



DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
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APR 19 2006

**MEMORANDUM FOR MEMBERS OF THE SECRETARY OF THE NAVY'S
RETIREE COUNCIL**

Subj: RELEASE OF THE UPDATE TO THE 2005 RETIREE COUNCIL REPORT

**Encl: (1) 2005 Retiree Council report (with updated responses to OPEN items)
(2) ASD(HA) ltr of 16 Mar 06**

The final update to the 2005 SECNAV Retiree Council report is at enclosure (1) for your information. It contains all of the 2005 Retiree Council report items developed at the Council's annual meeting and includes updated responses for those recommendations that remained in an OPEN status. Enclosure (2) is the response received from the Assistant Secretary of Defense (Health Affairs) for Item A-1.05, which contained seven sub-recommendations regarding the TRICARE benefit.

The enclosures will also be provided to the Navy and Marine Corps for publication in the official retiree newsletters, Shift Colors and Semper Fidelis, and will be posted on the Retiree Council's website.

A handwritten signature in black ink, appearing to read "W. Navas, Jr.", written over a horizontal line.

William A. Navas, Jr.
Assistant Secretary of the Navy
(Manpower and Reserve Affairs)

Item No: A-1.05

Subject: THE PROMISE OF SEAMLESS, COMPREHENSIVE HEALTHCARE

RECOMMENDATION:

That the Secretary of the Navy strongly urge TRICARE Management Activity to coordinate with appropriate agencies to provide a seamless, comprehensive healthcare benefit for all beneficiaries. Specifically,

- a.) Ensure that key and essential information about available TRICARE benefit options and information such as appointment processing, formulary and prescription policies, service availability, current phone numbers, and points of contact are disseminated in a timely manner.**
- b.) Have TRICARE publish status reports of their survey results in compliance with Public Law article 723-724, the requirement to inform both user and provider of program availability and usage. Enforce the contract reporting requirements as written.**
- c.) Encourage TRICARE contractors to aggressively increase the network capacity in underserved locations.**
- d.) Assure that TRICARE utilize all available mechanisms of marketing and education to make the TRICARE community knowledgeable and confident with the available options in order to make wise healthcare delivery choices.**
- e.) Initiate necessary legislative changes to include comprehensive eye examinations at all levels of the TRICARE benefit.**
- f.) Include FDA-approved technologies and technical advancements at all levels of the TRICARE benefit.**
- g.) Simplify and streamline the specialty referral authorization process.**

DISCUSSION:

Although, last year's recommendation by the same name was designated 'closed,' the Council understands that healthcare is the number one benefit that concerns retirees. We recognize and appreciate the considerable efforts and improvements in the military health system (MHS) and we are grateful for the significant effort extended on behalf of all retirees. We are impressed and encouraged by demonstrated progress that has been made in the improvement and refinement of the TRICARE health benefit for retirees. However, the Council is also concerned that economic forces, optempo, pending BRAC, increasing age diversity and volume of the retired population will continually threaten the promise of comprehensive healthcare for retirees.

ENCLOSURE(1)

Two major components of a seamless, comprehensive healthcare benefit are effective communication and easily identifiable access to quality care.

Communication Issues:

Healthcare transition points – Upon retirement and prior to TRICARE-for-Life (TFL) eligibility, major concerns exist. The retirees under 65 understand the system optempo and deployment requirements, but it raises their anxiety and frustration that access to their benefit may change with significant reliance on and utilization of the network providers and services. Establishing their confidence that the promise will be kept as their healthcare is transitioned from one delivery option to another should be the fundamental focus of attention.

Timely beneficiary and provider education – Changes in program execution are not consistently communicated to either beneficiaries or the providers with reasonable, adequate lead-time. Providers, both network and non-network, may have limited knowledge of program specifics. Too often retirees are made aware of new program modifications and local applications (appointment processing, prescription policies, dates of service availability, current phone numbers and points of contact) at the point of service when it is too late to make reasonable accommodations. There are many communication vehicles available including town hall meetings, retiree seminars, consumer councils, Fleet Family Support Centers, Pentagon channels, retiree newsletters, *Shift Colors/Semper Fidelis*, TRICARE website, messages on interactive voice response, direct mail, Veterans' Service Organization websites and other support organizations (DeCA, DFAS, DEERS) and education material at healthcare treatment facilities.

Formulary usage and pending changes – Proposed changes to DoD formulary policies are in process with potential for enormous impact on all participants. However, most customers are vaguely aware of proposed formulary and program changes on the horizon. There should be a comprehensive communication plan in place to inform retirees regarding changes prior to the effective date.

Contract compliance - Significant time and resources have been spent on the current successful contracts, however, there has been an inconsistent flow of information available to adequately evaluate the effectiveness of TRICARE contractor performance. The Council encourages responsible authorities to obtain timely reports and monitoring of contract compliance, both within and across TRICARE regions.

Customer service – The Delphi Council Survey completed in 2005 documents that a high percentage of callers surveyed were dissatisfied with phone courtesy. Entry point customer relations are pivotal to successful beneficiary experiences with the TRICARE system. Investment in customer service relations will enhance understanding, cooperation and facilitate improved utilization.

Access Issues:

A comprehensive benefit must include regular eye examinations. The retiree community has increasing need for optometry support as they age and lack of regular examinations could have detrimental effects on their long term health status. Current statutes preclude this examination for those utilizing TRICARE Extra, TRICARE Standard and TRICARE-for-Life. The Council strongly supports necessary legislative changes ensuring comprehensive eye examination as an integral part of good health care.

Proven technologies and advancements in healthcare delivery systems have markedly enhanced diagnostic capabilities and refined clinical screening. These clinical options which make early screening, diagnosis, and intervention possible are deemed safe and effective and approved by the FDA. These services are widely available but not currently covered by the TRICARE benefit. Including options such as digital scanning, C-reactive protein screening and virtual colonoscopy in covered services will direct austere funds to preventive and screening services, rather than more expensive treatment options with lower success rates. This will result in healthier population outcomes and decreased healthcare costs for the government.

The participating provider network is more robust in some areas than others, resulting in some underserved areas. This, compounded by low reimbursement rates, slow reimbursement response, a limited number of providers at maximum capacity, increased reliance on network providers, and increased optempo creates a lack of access for many potential beneficiaries in some geographic areas.

A cumbersome referral authorization process sometimes results in inappropriate billing of the retiree for approved specialty care. It is then incumbent upon the retiree to remedy the billing chaos. Many retirees have not developed the necessary skills to sort through the overwhelming process.

RESPONSE: DEFER TO TRICARE MANAGEMENT ACTIVITY. The Retiree Council's comments above have been forwarded to the Director of the TRICARE Management Activity as areas under his cognizance for response.

STATUS: OPEN.

UPDATE: The Assistant Secretary of Defense (Health Affairs) has responded to each of the Retiree Council's recommendations and comments in a memorandum dated March 13, 2006. Because of the length of the comments, the document is provided as an addendum to this report.

STATUS: CLOSED.

Item No: A-2.05

Subject: DEPARTMENT OF THE NAVY RETIRED ACTIVITIES PROGRAM

RECOMMENDATION:

A. That the Secretary of the Navy emphasize the value and importance of the Department of the Navy Retired Activities Program, specifically the Retired Activities Offices (RAO), as a valuable conduit to the retiree community.

B. The Secretary of the Navy direct the CNO and CMC communicate to Commanders the importance of the Navy Retired Activities Program as defined in SECNAV INSTRUCTION 5420.169H .

DISCUSSION:

Currently Secretary of the Navy Instruction 5420.169H, Department of the Navy Retired Activities Program, defines the parameters of the Retired Activities Offices' organization, structure, mission, and support requirements. As defined, Retired Activities Offices are staffed by volunteers with the primary responsibility of providing assistance and support to the retirees, their spouses, family members, and widows. The value of the Retired Activities Offices depends on their ability to provide a service to the retiree in time of need, provide timely information regarding benefits and provide administrative requirements to the retiree community as a whole in specific geographic areas. Command support to the Retired Activities Offices is an essential component to the Program.

