Exchange Due Diligence Study, Assistant Secretary of Defense (Force Management Policy)[69]
- Modified Business Case, UETF[70]

Recommendation 10: Improve access to child care on military installations by ensuring the Department of Defense has the information and budgeting tools to provide child care within 90 days of need.

The Commission's child care recommendation would not have a direct effect on annual DoD budgetary costs or Federal outlays. The recommendation reestablishes the authority to use operating funds for minor construction projects to create or modify Child Development Program (CDP) facilities. The proposal only has financial implications if the Services chose to fund projects under this authority. DoD may also address local needs and waiting times by funding additional CDP staff or expanding home- or community-based child care programs. Existing staff will track wait time data and implement the position description changes, as well as those contained in the proposed rules for background checks on individuals employed by DoD in child care services programs. These costs are expected to be minimal and are not included in the Commission's cost estimates.

---

[63] Office of the Assistant Secretary of Defense (Force Management and Personnel), *DoD Study of the Military Exchange System,* http://www.mcrmc.gov/public/docs/report/qol/DoD_Study-of-Military-Exchange-System_Sep1990.pdf.
[64] "Toward a More Efficient Military Exchange System," Logistics Management Institute, Report PL110R1, July 1991, accessed November 20, 2014, http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA255738.
[65] Government Accountability Office, *Potential Reductions to Operation and Maintenance Program*, GAO/NSIAD-95-200BR, September, 1995, 12, accessed December 21, 2014, http://www.gpo.gov/fdsys/pkg/GAOREPORTS-NSIAD-95-200BR/pdf/GAOREPORTS-NSIAD-95-200BR.pdf.
[66] DoD Review of GAO Report on Military Commissaries and Exchanges, December 9, 1995, provided by OSD (P&R) via CD on June 11, 2014.
[67] Systems Research and Applications (SRA) International, *Integrated Exchange System Task Force Analysis*, *1996*, accessed December 21, 2014, http://www.mcrmc.gov/public/docs/report/qol/1996_Exchange_Study-SRA_International-Provided_by_OSD-11JUN2014_DeRA-FN45.pdf.
[68] PricewaterhouseCoopers, *Joint Exchange Due Diligence,* 1999.
[69] Briefing on Joint Exchange Due Diligence Study, Assistant Secretary of Defense (Force Management Policy), 16 October 2000, provided by OSD (P&R) via CD on June 11, 2014.
[70] Unified Exchange Task Force, *Modified Business Case Analysis for Military Exchange Shared Services,* August 26, 2005, provided to MCRMC by the Office of the Under Secretary of Defense for Personnel and Readiness, June 11, 2014.

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

The Commission estimates that its recommendation related to Service member education would reduce DoD budgetary costs by $87 million during FY 2016–FY 2020 and result in annual steady-state savings of $17 million upon implementation. Federal outlays would decrease by $15.6 billion during FY 2016–FY 2020 and $4.8 billion annually starting in FY 2025. In this estimate, changes in DoD budgetary costs result from elimination of unemployment benefits for veterans who are using Post-9/11 GI Bill benefits. Reductions in Government outlays primarily accrue to VA, which funds the Montgomery GI Bill-Active Duty (MGIB-AD), Reserve Education Assistance Program (REAP), and the Post-9/11 GI Bill.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	-	-	-	-	-	-	-	-
DoD Budget	(17)	(17)	(17)	(17)	(17)	(17)	(17)	(17)
VA Budget	120	(2,126)	(4,667)	(4,478)	(4,542)	(4,757)	(4,757)	(4,757)
Treasury Budget	48	42	36	30	24	-	-	-
Federal Outlays	151	(2,102)	(4,649)	(4,466)	(4,535)	(4,774)	(4,774)	(4,774)
Federal Outlays (Then-Year $)	151	(2,144)	(4,836)	(4,739)	(4,909)	(9,929)	(10,127)	(10,329)

Assumptions

- These cost estimates are based on a model developed by the Commission to estimate future costs of the Post-9/11 GI Bill and its components,[71] including Service member/veteran tuition, Service member/veteran housing stipend, transferred tuition, and transferred housing stipend. The model is populated with historical data from DoD and VA on utilization and transference of Post-9/11 GI Bill and force structure data for FY 2009 through FY 2013. Future force structure and Service member YOS are projected. Future transfer of benefits to spouses and children, as well as the utilization of benefits by Service members, veterans, and their dependents, are consistent with historical data.

- Sunsetting the MGIB-AD increases annual costs of education benefits by $98 million initially. In FY 2013, the average payment to a MGIB-AD student was $8,551, compared to the average payment to a Post-9/11 GI Bill student of $13,465.[72] This cost estimate includes reductions to payments to the Department of the Treasury, which currently receives $1,200 from each Service member signing up for the MGIB-AD.[73] These costs decrease over time because MGIB-AD participation is already decreasing as more Service members choose the Post-9/11 GI Bill.[74]

- Sunsetting REAP increases annual costs of education benefits by $22 million initially. In FY 2013, REAP students received an average payment of only

[71] The Commission was unable to obtain such cost projections from DoD or VA.
[72] U.S. Department of Veterans Affairs, *Congressional Budget Submission for FY 2015 Volume III Benefits and Burial Programs and Departmental Administration,* VBA-33.
[73] Veterans' Benefits, 38 U.S.C. § 3011(b).
[74] Data provided by Office of the Under Secretary of Defense for Personnel and Readiness, e-mail to MCRMC, September 26, 2014.

