



Citizen warriors must be ready to deploy — they shouldn't pay for health care

BY JEFFREY E. PHILLIPS, OPINION CONTRIBUTOR — 06/02/19 01:00 PM EDT
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Over the past year or so, ROA has written about the endemic inequities between service in the active-duty military and duty in the Reserve and National Guard, known as the reserve components.

These inequities are not, by and large, the result of malign forces conspiring against the Reserve and Guard. For decades, before World War II, the reserve components were considered the “strategic reserve,” meant to be used only in the event of a major call-up of forces, such as we saw in that war or, later, in Korea. The reserve components rarely were deployed; they trained on weekends and two weeks in the summer (thus the moniker “weekend warrior”).

Being such an inactive part of the military, they were accorded benefits, support and funding considered by the Pentagon and Congress to be commensurate with their usage. That wasn’t much, actually. Members of the Reserve and Guard got no medical care when not training, for example.

That perhaps made sense in 1972 when the reserve components were not fighting a war in South Asia or mobilized to Poland as part of our response to a resurgent Russia’s ambitions for Eastern Europe’s recapture.

But that is precisely what they’re now doing. By [the most recent](#) Department of Defense (DOD) numbers, use of the Reserve and Guard is at least 15 times greater than it was before Operation Desert Storm. With the Pentagon’s reliance on the reserve components, their readiness now is much more important than it was in 1972, 1982, or even 1992.

So you'd think that our nation would ensure that these citizen-warriors get the health care they need to be as constantly ready as they are expected to be constantly available to drop everything and deploy.

You'd be wrong.

A recent DOD policy that requires service members to be fit for deployment or be discharged from the military identified 235,000 personnel in the active and reserve components who would be processed for separation if their issues were not resolved; that's about 11 percent of the total force. We have fought wars with fewer people engaged.

Maintaining deployable status requires a continuous and — forgive the cliched term — seamless flow of health care coverage. We must preserve what we have: fewer than one in three young Americans is eligible to join the military; 2 percent are eligible and have a propensity to serve. Retention of good troops is mighty important.

A 1999 report, "Strategies to Protect the Health of Deployed U.S. Forces," identified readiness issues in health care for National Guard and Reserve members. The report found that most of their care comes from civilian providers. Their medical records are not readily available to the Pentagon to ensure their fitness; if a sergeant is being treated by the family doctor (at the sergeant's expense) for an onset of asthma and then is alerted for deployment, this new issue becomes a real problem for the sergeant's deployability and the unit's readiness.

In the two decades since the report, use of the reserve components has vastly increased, but too little has changed to fundamentally address the report's findings. (It's especially disappointing that we see the military's active-duty chieftains making few demands for corrective measures to help our citizen-warriors.)

As I told the Senate Committee on Veterans' Affairs in a May 22 hearing, the military and civilian medical records of citizen-warriors tend to be scattered over several locations. Exacerbating this — a phenomenon of the frequent mobilizations now a matter of routine — members of the Reserve and Guard are mobilized under various "duty statuses." That means that from one mobilization to another they may get different benefits and be paid from different pots of DOD money (visions of bureaucracy should be dancing in your head).

Long story short, they and their families must jump from their civilian care provider to one supplied by or approved by the military within its TRICARE health care regime. Continuity of care goes out the window. Imagine if your child has a special health issue and from one year to the next — even one visit to the next — your child must see a different doctor.

The wonder here is that these families tolerate this and selflessly commit to their nation's service — especially when the vast majority of their fellow citizens don't give it a thought.

ROA advocates providing the same active-duty medical coverage (called [TRICARE Prime](#)) to the reserve components as is available to the active component. That would eliminate these problems. It also would save money: continuity of care means less wasted care and less need for expensive corrective care, versus cheaper preventative care.

Continuity of care means more effective training: reserve component drills and annual training can focus on training and not physical examinations, immunizations, health appraisals and briefings on health risks — all which can be done at any time under TRICARE Prime.

The federal government provides coverage to 37.7 percent of the population and, of that amount, military coverage is only 4.8 percent, according to a Census Bureau report, "[Health Insurance Coverage in the United States: 2017.](#)"

A single TRICARE Prime health care option for the reserve components is the cost to ensure their readiness and eliminate the expensive, readiness-robbing complications of the current bureaucratic tangle. Anything less shortchanges our citizen-warriors and their families.

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