The SECNAV Retiree Council members conducted an informal survey of various Retired Activities Offices with the aim of identifying their effectiveness and utilization. During this survey, we asked what their needs were and reviewed the issues they are addressing with the retirees who avail themselves of their services. The survey indicated significant differences among the various Retired Activities Offices. Some offices were well staffed with volunteers, receiving good support from the local Commanders, and consequently providing excellent service to the retiree community. Others appeared to have limited to no volunteers available and minimal support from local commanders. Further review indicated a reduction in the number of Retired Personnel Seminars being conducted. In some cases the RAO existed in name only with no services provided.

RESPONSE: CONCUR. Correspondence has been sent to the Navy and Marine Corps to request their assistance in reemphasizing the RAO program. SECNAV Instruction 5420.169H has been updated; SECNAVINST 5420.169J was signed on 17 October 2005. This new instruction was included in the correspondence to encourage the use of the updated guidance to reemphasize the importance of the RAO program in each Service.

STATUS: CLOSED.

Item No: A-3.05

Subject: DEVELOPING A NAVAL DEPARTMENT AUXILARY FORCE

RECOMMENDATION:

That the Secretary of the Navy continue to strongly support development of a Department of the Navy Auxiliary Force – a program which the Total Force Transformation Working Group is planning to examine.

DISCUSSION:

In our 2004 Report, the Council recommended commissioning a study to evaluate the viability of developing a Department of the Navy Auxiliary Force from the Navy and Marine Corps retiree community. In response, the Secretary referred the recommendation to the Total Force Transformation Working Group stating, that the proposal was “clearly feasible” and held “great promise for the Department of the Navy organization as it seeks to restructure itself into a more agile, flexile workforce...”

The Retiree Counsel thanks the Secretary for his positive response to this initiative and strongly urges continued support of the Secretariat for an expanded role for the retired community as volunteers supporting the active force. The retired community represents a largely untapped resource of experience, skills, and talent which stands ready to answer the call to support active duty commanders. It is the Council’s strong position that the retired community should be an essential element of any future Navy Auxiliary Force.

The Council requests that this item remain in an “OPEN” status pending results of the Total Force Transformation Working Group’s final report on this item.

RESPONSE: CONCUR. Through the leadership of the Force Management Oversight Council (FMOC) and the ASN(M&RA), the Department of the Navy is about to launch a concentrated effort to transform and better integrate the Total Force. Entitled “Human Capital Transformation,” this process seeks as an end product “a total force of dedicated, courageous, innovative professionals—Sailors and Marines (active duty and Reserve), government civilians, government contractors, and *volunteers*—who can master the challenges of this new operational and business environment.” One of the strategic goals developed for this transformation process is to “provide more flexibility in how our people transition out and across systems, including multiple options to move between statuses (i.e., active duty military, reserve, *volunteer*, retirement), giving both the DON and the individual service member greater freedom of maneuver.” Among the future efforts in support of this strategic goal will be to flesh out the necessary policy initiatives, tasks, and milestones necessary to achieve to achieve this strategic goal. Additionally, it should also be noted that the DoD Quadrennial Defense Review effort has been closely aligned with the DON effort and has included volunteers in its list of Total Force players. Additional information will be provided as future events warrant.

STATUS: OPEN.

UPDATE: In a memorandum dated February 8, 2006, the Secretary of the Navy, Chief of Naval Operations, and Commandant of the Marine Corps approved the Department of the Navy's Objectives for 2006. One of those objectives was to implement the 2006 priorities in the Force Management Oversight Council's Strategic Plan for Human Capital Transformation. Work on the Strategic Plan has begun, guided by the Total Force Transformation Office within the office of the ASN(M&RA). Policy development teams for each of the components of the strategic plan have been stood up. One of those teams is leading the Continuum of Service effort, which has as its overarching goal the development and implementation of personnel management options to facilitate personnel movement and transitions across service status categories (active, reserve, government civilian, government contractors, and volunteers/retirees/auxiliaries).

A member of the Total Force Transformation Office is scheduled to brief the Retiree Council during its annual meeting on the strategic plan, and will focus specifically on the Continuum of Service component and engage in a dialogue with the Council about the volunteer auxiliary proposal and potential steps ahead for such an effort within the context of the plan.

STATUS: OPEN.

Item No. A-4.05

Subject: FULL RETIREMENT PAY FOR RETIREES CLASSIFIED AS INDIVIDUAL UNEMPLOYABILITY (IU)

RECOMMENDATION:

A. That the Secretary of the Navy support a change in DoD policy to permit eligible retirees who have a combined combat-related disability of 60 percent or greater *and* who are considered by the VA to be unemployable, to receive Combat Related Special Compensation (CRSC) at the 100 percent rate if their Department of Veterans Affairs (VA) disability ratings are increased to 100 percent.

B. That the Secretary of the Navy support legislation to allow full retirement pay for retired military personnel who have an Individual Unemployability (IU) rating from the VA and receive Concurrent Retirement and Disability Pay (CRDP).

DISCUSSION:

There are two ways for a claimant to achieve a total disability rating with the Department of Veterans Affairs (DVA): the first is to qualify for a 100 percent rating under the schedule set forth in part 4 of 38 C.F.R; the second is to meet the standards of the regulations governing "individual unemployability" (IU). IU exists to cover the situation in which a service-connected disability makes the veteran unemployable under "the established policy of the Department of Veterans' Affairs that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled."

The definition of IU is provided above because the term plays a significant role in the amount of compensation paid by DoD for Combat Related Special Compensation (CRSC) and Concurrent Retirement and Disability Pay (CRDP). When Congress approved the most recent changes in concurrent receipt, there were apparently unintended consequences for these two groups (CRSC and CRDP) of disabled retirees. Specifically:

1) DoD established a policy to allow military retirees who had a combined combat-related disability rating of 60 percent or greater *and* who meet the VA's IU requirements to receive CRSC at the 100-percent rate. Although this policy is advantageous for most retirees in that situation, some will lose military retired benefits. For example, if a retiree's VA disability rating is increased to 100 percent and their CRSC rating remains unchanged, total compensation may actually decline. Let's say, a military retiree has an 80 percent CRSC rating and a VA rating of 90 percent and is unemployable (IU), he/she will receive a CRSC payment based on 100 percent. But if the VA changes this same retiree's disability rating to 100 percent, the IU rating (usually) is withdrawn and the retiree's CRSC payment would be reduced to 80 percent, resulting in a loss of military retired pay. (The VA does not necessarily classify veterans who are 100 percent disabled as IU.) This inequity can be corrected by changing DoD policy to allow those military retirees considered IU who are subsequently increased to a 100 percent disability

rating, to continue to receive their CRSC entitlement at the 100 percent dollar amount. The Council strongly supports this change in DoD policy.

2) A similar situation exists for those military retirees entitled to CRDP and who are IU. Section 642 of the FY 2005 National Defense Authorization Act (NDAA) repealed the phase-in period of concurrent receipt for retirees receiving VA disability compensation for a disability rated as 100 percent. But it did not directly address military retirees who are rated less than 100 percent disabled by the VA but who are IU and therefore are compensated by the VA at the 100 percent rate. These military retirees – who are being paid at the VA 100 percent disability rate although they are not 100 percent rated – are not entitled to immediate full concurrent receipt. These retirees (estimated to be about 30,000), who are IU and in many cases whose only source of income is their VA disability compensation and their DoD retired pay, are required to wait the entire 10 year phase-in period to receive full concurrent receipt. It is the opinion of the Council that they should receive the same treatment as the other 100-percent disabled retirees. A legislative amendment to section 642 of the FY 2005 NDAA is needed to clarify the eligible pool of those military retirees entitled to full concurrent receipt. The Council encourages the Secretary to support legislation to include this group of military retirees among those entitled to immediate full concurrent receipt.

RESPONSE TO ITEM A: DO NOT CONCUR. Individual Unemployability (IU) is a VA determination designed to assist a veteran who cannot work due to severity of disabilities rated at less than 100% overall. The VA Legal Counsel stated that no additional benefit is accrued to an IU individual who is later evaluated as 100% disabled due to medical conditions, so the IU status is removed by the VA at such time as the veteran is rated 100% disabled. This legal decision was rendered before the CRSC program came into effect.