$4,028.[75] These incremental costs are expected to decrease over time because REAP participation is already declining.[76]

- Eliminating unemployment benefits of veterans receiving housing stipend payments as part of Post-9/11 GI Bill reduces DoD unemployment payments by approximately 2 percent.[77] In FY 2013, the Services paid $828 million in unemployment benefits.[78] A 2 percent reduction decreases annual unemployment costs by $17 million.

- Eliminating the housing stipend for dependents who receive Post-9/11 GI Bill benefits through transfer, and changing the eligibility requirement for transferring Post-9/11 GI Bill benefits from 6 years of service (YOS), with a 4-year additional commitment, to 10 YOS, with a 2-year additional commitment, reduces annual costs by $4.8 billion.

- DoD and VA currently collect some limited data on students enrolled in programs with the Post-9/11 GI Bill and Tuition Assistance. Expanded data collection for those enrolled in these programs should be incorporated into the existing system, limiting the cost to the VA and DoD. Because these costs are expected to be limited, they are not estimated.

- No significant implementation costs are identified.

- For the high-cost (low-savings) estimate, 10 percent is added to all cost estimates to adjust for uncertainties. For the low-cost (high-savings) estimate, 10 percent is reduced from all cost estimates to adjust for uncertainties.

Validation

The Commission validated the results of this estimate using the internally generated cost model described above. As expected, this model predicted cost increases beyond simpler projections that were based solely on historical growth and general inflation. This accelerating growth in cost is also consistent with the inputs received from Service members and advocacy groups indicating the increasing awareness and utilization of education assistance, either by Service members or their dependents. Estimated costs for the MGIB-AD and REAP programs were also validated against historical costs and trends.

Recommendation 12: Better prepare Service members for transition to civilian life by expanding education and granting states more flexibility to administer the Jobs for Veterans State Grants Program.

The Commission estimates that its recommendation related to transition benefits would increase DoD budgetary costs and Federal outlays by $65 million during

[75] U.S. Department of Veterans Affairs, *Congressional Budget Submission for FY 2015 Volume III Benefits and Burial Programs and Departmental Administration,* VBA-33.
[76] Ibid.
[77] Data was not available to precisely calculate the number of Service members simultaneously receiving unemployment compensation and BAH benefits under the Post-9/11 GI Bill.
[78] Department of Defense, *Budget Amendment to the Fiscal Year 2015 President's Budget Request for Overseas Contingency Operations (OCO),* June 2014, accessed September 25, 2014, http://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2015/amendment/fy2015_m1a.pdf.

FY 2016–FY 2020 and result in annual steady-state cost increases of $13 million upon implementation. In this estimate, these cost increases result from requiring greater participation in the Transition GPS education track, which is currently optional, thereby increasing the number of mandatory transition classes.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	-	-	-	-	-	-	-	-
DoD Budget	13	13	13	13	13	13	13	13
Federal Outlays	13	13	13	13	13	13	13	13
Federal Outlays (Then-Year $)	13	13	14	14	14	27	28	28

Assumptions

- In FY 2013 DoD spent $123 million for Transition GPS.[79] Increasing mandatory training is expected to increase DoD program costs by 10 percent, or $13 million in FY 2016.
- Increasing attendance of One-Stop Career Center employees at Transition GPS classes, and expanding their reporting, is not expected to affect costs.
- Requiring a one-time report to the Congress regarding the challenges employers face when seeking to hire veterans is not expected to be substantial and was not estimated.
- Implementation costs are expected to be negligible.
- For the high-cost (low-savings) estimate, costs are increased by 10 percent to adjust for the uncertainty of current participation in the Transition GPS education track. For the low-cost (high-savings) estimate, costs are decreased by 10 percent to adjust for the uncertainty of current participation in the Transition GPS education track.

Validation

The Commission validated the cost increases associated with modifications to the Transition GPS course using historical program funding costs. The assessment that One-Stop Career Center employees can increase their participation in Transition GPS classes with no significant increase in personnel costs was validated through discussions with individuals serving as Disabled Veterans' Outreach Program Specialists and/or Local Veterans' Employment Representatives.[80]

Recommendation 13: Ensure Service members receive financial assistance to cover nutritional needs by providing them cost-effective supplemental benefits.