The Office of the Secretary of Defense issued revised Program Guidance for CRSC (dated April 15, 2004) that established the policy that CRSC is to be paid at the 100% rate for all qualifying cases judged IU by the VA. It is important to note that this is a blanket policy; in other words, CRSC is paid at the 100 percent rate *whether or not* the reason for the IU determination is connected to combat-related injuries.

The recommendation made by the Council above is, in effect, a “grandfather clause” whereby once a retiree has received CRSC at the 100% rate due to IU, they should forever receive CRSC at the 100% rate regardless of the actual percentage of combat-related injury. The problem with this is that it establishes a precedent whereby if any retiree’s CRSC percentage is decreased, then he or she should always be paid at the higher rate. It is additionally problematic because the IU determination may not even be based on a combat-related injury.

It may not be generally known, but VA ratings can fluctuate up and down several times during the lifetime of a veteran (i.e., rapid/slow progression of a disease, surgeries, extended hospitalization, remission, frequency of VA examinations requested by the individual, changes in medical findings, court decisions, etc.). For example, a retiree may be rated at 30% for Post-Traumatic Stress Disorder (PTSD) for many years, be hospitalized for a PTSD episode, and be reevaluated by the VA as 100%. At a later date, once treatment has been received, the rating may be adjusted downward again by the VA. VA disability compensation to the veteran also is

increased and decreased accordingly. There is no precedent for VA benefits to be paid only at the highest level attained. Each case is reevaluated and changes are made to benefit levels as needed. Likewise, CRSC eligibility, which is by law tied to the VA's disability ratings and diagnoses, must also be reevaluated as these ratings and diagnoses codes change, and benefit levels must be adjusted accordingly.

An alternative solution that would remove this perceived inequity would be to change DoD policy to de-link IU from CRSC, and only pay CRSC for those diagnoses determined to be combat-related and for those Special Monthly Compensation (SMC) codes linked to a combat-related diagnosis. However, this solution would have a negative impact on the many retirees currently receiving a 100% CRSC payment due to an IU determination.

Viewed in this light, the policy as it currently stands provides the greatest "benefit of the doubt" for IU retirees by providing them with a 100% CRSC payment (regardless of the nature of the unemployability), but also retains the essential connection between CRSC and the VA process.

STATUS: CLOSED.

RESPONSE TO ITEM B: DEFER TO CONGRESS. As noted above, this remedy must be made through change to the statute. As of this writing, similar provisions in both the House and Senate versions of the FY 2006 National Defense Authorization Act (NDAA) would provide full immediate concurrent receipt of retired pay and VA disability compensation to qualifying retirees with an IU determination from the VA. It appears virtually certain that this provision will end up in the final version of the NDAA passed by Congress.

STATUS: OPEN.

UPDATE TO ITEM B: On January 6, 2006, President Bush signed the FY 2006 NDAA into law. The NDAA included the provision to restore full concurrent receipt of retired pay and VA disability compensation to IU retirees.

STATUS: CLOSED.

Item No: A-5.05

**Subject: ELIMINATE THE SURVIVOR BENEFIT PLAN (SBP)
DEPENDENCY INDEMNITY COMPENSATION (DIC) OFFSET**

RECOMMENDATION:

That the Secretary of the Navy support legislation to repeal the requirement to reduce Dependency Indemnity Compensation by the amount a survivor receives from the Survivor Benefit Plan.

DISCUSSION:

Survivor Benefit Plan (SBP) and Dependency Indemnity Compensation (DIC) are paid for different reasons. SBP is purchased by the retiree and is intended to provide a portion of retired pay to the survivor. DIC is a special indemnity compensation paid to the survivor when a member's service causes his or her premature death. In such cases, the Department of Veterans Affairs (DVA), DIC should be added to SBP, not substituted for it. It's also a matter of equity that surviving spouses of federal civilian retirees (who were disabled veterans and died of military-service-connected causes) can receive DIC without losing any of their purchased federal civilian SBP benefits.

Due to the increasing number of casualties from Operation Iraqi Freedom and Operation Enduring Freedom, Congress extended SBP eligibility to the survivors of all service members who die on active duty regardless of time in service. Under current law, the surviving spouse of a retired member who dies of a service-connected cause is entitled to DIC from the DVA. If the military retiree was also enrolled in SBP, the surviving spouse's SBP benefits are reduced by the amount of DIC (currently \$993 per month). A pro-rated share of SBP premiums is refunded to the widow upon the member's death in a lump sum, but with no interest. The offset also affects all survivors of members who are killed on active duty.

In the case of members killed on active duty, a surviving spouse with children can avoid the dollar-for-dollar offset by electing Child-Only SBP. However, this means that SBP payments will cease when the youngest child attains his/her majority (age 18, or 22 if in school). Additionally, Social Security survivor benefits stop when the youngest child reaches age 18. This leaves the spouse with only the monthly DIC annuity from the DVA. The surviving spouses of those who give their lives for their country deserve fairer compensation.

H.R.808 proposes repeal of the provisions of Title 10 which require the offset of DIC payments from SBP annuities. The bill also provides for the recoupment of certain portions of SBP premiums that may have been refunded to the surviving spouse. The Retiree Council strongly supports the proposed legislation.

RESPONSE: DEFER TO CONGRESS. As of this writing, the Senate version of the FY06 National Defense Authorization Act (NDAA) contained a provision to remove the DIC/SBP offset, and in the House, Representative Chet Edwards recently introduced a discharge petition to

force a House vote on H.R. 808, which, if passed, would virtually assure that the final version of the NDAA would include this provision.

However, the Department of Defense has previously gone on record to Congress in opposition to H.R. 808. Among the reasons cited for opposing the bill are that it duplicates Government benefits, since the federal government fully funds both SBP and DIC for active duty deaths; does not take into account that SBP premiums paid by retirees which are attributed to the reduction for DIC are returned to the beneficiary, generally in a lump sum; disregards the finding of a 2004 study that the SBP/DIC offset is consistent with the benefits offered by other employers; and does not take into account that survivors of members who die on active duty and have children may avoid the offset by having the SBP paid to the children.

STATUS: OPEN.

UPDATE: The final version of the FY 2006 NDAA signed into law by President Bush did not include the Senate provision to end the DIC/SBP offset.

STATUS: CLOSED.

Item No: A-6.05

Subject: 30-YEAR PAID-UP SURVIVOR BENEFIT PLAN

RECOMMENDATION:

That the Secretary of the Navy support proposed legislation changing the effective date of paid-up Survivor Benefit Plan from October 1, 2008 to October 1, 2005.

DISCUSSION:

The FY1999 National Defense Authorization Act authorized a 30-year paid-up Survivor Benefit Plan (SBP) provision allowing retired SBP enrollees who have attained age 70 and paid SBP premiums for at least 30 years (360 months) to stop paying premiums, while retaining SBP coverage for their survivors. However, because of budget constraints at the time, Congress delayed the effective date of this provision until October 1, 2008.

When paid-up SBP legislation was first proposed in 1997, it was to be effective five years later in 2002 -- 30 years from the date of SBP enactment in 1972. After multiple 'false starts', Senate and House conferees slipped the effective date to 2008 to allow "scoring" it as a no-cost proposal under the House 10-year budget window. This had the effect of fully covering members who retired after 1978, but disadvantaged earlier SBP enrollees, who will have to pay up to 36 years of premiums. This presumably unintended consequence has been dubbed a tax on the 'greatest generation' because it affects only retirees from that era.

Current proposed legislation (H.R. 968) would move up the existing 2008 implementation date, making the 30-year paid-up SBP coverage provision effective October 1, 2005.

RESPONSE: DEFER TO CONGRESS. As of this writing, a provision was inserted into the Senate version of the FY 2006 National Defense Authorization Act that would move the SBP paid up date to October 1, 2005. However, the Department of Defense has previously gone on record opposing the move-up date as too difficult for DFAS to accomplish administratively.

STATUS: OPEN.

UPDATE: The final version of the FY 2006 NDAA signed by President Bush did not include the Senate provision to move the SBP paid up date to October 1, 2005.

STATUS: CLOSED.

Item No. B-1.05

Subject: PRE-TAX HEALTH INSURANCE PREMIUMS

RECOMMENDATION:

That the Secretary of the Navy support legislation to amend the Internal Revenue Code to allow active duty, retired military members, and federal civilian annuitants to pay their health insurance premiums on a pre-tax basis.

DISCUSSION:

Many uniformed services beneficiaries, including retirees, pay premiums for a variety of health insurance programs, such as TRICARE Prime enrollment fees, TRICARE Standard supplemental premiums, TRICARE Dental Plan, and TRICARE Retiree Dental Plan. For the vast majority, these premiums and enrollment fees are not tax-deductible because their health care expenses do not exceed 7.5 percent of their adjusted gross taxable income.

Since 2000, Federal civilian employees have been able to use pre-tax dollars to pay health insurance premiums to the Federal Employees Health Benefits Program under the "Premium Conversion" program. Premium conversion uses Federal tax rules to let employees deduct their share of health insurance premiums from their taxable income, thereby reducing their taxes. This plan is similar to the private sector, in which their employees have been allowed to deduct health insurance premiums from their taxable incomes for many years.

Similar legislation for all active and retired military beneficiaries would restore equity with many private sector and federal civilian workers who can pay their health premiums with pre-tax dollars. Compensation and benefits issues remain integral to retaining a top-quality all-volunteer force to wage the war against terrorism at home and abroad. The stresses of military life along with the recent increase in operations tempo are taking their toll on military families. While certain sacrifices are taken for granted as a part of the military life, it is important that every attempt be made to provide them with a Quality of Life that is competitive with the private sector.

Proposed legislation that currently addresses this issue includes H.R. 1231, H.R. 994, and S. 484. These bills would amend the IRS Code to allow active duty and retired military members and federal civilian annuitants to pay their health insurance premiums on a pre-tax basis. Military retirees and federal annuitants should be afforded the same tax relief for their health care premiums as private sector and civilian federal workers.

RESPONSE: CONCUR. The Department of the Navy has not been specifically asked to provide input on the bills listed above but can concur in concept with the idea of extending the payment of health insurance premiums on a pre-tax basis to active duty, military retirees and federal civilian annuitants.

STATUS: CLOSED.

Item No: B-2.05

Subject: ISSUANCE OF DD214

RECOMMENDATION:

That the Secretary of the Navy support issuing DD 214s to separating and retiring service members early in order to facilitate completion of the DVA compensation decision at separation.

DISCUSSION:

Current practice prohibits issuance of a DD 214 to a retiring or separating member prior to the day of active duty expiration. To adjudicate a Department of Veterans Affairs (DVA) compensation claim in conjunction with the service member's discharge, the DD 214 must be provided to the DVA office performing Benefits Delivery on Discharge (BDD) at the installation. The DVA reports that it takes approximately 45 days to complete the process for adjudication and notification of findings to the member. Retiree Council VA briefer, Mr. Tom Pamperin stated, "the U. S. Army issues DD 214's for member's submitting DVA compensation claims 45 days before date of separation" so that the DVA may adjudicate the claim, and provide notification of their findings to the separating soldier on the day of separation.

To adopt a "Best Practice," as identified by the DVA, Sailors and Marines' being separated or retired that are submitting DVA compensation claims should be issued a completed and signed DD 214 in a timely manner to satisfy BDD policy for rendering a compensation decision on the day of separation or retirement.

RESPONSE: DO NOT CONCUR. DD Form 214 is an important record of service that must be prepared accurately and completely because it is a source of significant and authoritative information used by civilian and governmental agencies to validate veteran eligibility for benefits. Issuing signed DD Form 214s so far in advance of the discharge date creates an overwhelming "margin for error." Some examples of situations that would necessitate a correction or a change to the information in the DD Form 214 if issued early: settlement of the leave account at the time of separation often changes initial calculations of the service member's leave balance; the separating service member is still under the authority of the UCMJ and could do something while on terminal leave that could affect their ultimate characterization of service; the service member may decide at the last moment to remain on active duty instead of separating; or the service member becomes seriously injured or ill while on terminal leave. These errors then have to be corrected—and redoing work does not constitute a "best practice."

The governing DoD Instruction 1336.1, "Certificate of Release or Discharge from Active Duty (DD Form 214/5 Series)" states that "the original of DD Form 214 showing separation from a period of active service with a Military Service, including release from a status that is legally determined to be void, will be physically delivered to the separatee prior to departure from the separation activity (a) on the effective date of separation; or (b) on the date authorized travel time commences. . . When the recipient departs in advance of normal departure time (e.g.,

on leave on conjunction with retirement; or at home awaiting separation for disability), the original DD Form 214 will be mailed to the recipient on the effective date of separation.”

Contact with the Army reveals that Army Regulation 635-5 (titled “Separation Documents”) states that Copies 1-8 of the DD Form 214 are not distributed until the soldier’s separation date, except for the “Copy 4” version (personal copy) of the DD Form 214, which can be provided to the soldier at the time they detach from the command for terminal/transition leave. Note however, that this is not the official copy of the DD 214 that is specifically for use by the Department of Veterans Affairs (Copy 3) for determining benefits. Copy 4 is considered to be a “courtesy copy” for the service member’s personal use. The Army advises that Copy 4 should not be considered an “official” copy of the DD Form 214 prior to separation.

Recognizing that there is a real need to provide separating Marines and Sailors with documentation that summarizes their accomplished service in advance of their separation date, the Marine Corps issues a “Statement of Service” to those Marines who request it for purposes of employment, benefits, etc. The document is versatile and allows inclusion of any or all data covered in the DD Form 214. The Statement of Service serves as an “interim working document” for requesting institutions. In the case of the Navy, upon request of the Sailor, he or she may receive an unsigned, zeroxed copy of the “Copy 4” version of the DD Form 214 prior to separation for personal use.

While the methods may vary from Service to Service, separating and retiring personnel are being provided with unofficial information that can be used by other agencies, at their discretion, for making determinations for benefits.

STATUS: CLOSED.

Item No. B-3.05

Subject: SURVIVOR BENEFIT PLAN (SBP) MULTIPLE BENEFICIARIES

RECOMMENDATION:

That the Secretary of the Navy encourage the drafting of legislation to enable a service member to elect multiple Survivor Benefit Plan (SBP) beneficiaries as a result of divorce.

DISCUSSION:

Generally, Survivor Benefit Plan (SBP) coverage is an irrevocable decision. However, under limited circumstances, the service member may withdraw from SBP or change his/her coverage. As an SBP participant, a service member has a one-year window to terminate SBP coverage between the second and third anniversary following the date he/she begins to receive retired pay. Should a service member make such a choice, premiums already paid will not be refunded and no annuity will be payable upon death. The covered spouse or covered former spouse must consent to the termination. Termination is permanent and participation will not be resumed under any circumstances and future enrollment is barred unless there is an authorized open enrollment period.

In the case of divorce, under current law, members can elect the SBP for only one spouse, either the current spouse or former spouse. Often, the election of a former spouse as the beneficiary of SBP is negotiated or court-ordered and made a part of the divorce decree. A former spouse who procures such a settlement or court-order freezes out any subsequent spouse and family the member may later acquire. This potentially creates the anomalous result that a former spouse might be entitled to, for example, only 10 percent of a member's retired pay, but upon the member's death, the former spouse will receive 100 percent of SBP and a current spouse would receive nothing.

In 2001, a DoD study (undertaken in accordance with the 1998 National Defense Authorization Act), concluded that this practice is unfair to the member and subsequent spouses. The study report recommended that SBP benefits be presumptively based on the share of retired pay a former spouse receives and recommended that SBP benefits be divisible among multiple spouses. To date, Congress has failed to act on DoD's recommendation.

We ask the Secretary to encourage DoD to resurrect the study and appeal, once again, to Congress to draft legislation to make SBP divisible among multiple spouses and create a presumption that the former spouse(s)'s share of SBP be consistent with the share of retired pay they receive.

RESPONSE: CONCUR. It is true that one of the recommendations in the 2001 Report to Congress by DoD concerning federal former spouse protection laws was to change the statute to allow SBP to be designated for multiple beneficiaries. However, Congress has not acted on DoD's recommendations.