The Commission estimates that its recommendation related to the Family Subsistence Supplemental Allowance (FSSA) program would reduce DoD budgetary costs by $4 million during FY 2016–FY 2020 and result in annual steady-state savings of $1 million by FY 2017. Federal outlays would not be substantially affected by this

[79] MCRMC, *Report of the Military Compensation and Retirement Modernization Commission: Interim Report*, June 2014, 248-267 and 284, http://www.mcrmc.gov/index.php/reports.
[80] Virginia Employment Commission Workforce Center, discussion with MCRMC, October 3, 2014.

recommendation. In this estimate, these reductions result from elimination of the FSSA program in the United States and other regions in which benefits are available under the Department of Agriculture's Supplemental Nutrition Assistance Program (SNAP). Government outlays would not change substantially, because benefits received under FSSA would instead be provided under SNAP.

$ Millions	2016	2017	2018	2019	2020	2053	2054	2055
Implementation	-	-	-	-	-	-	-	-
DoD Budget	-	(1)	(1)	(1)	(1)	(1)	(1)	(1)
USDA Budget	-	1	1	1	1	1	1	1
Federal Outlays	-	-	-	-	-	-	-	-
Federal Outlays (Then-Year $)	-	-	-	-	-	-	-	-

Assumptions

- FY 2013 funding for the FSSA program was $1.1 million.[81] Assuming 75 percent of FSSA recipients reside in locations in which SNAP is available, sunsetting FSSA in such locations reduces DoD costs by approximately $0.9 million.
- SNAP costs increase by approximately $1 million. As discussed in the findings section for this recommendation, SNAP payments are often larger than those received through FSSA.
- Implementation costs are expected to be negligible.

Validation

The Commission validated estimates of cost reductions in DoD and the additional cost imposed on the Department of Agriculture through an internal analysis of data from the Defense Manpower Data Center. These data included much of the input used in the determination of SNAP and FSSA payments for Service members, allowing the Commission to validate estimates of the difference between the payments an individual might receive under each program and the demographics of eligible Service member households.

Recommendation 14: Expand Space-Available travel to more dependents of Service members by allowing travel by dependents of Service members deployed for 30 days or more.

The Commission estimates that its recommendation related to space-available travel would not have a noticeable effect on annual DoD budgetary costs or Federal outlays. This recommendation reprioritizes the use of available spaces for unofficial travel, but does not propose any change in the operation of military aircraft. The only costs expected with this recommendation are those associated with changing DoD regulations, local waiting list processes, and associated informational material. These costs are expected to be minimal and are not included in the Commission's cost estimates.

[81] Seventy-five percent of FY 2013 FSSA recipients resided in CONUS. Director of Military Compensation, Office of Personnel and Readiness, data supplied by e-mail to MCRMC, August 13, 2014. Of the 80 recipients stationed overseas, 62 were in Germany. Director of Military Compensation, Office of Personnel and Readiness, data supplied by e-mail to MCRMC, September 5, 2014.

Recommendation 15: Measure how the challenges of military life affect children's school work by implementing a national military dependent student identifier.

The Commission estimates that its recommendation related to a military dependent student identifier would not have a noticeable effect on annual DoD budgetary costs or Federal outlays. Establishing a national military student identifier requires changes to processes and data systems at the local, state, and national levels, which rely upon a variety of technologies. Some advocates have described the necessary modification costs to be small,[82] and they are not included in the Commission's cost estimates.

[82] "Issue 9: Assign an identifier for military children in education data systems," USA4Military Families Initiative, accessed September 17, 2014, http://www.usa4militaryfamilies.dod.mil/MOS/f?p=USA4:ISSUE:0::::P2_ISSUE:9. (Adding a field in an existing student information system should cause minimal additional cost, especially if the state has a single statewide system for collecting education data.)

SPECIAL ADVISORS TO THE COMMISSION

Mr. Daniel F. Huck
Mr. Frank Thorp IV

DEPUTY GENERAL COUNSEL

Ms. Allison C. George

LEADERSHIP DEPUTIES AND TEAM LEADS

Mr. Benjamin Bryant
Ms. Claire Zipf Giambastiani
Dr. Lyle J. Hogue
Ms. Jennifer R. Knowles
Mr. Mark A. Murphy
Ms. Alexis Lasselle Ross
Mr. Garrett Summers
Ms. Shawn Woodbridge
Mr. Thomas J. Zamberlan

REPORT CREDITS

INTERIM AND FINAL REPORT VOLUMES

Mr. Benjamin Bryant, Lead Writer, Editor, and Production Manager
Ms. Jennifer E. McKinney, Managing Editor
Dr. Wendy J. LaRue, Senior Editor
Mr. Donald J. Cicotte, Portfolio Writer and Editor
Ms. Christy Samuels, Portfolio Writer and Editor

PROPOSED LEGISLATIVE LANGUAGE VOLUME

Mr. Mark Koster, Legislative Counsel

GRAPHIC DESIGN (ALL VOLUMES)

Mr. Carl B. Berry III

WWW.MCRMC.GOV

MILITARY COMPENSATION AND RETIREMENT MODERNIZATION COMMISSION

WWW.MCRMC.GOV