Rather than resurrecting the study, an alternate way to raise the issue may be through the Department of Defense Unified Legislation and Budgeting (ULB) process. The ULB process provides an opportunity for multiple stakeholders to consider no-cost/low-cost proposals, which, if agreed upon by the stakeholders, then become part of the Omnibus legislative package submitted by DoD to Congress. A draft ULB proposal on this issue has been developed and will be vetted within the DoN in the upcoming months for possible insertion into the next ULB cycle, which will take place in mid-2006. Updates will be provided on the status of this item as events warrant.

STATUS: OPEN.

UPDATE: The draft ULB proposal has been reviewed by subject matter experts within the Navy, Marine Corps, and the office of the Assistant General Counsel (Manpower and Reserve Affairs). In all cases, the recommendation was to non-concur with moving this proposal forward as an item in the ULB process. A number of concerns and unanswered questions were expressed and these are summarized below.

- The recommendation in the 2001 USFSPA study cited by the Council was to “establish a presumption (*unless otherwise agreed by the parties or ordered by the court* (emphasis added)) that multiple beneficiary designations and related allocations of SBP benefits must be proportionate to the allocation of retired pay.” Such a loophole could allow courts to negate the presumption of the retired pay allocation for SBP benefits. Also, state legislatures and state courts may seek to fashion legislation, divorce decrees and property settlements that could counter much of what this proposal seeks to accomplish—for example, by maximizing a former spouse’s percentage of the service member’s retirement pay, leaving less of a SBP benefit for a subsequent spouse, and/or by making up any differences through the division of other marital property. However, removing these caveats can also work against those service members who actually desire to provide a full SBP annuity for their former spouse.
- If the law allowed for a negotiated or lower percentage of the annuity during the divorce process, would this guarantee the subsequent spouse the remainder of the annuity? What if a second marriage ends and the member married a third time and wanted to insure the spouse?
- If only part of the benefit will be provided to a former spouse, does the member pay the full premium amount with the expectation that the rest of the annuity can be assigned to a subsequent spouse in the future? What if there is no “subsequent spouse?”
- If the SBP election is made prior to the divorce and full premium annuity amounts are already established for a (then) current spouse, how will that affect a subsequent divorce and a division of annuity?
- When could the request be made to limit the annuity? During a special open season? Any time after the date of divorce? During the first year after the date of divorce?

- Would this law be retroactive? If a former spouse is currently entitled to the full annuity, how would such a change affect their annuity? If the law is not retroactive, what effect will it have on service members currently with second spouses who will not be able to designate a portion of the SBP benefit for their current spouse?
- It is anticipated that having more than one beneficiary of the spouse benefit would increase premium cost. However, if the SBP selection is made before any divorce occurs, does this change future premium cost if a service member divorces and subsequently remarries?

In short, due to the large number of unaddressed concerns the proposal raises, this proposal will not be placed in the ULB process.

STATUS: CLOSED.



THE ASSISTANT SECRETARY OF DEFENSE

**1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200**

HEALTH AFFAIRS

MAR 13 2006

MEMORANDUM FOR ASSISTANT SECRETARY OF THE NAVY (M&RA)

SUBJECT: 2005 Secretary of the Navy Retiree Council Report

This memorandum and the attached information paper respond to your December 28, 2005 memorandum requesting a review of recommendations made by the Secretary of the Navy Retiree Council for providing a seamless, comprehensive healthcare benefit for all beneficiaries. The retiree council's recommendations span a range of important issues, and we welcome the opportunity to comment on their recommendations and highlight several initiatives the Department pursues to ensure our beneficiaries continue to have a world class health care system and benefit.

William Winkenwerder, Jr.
William Winkenwerder, Jr., MD

Attachment:
As stated

ENCLOSURE (2)

Information Paper
on the
2005 Secretary of the Navy Retiree Council Recommendations for a Seamless
Comprehensive Healthcare Benefit

Background: The 2005 Secretary of the Navy Retiree Council recommended that the Secretary strongly urge the TRICARE Management Activity (TMA) to coordinate with the appropriate agencies to provide a seamless, comprehensive healthcare benefit for all beneficiaries. The Assistant Secretary of the Navy for Manpower and Reserve Affairs requested that the Assistant Secretary of Defense for Health Affairs (ASD (HA)) respond to the following seven elements of the recommendation:

- Ensure that key and essential information about available TRICARE benefit options and information such as appointment processing, formulary and prescription policies, services availability, current phone numbers, and points of contact is disseminated in a timely manner.
- Have TRICARE publish status reports of their survey results in compliance with Public Law article 723-724, the requirement to inform both user and provider of program availability and usage. Enforce the contract reporting requirements as written.
- Encourage TRICARE contractors to aggressively increase the network capacity in underserved locations.
- Assure that TRICARE utilize all available mechanisms of marketing and education to make the TRICARE community knowledgeable and confident with the available options in order to make wise healthcare delivery choices.
- Initiate necessary legislative changes to include comprehensive eye examinations at all levels of the TRICARE benefit.
- Include FDA-approved technologies and technical advancements at all levels of the TRICARE benefit.
- Simplify and streamline the specialty referral authorization process.

Discussion: In order to maintain TRICARE as an exceptional benefit, there are processes in place to continually examine all facets of the program and how we communicate new, updated, or changed aspects of the benefit. The attachments to this paper address each of the elements of the 2005 Secretary of the Navy Retiree Council recommendation.

Attachment 1

Ensure That Key And Essential Information About Available TRICARE Benefit Options And Information Such As Appointment Processing, Formulary and Prescription Policies, Services Availability, Current Phone Numbers, and Points Of Contact Are Disseminated In A Timely Manner.

BACKGROUND: Each year, as the TRICARE benefit is enhanced or new benefits become authorized, the TRICARE Management Activity (TMA) Communications and Customer Service Directorate (C&CS) uses multiple communication vehicles to inform beneficiaries about all changes to their benefit. These communication efforts include the news media, TRICARE web sites, printed materials, emails, and training/updates for all government and contractor customer service individuals in call and contract centers. All communications efforts are based on scientific research and audience analysis to determine the preferred source of information for each beneficiary target audience.

DISCUSSION: In 2005, communications vehicles included approximately 200 printed materials 21 news releases, 19 fact sheets, thousands of emails, hundreds of Frequently Asked Questions, new training modules, and more than 100 web pages.

Printed (marketing and education) materials are developed and distributed world-wide to Prime households, 500 MTFs and TRICARE Service Centers, Family Service Centers, Guard and Reserve units, etc. More than 3,000 certified SMART site bulk users around the world provide these materials at military facilities, community meetings, unit briefings, deployment and redeployment sites, and by direct mail to members' homes. Monthly bulletins and quarterly newsletters are direct-mailed to every Prime household to ensure they have the most current and complete information on their benefit. Network providers also receive monthly bulletins and quarterly newsletters to ensure they are current on the benefit in order to best service beneficiaries using the TRICARE network.

Marketing and communications campaigns for major changes or enhancements to the benefit use all communications vehicles to ensure affected beneficiaries are kept informed. In 2005, campaigns targeting Guard and Reserve members, families eligible for the TRICARE Reserve Select benefit, and the victims of Hurricanes Katrina, Wilma and Rita were so comprehensive and effective that C&CS won communications awards for them.

21 TMA New Releases were distributed via hundreds of media around the world—often targeted to locations where the affected beneficiary resides or is assigned. During the launch of the TRICARE Reserve Select Benefit, approximately 1,800 media outlets were targeted based on their proximity to Guard and Reserve units and hometowns of Guard and Reserve members. These same releases are 'pushed' to hundreds of interested beneficiaries who subscribe to C&CS listserv.

News Release Topics Include:

Medicare Parts B & D (2)
TRICARE Reserve Select (5)
Uniform Formulary (4)
Health Choices (1)
Mental Health (1)

TRICARE Overseas Prime Survivors (1)
Extended Care Health Option (1)
TRICARE Dental (2)
Claims Processing (1)
Permanent ID Cards (1)

Hearing Aids (1)

Patient Management System (1)

19 TMA Fact Sheets were developed or updated, posted on the TRICARE Web site, and ‘pushed’ via email to hundreds of interested beneficiaries who subscribe to C&CS listserv. Fact Sheets are one of the most heavily used sources of information on the TRICARE web site.

Topics Include:

Defense Enrollment Eligibility Reporting System (2)	TRICARE Pharmacy Options (1)
Extended Care Health Option (2)	TRICARE Prime Travel (1)
Supplemental Insurance (1)	TRICARE Reserve Benefits (1)
TRICARE Dental Program (2)	TRICARE Reserve Select (1)
TRICARE Medical of Honor Recipients (1)	Survivor Benefits ADFM (1)
TRICARE For Life and Medicare (1)	TRICARE Retiree Dental (1)
TRICARE Maternity Care Options (1)	TRICARE Eligibility (1)
Transitional Assistance Management Program (1)	TRICARE Standard (1)

TMA also meets twice a month or more as needed with members of the **Military Coalition and National Military/Veterans Alliance**—two groups comprised of organizations representing uniformed services members, including active duty members, reservists, retirees, survivors, veterans, and their families. The Coalition and Alliance members lobby the legislative and executive branches of government on a wide range of military quality of life issues, including compensation, health care, veteran and survivor benefits, housing and education. In 2005, a total of 25 TRICARE Beneficiary Panel (TBP) meetings were held to educate this group on all new program initiatives which helped to significantly improve the public trust and confidence in the Military Health System.

25 TBP Meetings —19 TRICARE Topics

TRICARE For Life (1)	TRICARE Reserve Select (6)
Healthy Choices for Life (1)	Reserve Health Benefit Program (1)
America Supports You” Program (1)	TRICARE Dental Program (1)
TRICARE Network Adequacy (2)	DoD Pharmacy Program (1)
Primary Care Manager By Name Program (1)	TRICARE Standard Beneficiary Newsletters (1)
Mental Health Counselor Demonstration (1)	
Extended Care Health Option (ECHO) Program (1)	
Permanent ID Card for Beneficiaries age 65 and Older (1)	

The TRICARE Web site (www.tricare.osd.mil) provides the information beneficiaries need to make appropriate healthcare decisions when they need it. On the TRICARE website, one will find information about all TRICARE benefit options, including TRICARE for Life and TRICARE Dental. Beneficiaries can explore benefit information, plan options, eligibility requirements, applicable cost shares, how to access care, covered benefits, and customer service/contact information 24-hours a day. Appointment processing is a function of the direct care portion of the TRICARE program. However, a beneficiary can go to the website, locate the medical treatment facility that provides his or her care, and learn about the specifics behind that facility’s process for obtaining appointments. The site is updated daily, and all benefit changes and new program modifications are reflected in a timely manner. C&CS has learned via scientific research that beneficiaries prefer a more simple navigation method on the website and has undertaken a massive effort to completely revamp the entire TRICARE web site. Based on

continuing focus group testing and on-going beneficiary surveys, this year-long effort will greatly enhance a beneficiary's ability to find key information he or she needs quickly and easily.

BCACs, DCAOs, HBAs and Contractor customer service representatives are kept current on changes to the benefit via weekly updates from C&CS and annual training. Weekly updates include details on changes as well as FAQs to aid in responding to beneficiary questions and concerns. Annual training programs include training via TRICARE University Online and in-resident training on both CONUS and OCONUS. Curriculum is updated regularly and instructors are provided the latest information via their instructor manual.

RECOMMENDATION: None. For information purposes only.

Attachment 2

Have TRICARE Publish Status Reports Of Their Survey Results In Compliance With Public Law Article 723-724, The Requirement To Inform Both User And Provider Of Program Availability And Usage. Enforce The Contract Reporting Requirements As Written.

BACKGROUND: The Public Law referenced requires states: "The Comptroller General shall, on an ongoing basis, review--

(A) the processes, procedures, and analysis used by the Department of Defense to determine the adequacy of the number of health care providers--

(i) that currently accept TRICARE Standard beneficiaries as patients under TRICARE Standard in each TRICARE market area (as of the date of completion of the review); and

(ii) that would accept TRICARE Standard beneficiaries as new patients under TRICARE Standard in each TRICARE market area (within a reasonable time after the date of completion of the review); and

(B) the actions taken by the Department of Defense to ensure ready access of TRICARE Standard beneficiaries to health care under TRICARE Standard in each TRICARE market area.

It further directs: The Comptroller General shall submit to the Committees on Armed Services of the Senate and the House of Representatives a semiannual report on the results of the review under paragraph (1). The first semiannual report shall be submitted not later than June 30, 2004.

DISCUSSION: The 2004 survey of civilian providers on their acceptance of TRICARE Standard was briefed to Congressional committees in late 2004 and early 2005 as well as to the beneficiary coalition. The results of the 2005 survey have been briefed to senior HA/TMA leadership and will be available for briefing to Congressional committees and beneficiary coalitions in the near future.

RECOMMENDATION: None. For information purposes only.

Attachment 3

Encourage TRICARE Contractors To Aggressively Increase The Network Capacity In Underserved Locations.

BACKGROUND: TRICARE provider networks are required in Prime Service Areas (PSAs) only, and there is no requirement to develop networks outside of a PSA. Network development and adequacy are key components of the TRICARE managed care support contracts. The TRICARE Regional Offices have primary responsibility for monitoring the status of networks in their regions and working with their managed care support contractor partners to assure that all beneficiaries in the region have access to primary care and specialty providers that meet the required access standards.

DISCUSSION: The managed care support contractors for all regions continue to increase the number of network providers. As an example, in October 2004, there were just over 62,000 providers in the West region network, and as of January 2006, there are over 100,000. In what were formerly called Military Treatment Facility (MTF) "Catchment Areas," there are now PSAs that incorporate zip codes in areas that approximate the 40-mile radius catchment, Non-Catchment Prime (NCP) Service Areas that have been established due to significant beneficiary presence, and Base Realignment and Closure (BRAC) sites throughout all regions.

Some of these PSA locations are situated in what could be described as underserved areas. The managed care support contractors actively recruit providers in areas with noted specialty shortages and report outcomes on the monthly Network Status Report and quarterly Network Adequacy Report. Network adequacy is measured in terms of the number of referrals sent to the MTF and/or the network. A network is inadequate anytime a TRICARE Prime beneficiary cannot be seen by an appropriate clinician within the access standards contained in 32 CFR 199.17. The contracts contain performance guarantees which require the MCSCs to pay the Government if less than 96 percent of contractor referrals of prime beneficiaries residing within a PSA are not to an MTF or network provider with an appointment available within the access standards. The 96% level recognizes that in, some remote areas, not all specialties exist within the access standards. The 96% performance guarantee is not the only motivator, however. Whenever a TRICARE prime beneficiary is referred to a non-network provider, the MCSC must pay the difference between CMAC and 115% of CMAC on behalf of the beneficiary and from their corporate resources. The MCSC's desire to provide a high quality, accessible network combined with these financial incentives and contract maturity has resulted in a reported steady improvement in network growth and specialty participation.

In certain communities where there have been challenges in provider acceptance of TRICARE, the managed care support contractors and the TRICARE Regional Office Directors have partnered to conduct communication and outreach efforts to stimulate provider acceptance of, and participation in, the TRICARE program. TMA, the TRICARE Regional Directors, and the managed care support contractors remain committed to continually assess, monitor and, where necessary, improve provider networks in all region operations so that access to quality care is maintained for all beneficiaries, including retirees who have given so much for the defense of our country.

RECOMMENDATION: None. For information purposes only.

Attachment 4

Assure That TRICARE Utilize All Available Mechanisms Of Marketing And Education To Make The TRICARE Community Knowledgeable And Confident With The Available Options In Order To Make Wise Healthcare Delivery Choices.

BACKGROUND: The TRICARE Management Activity's Communications and Customer Service (C&CS) Directorate is responsible for the development and management of programs to market the TRICARE program and benefit package, and educate the 9.1 million TRICARE beneficiaries on the TRICARE benefit. C&CS has several ongoing initiatives related to its marketing and education mission.

DISCUSSION: Marketing/communications efforts are based on research and analysis to ensure the most affective outreach to TRICARE beneficiaries. Divisions within C&CS responsible for different components of the marketing/communications efforts include the TRICARE Marketing Office, Research and Analysis Division, Strategic Communications Branch within the Communications Division, and Web and Creative Services. Marketing and communication efforts begin with a Communications Plan developed and implemented by C&CS Communications Action Teams (CAT). Each CAT includes representatives from each division to ensure comprehensive and coordinated marketing/communications strategies and tactics for each change to the benefit.

The Research and Analysis Division conducts scientific research annually to include at least one telephone survey, on-going 'pop-up' surveys on the TRICARE website, focus groups testing by the Delphi Council and other groups as needed, and review and analyze of other research efforts. All marketing/communications plans and strategies are based on knowledge gained by these survey and analysis activities.

The Strategic Communications Branch within the Communications Division leads C&CS teams in developing and launching comprehensive and timely communications plans and strategies to ensure consistent messages and facts are delivered to the beneficiary via the news media, web, printed materials, customer service representatives, and other sources of materials. Outreach via the news media continues to grow as more and more media outlets are identified and used to reach beneficiaries wherever they are, including remote locations around the nation and even to troops deployed in hostile environments such as Iraq.

The TRICARE Marketing Office (TMO) works closely with each of the Services, managed care support contractors, and TRICARE regional and overseas area offices to ensure the most current information is readily available for all users of the TRICARE system.

- The Marketing and Education Committee (MEC) (comprised of representatives from each Service, TRICARE regional office, and managed care support contractor) meets quarterly to strategize and develop an annual marketing and education material plan that thoroughly identifies and addresses each beneficiary and provider audience need and requirement for educational materials. In response to TMA initiatives, implementation of new programs, and benefit changes, TMO develops, produces and distributes educational materials to inform and educate beneficiaries of the most current and accurate information available regarding their TRICARE benefit.
- TMO designs and develops marketing and educational materials (CONUS/OCONUS), briefing slide presentations, brochures, handbooks, flyers, newsletters, bulletins, wallet

cards, two-sided fact sheets, and posters. All materials are created and designed with a consistent TRICARE look and feel to include the TRICARE logo on all products. All materials are Web-based to afford easy access, customization, and reproduction at the local level. TMO coordinates the printing and distribution of marketing and educational materials in coordination with the needs and requirements of the MCSCs, MTFs, and SMART site orders, launch of new materials, and overall needs of all audiences on a timely production schedule. They also coordinate with each MTF, Beneficiary Counseling and Assistance Coordinator (BCAC), Debt Collection Assistance Officers (DCAO), and National Guard/Reserve representative to ensure participants are registered Bulk Order SMART site users in order to order materials for education and distribution.

The Beneficiary Education and Staff Training (BEST) within C&CS has an important role in communicating the TRICARE benefit by providing the templates for beneficiary education, training staff across the Military Health System (MHS), and enhancing customer service delivery by:

- Researching, developing and disseminating TRICARE information through worldwide email pushes/Web postings to beneficiary support staff (BCACs, DCAOs, Family Support, Partner Call Centers, etc.) once policy and programs finalized.
- Partnering with customer call centers while networking with BCACs, DCAOs, and Uniformed Services partners to share new benefit information once it becomes available, discussing program information that needs clarification and dissemination, making recommendations for marketing and educational product development.
- Maintaining and updating the TMA Frequently Asked Questions (FAQs) database, a Web-based source of basic program questions and answers.
- Responding directly to escalated beneficiary and beneficiary-focused queries, as well as track and trend beneficiary issue resolution through TMA Assistance Reporting Tool (ART).
- Designing, developing, and maintaining instructionally sound, multi-level and multi-venue (classroom-based, online, and distant learning) training courses and associated training materials with up-to-date information for those assisting the beneficiary population (BCACs, DCAOs, and others).
- Supporting the TRICARE Information Service (TIS) call center's delivery of responsive, professional customer service by pushing updates and FAQs to the TIS training staff, clarifying program/policy information, and resolving escalated cases.
- During FY 2005, 481 active duty and civilian staff members from the Services and managed care support contractors attended one of 20 TRICARE Fundamentals Courses, an entry-level 3-day program designed for those personnel involved in providing TRICARE assistance and counseling to beneficiaries. Major topics for this course include TRICARE eligibility, medical benefits, Reserve Component benefits, transitional benefits, pharmacy, dental, claims and appeals, and customer service. These courses were held in each of the TRICARE regions, Alaska, Europe, and the Pacific theatre.

The TRICARE web site contains approximately 650K pages of information on the TRICARE benefit and about 250 sub sites for benefit information on individual programs such as the Pharmacy benefit, TRICARE Reserve Select and Disaster Response.

Due to recent research, C&CS has learned that beneficiaries prefer a more simple navigation mode on the site, so the entire web site is under/going extensive renovation. This year-long effort is being focus group tested every step of the way to ensure the end result best meets beneficiary needs.

RECOMMENDATION: None. For information purposes only.

Attachment 5

Initiate Necessary Legislative Changes To Include Comprehensive Eye Examinations At All Levels Of The TRICARE Benefit.

BACKGROUND: The TRICARE Program provides one of the richest benefits of any health plan in the nation. TRICARE is prohibited under 10 U.S.C. 1086(a) from providing eye examinations to retirees and their dependents under TRICARE Standard, Extra, or TRICARE for Life. TRICARE is authorized under 10 U.S. C. 1098, as implemented by 32 CFR 199.18(b), to provide certain preventive health care benefits to retirees and their dependents enrolled in TRICARE Prime, including eye examinations. The Department has a Sustain the Benefit initiative with an objective of maintaining the exceptional health benefit offered to the 9.1 million beneficiaries by placing the TRICARE Program on a more fiscally sound foundation for the long term

DISCUSSION: Routine vision care is considered an integral part of good health care and a service that would enhance the benefit in the retiree population. However, the provision of an optometry benefit for retired non-enrollees and TRICARE for Life beneficiaries could have a significant cost impact on the overall TRICARE Program. The Medicare program does not cover routine eye exams for its beneficiary population, although many commercial Medicare risk plans do offer vision benefits as an enhancement to the Medicare benefit.

The process of adding to or changing the TRICARE benefit requires careful analysis and study. Costs involved include the costs of the added services and the administrative costs associated with implementing those services through the Managed Care Support and TRICARE – Medicare Dual Eligible Fiscal Intermediary contracts. Once a new benefit is approved and authorized, the funds must be either appropriated or identified within the existing budget.

Based on the recommendation of the 2005 Secretary of the Navy Retiree Council to enhance the eye care benefit, the TRICARE Management Activity (TMA) has initiated the process of examining the advisability of adding this benefit to the TRICARE program. To ascertain the estimated costs involved, TMA is developing an Independent Government Cost Estimate (IGCE) regarding the proposed benefit change. When the IGCE is known, a decision paper outlining the benefits and potential impacts of adding this benefit to the program will be prepared and presented to the TMA and Health Affairs senior leadership for consideration and whether to support a legislative proposal to expand this benefit.

RECOMMENDATION: None. For information purposes only.

Attachment 6

Include Federal Drug Administration (FDA) - Approved Technologies and Technical Advancements at all levels of the TRICARE Benefit.

BACKGROUND: By law, the TRICARE program may provide coverage only for treatments that are proven to be both safe and effective. The main intent of this requirement is to protect patients from potentially harmful or unscrupulous therapies. The document from the Secretary of the Navy Retiree Council states:

“Proven technologies and advancements in healthcare delivery systems have markedly enhanced diagnostic capabilities and refined clinical screening” and goes on to say, “These clinical options which make early screening, diagnosis, and intervention possible are deemed safe and effective and approved by the FDA. These services are widely available but not currently covered by the TRICARE benefit.”

The Council also opines that “including options such as digital scanning, C-reactive protein screening and virtual colonoscopy in covered services will direct austere funds to preventive and screening services, rather than more expensive treatment options with lower success rates” and that “this will result in healthier population outcomes and decreased healthcare costs for the government.”

DISCUSSION: FDA approval does not imply strict clinical efficacy. The FDA is a Federal regulatory institution whose primary role is to ensure a consistent level of standardization and safety for medical therapeutics and devices. FDA approval does not imply a standard of care or recommendation for diagnosis or treatment

By law, TRICARE may only reimburse providers for medical services that are medically or psychologically necessary as indicated by the standard of care. In order to ensure that our beneficiaries receive services that meet the standard of care, the Code of Federal Regulations (32 CFR 199.4(g)(15)) requires that there be reliable evidence, as defined by 32 CFR 199.2(b), showing studies of clinically meaningful endpoints that demonstrate safety and efficacy compared with standard means of treatment or diagnoses. Chapter 7, Section 16.1 of the TRICARE Policy Manual lists the TRICARE hierarchy of reliable evidence required by the Code of Federal Regulations that is used to determine whether a drug, device, medical treatment, or procedure has moved from the status of unproven to the position of nationally accepted medical practice as follows:

- Well-controlled studies of clinically meaningful endpoints, published in refereed medical literature.
- Published formal technological assessments.
- Published reports of national professional medical associations.
- Published national medical organization policy positions.
- Published reports of national expert opinion organizations.

Specifically not included in the meaning of reliable evidence are reports, articles, or statements by providers or groups of providers containing only abstracts, anecdotal evidence, or personal professional opinions. Also not included in the meaning of reliable evidence is the fact

that a provider or number of providers have elected to adopt a drug, device, or medical treatment or procedures as their personal treatment of choice or standard of practice.

TRICARE uses a well recognized process to search for and review reliable evidence, as well as policies of the Centers for Medicare and Medicaid Services (CMS) and other carriers, to determine whether a procedure is safe, effective, comparable to conventional treatment, and the standard of care in the United States. The result is a balance between ensuring the safety and efficacy of the care our beneficiaries receive and access to better ways of practicing medicine.

The process TMA uses to determine whether an emerging technology should become a TRICARE benefit is outlined below for virtual colonoscopy, a procedure named by the Council as an example of an FDA-approved procedure that should be a TRICARE benefit. TMA has, in fact, already evaluated this procedure to see if there is reliable evidence (per 32 CFR 199.4(g) (15)) that the procedure is proven safe and effective.

- In determining what preventive services should be covered under the TRICARE Prime preventive services benefit, TMA primarily relies upon guidance from the U.S. Preventive Services Task Force (USPSTF) from the Agency for Healthcare Research and Quality (AHRQ). If the USPSTF gives a preventive service an “A” recommendation, then that recommended service will almost certainly become a TRICARE Prime preventive service. The USPSTF recently (2005) updated its review and recommendations in regards to colorectal cancer screening. While the USPSTF strongly endorsed colorectal cancer screening as a Grade “A” recommendation (highest), it did not endorse virtual colonoscopy as one of the “proven” screening procedures. Indeed, the USPSTF stated “no studies have evaluated the effectiveness of CT colography in reducing morbidity or mortality from colorectal cancer.” As of this date, virtual colonoscopy has not yet been found to have sufficient evidence of efficacy to justify an “A” recommendation.
- Additionally, research experts at the independent Hayes Health Technology Assessment Company, a widely recognized and respected scientific organization that provides expert, independent assessments of medical innovations, evaluated the efficacy of virtual colonoscopy in February 2003 and concluded that there was insufficient evidence to conclude that the widespread use of virtual colonoscopy would have an impact on improving patient management or disease outcomes.

With regard to the specific language and examples provided by the Retiree Council:

- “Proven technologies and advancements...These services are widely available but not currently covered by the TRICARE benefit.” – TMA continually monitors the medical literature concerning emerging technologies. When the safety and efficacy of a new test, device, treatment intervention, or other healthcare service proves to be comparable to, or superior to, standard therapy, then that service will become a covered benefit under TRICARE unless otherwise excluded by statute, regulation, or policy.
- “Options such as digital scanning, C-reactive protein screening and virtual colonoscopy...” – The TRICARE Reimbursement Manual lists C-reactive protein as a diagnostic test that will be covered starting 1 November. There is not yet reliable

evidence to support the use of C-reactive protein or virtual colonoscopy for screening purposes. The Council's reference to "digital scanning" probably means total body scanning – a screening test that is not yet endorsed by any respected medical authority.

Conclusions:

- There are numerous examples of unproven screening tests, diagnostic tests, and treatment interventions that are marketed directly to the consumer despite the fact that there is minimal evidence to support their effectiveness. It appears that the Retiree Council is addressing such services.
- The FDA and TRICARE have different missions and responsibilities. Thus, each is governed by different rules and regulations. TRICARE has the responsibility to provide safe, effective, medically necessary, and appropriate care to TRICARE beneficiaries. The FDA, on the other hand, does not provide medical care.
- The FDA has the responsibility to ensure that a drug, device, or treatment is safe; this means that any potential harms of the drug, device, or treatment when weighed against the potential benefits are acceptable. In addition, the FDA has the responsibility to ensure that a drug, device, or treatment is effective; this means that the drug, device, or treatment does what proponents say it does. The FDA, however, does not compare the safety, efficacy, or cost-effectiveness of a new drug, device or treatment to the current standard of care in the United States.
- The FDA approval or clearance of a drug, device, or treatment is considered a required *prerequisite* by TRICARE and other third party payers when determining medical benefits, but does not determine medical coverage. The FDA has rules and regulations that define requirements to be used in their review of the safety and efficacy of a drug, device, or treatment. However, they are different than those requirements that must be followed when determining TRICARE benefits. Under TRICARE there must be reliable evidence as defined in 32 CFR199.2 which supports safety and efficacy.

RECOMMENDATION: Based on the current available scientific evidence, and in accordance with the Code of Federal Regulations and current TRICARE Policy guidance, the Chief Medical Officer recommends that TMA retain its current process for evaluating the efficacy of various procedures, treatments, and tests. TMA does not concur that the TRICARE should cover "all FDA-approved technologies and technical advancements at all levels of the TRICARE benefit."

Attachment 7

Simplify and Streamline the Specialty Referral Authorization Process.

Background: The TRICARE Management Activity (TMA) is working on a Military Health System (MHS) – wide solution to streamline the referral and authorization process. An MHS Enterprise-Wide Referral and Authorization Process (EWRAP) Integrated Project Team (IPT) was established in September 2004 to clarify business rules and ensure workable referral and authorization processes are established between the Military Treatment Facilities (MTFs) and the TRICARE managed care support contractors who operate the private sector care portion of the TRICARE benefit.

Discussion: The most critical authorization requirement for beneficiaries was defined by the IPT as assuring the authorization process is simple, consistent and transparent as evidenced by an elimination of paperwork and hassle for the beneficiary. The process must also assure beneficiaries have timely access to care and a clear understanding, in advance, of their out-of-pocket expenses.

The EWRAP IPT implemented several improvements to the referral and authorization process over the past 12 months:

- Use of a unique Referral Tracking Number (RTN) for all referrals as part of an automated tracking system for referrals and authorizations. The unique RTN is designed to follow the referral throughout the entire process and include claims. This initiative will help to expedite answering beneficiary questions or concerns.
- Removed the requirement to include clinical information in letters currently sent to beneficiaries to authorize care to the network. This eliminates the need for beneficiaries to hand carry clinical information and prevents sensitive clinical information from being mailed to an incorrect DEERS address.
- Developed a standardized clinical business process for use of Episodes of Care (EOC). An EOC is a list of procedures or visits related to the treatment or evaluation of a diagnosis. The standardized process will alleviate the current requirement for the beneficiary to go back to the referring provider numerous times to get individual authorizations for the same episode of care.
- Developed policy guidance for Referral Management Right of First Refusal (ROFR). ROFR is the process that facilitates optimum use of the direct care system by allowing the local MTF to decide if they have the capacity to provide care within the access standard period. The current process has been simplified and establishes common standards for referral management processes across the MHS enterprise.

Conclusion: The EWRAP IPT continues to work on this process, and has developed a concept of operations (CONOPS) for an automated Enterprise- Wide Referral and Authorization System (EWRAS) that is compliant with the Health Insurance Portability and Accountability Act (HIPAA). The EWRAS CONOPS is being thoroughly examined to

assure that implementation of an automated system will provide a cost-effective enhancement to the process of providing care across the MHS.

RECOMMENDATION: None. For information purposes only.