CONGRESSIONAL POLICY WHITE PAPER

TO: Members of Congress, Armed Services Committees & Health Policy Staff
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SUBJECT: *Restoring Parity, Protecting Readiness: Eliminating Statutory Exemptions and Bureaucratic Administrative Barriers in the Defense Health Agency*

EXECUTIVE SUMMARY

The Military Health System (MHS) is operating under an administrative framework that threatens warfighter retention, shifts federal healthcare costs onto state taxpayers, and denies evidence-based medical care to military dependents.

By insulating itself behind obsolete "grandfathered" exemptions under Section 1251 of the Patient Protection and Affordable Care Act (ACA) and Title 10, U.S. Code, the Defense Health Agency (DHA) and its managed care support contractors (e.g., Humana Military) operate below commercial health insurance market standards.

This Congressional White Paper outlines:

1. **Specific Title 10 Violations** where the DHA exceeds its statutory authority.
2. **Systemic Bureaucratic Tactics** used by the agency to evade Congressional oversight and judicial review.
3. **Empirical Field Study Data** documenting the impact on force readiness, retention, and military family welfare.
4. **The Legislative Remedy:** The *Military Health Care Accountability and Parity Act of 2026*.

SECTION 1: STATUTORY VIOLATIONS OF TITLE 10, U.S. CODE

1. Override of Physician Medical Necessity Determinations (10 U.S.C. § 1079(a)(12))

- **Statutory Requirement:** Title 10 U.S.C. § 1079(a)(12) mandates that TRICARE cover services and supplies that are medically or psychologically necessary to treat a mental or physical illness, injury, or bodily malfunction, as diagnosed by an authorized clinical provider.
- **DHA Violation:** The DHA routinely overrides individual clinical assessments made by licensed physicians, psychiatrists, and Board-Certified Behavior Analysts (BCBAs). By enforcing blanket, non-clinical administrative bans, such as excluding coverage for Activities of Daily Living (ADLs) and care delivered in educational or community settings, the DHA substitutes administrative manual rules for treating physicians' diagnostic determinations.

2. Perpetual Abuse of Demonstration Authority (10 U.S.C. § 1092)

- **Statutory Requirement:** Title 10 U.S.C. § 1092 authorizes the Secretary of Defense to conduct temporary "studies and demonstration projects" to test innovative healthcare delivery models and cost-effectiveness, with defined reporting timelines to Congress.
- **DHA Violation:** The DHA has weaponized § 1092 to operate major care initiatives, such as the Autism Care Demonstration (ACD), perpetually for over 12 consecutive years. Keeping comprehensive medical care in "demonstration" status indefinitely allows the agency to bypass standard Chapter 55 benefit mandates, market parity protections, and formal congressional oversight.

3. Misrepresentation of Network Adequacy & Provider Directories (10 U.S.C. § 1073)

- **Statutory Requirement:** Title 10 U.S.C. § 1073 and National Defense Authorization Act (NDAA) directives require the DoD to administer managed care contracts ensuring stable, reliable access to healthcare infrastructure for covered beneficiaries.
- **DHA Violation:** Managed care contractors publish unverified provider directories containing widespread inactive, retired, or non-existent provider listings ("ghost networks"). The DHA routinely greenlights Permanent Change of Station (PCS) orders based on these false baselines, placing military families into severe care deserts.

4. Violation of NDAA Directives & Scientific Consensus

- **Statutory Requirement:** In multiple NDAAs, Congress directed the DoD to ensure comprehensive, evidence-based care for special-needs dependents.
- **DHA Violation:** When independent statutory panels commissioned under Congressional authority, specifically the National Academies of Sciences, Engineering, and Medicine (NASEM), issue evidence-based recommendations, the DHA selectively ignores them, maintaining non-clinical exclusions that conflict with established scientific parameters (e.g., standard DSM-5 parameters).

SECTION 2: BUREAUCRATIC TACTICS USED TO EVADE OVERSIGHT

The DHA employs a multi-layered bureaucratic shield to insulate itself from legislative and judicial accountability:

The Chevron/Auer Deference Trap: Historically, the DHA argued that courts and Congress must defer to agency expertise under 32 CFR § 199. *Crucial Vulnerability:* Following the Supreme Court's ruling in *Loper Bright v. Raimondo*, courts no longer defer to agency interpretations of ambiguous statutes. Under a strict reading of 10 U.S.C. § 1079(a)(12), medical necessity is determined by authorized clinicians, not agency administrators.

Malicious Compliance via Sub-Regulatory Guidance: When Congress issues statutory directives, the DHA complies on paper while undermining the intent in practice by altering internal sub-regulatory manuals (e.g., *TRICARE Operations Manual* [TOM]) and contractor change orders.

Self-Policed Appeal Structures: TRICARE beneficiaries facing care reductions are trapped in an internal appeal system where the contractor and the DHA act as their own appellate judge. Beneficiaries are denied access to an Independent External Review conducted by neutral, third-party physicians, a standard consumer right under the ACA.

SECTION 3: EMPIRICAL FIELD STUDY DATA

Field data collected by The Military Family Advocacy Group (MFAG) across military health surveys reveals the real-world impact of these administrative barriers:

1. Force Readiness & Warfighter Attrition

- **100% Retention Risk: 100% of respondents** in the *National Military Family Healthcare Experience Survey* reported that TRICARE administrative friction has caused them or their sponsor to consider separating early from active-duty service (63% High Influence, 38% Moderate Influence).
- **Impacted Elite Communities:** Communities affected include C-17 Pilots, EOD Technicians, Nuclear Engineers (ETN5), Pararescue (PJs), Special Operations, Infantry, and Medical Corps personnel.
- **Fiscal Impact of Attrition:** Replacing a single specialized operator or fighter pilot costs the DoD between **$5.6 million and $10+ million** in direct pipeline retraining expenses.

2. Prevalence of Non-Clinical Care Denials

- **88% Administrative Denials: 88% of respondents** reported that care denials or restrictions were based on **non-clinical or administrative rules** (care setting, billing provider type, or demonstration parameters) rather than a physician's medical opinion.
- **Care-Setting Restrictions:** 50% experienced coverage denials for care in Educational/School settings, and 25% experienced denials for Telehealth/Out-of-state specialist facilities.

3. Appeal Failure & Consumer Parity Gap

- **63% Abandonment: 63% of military families** never file a formal appeal because the process is "too confusing or overwhelming".
- **0% Overturn Rate:** 100% of formal appeals failed to overturn care: **57% were upheld internally** by the contractor/DHA, and **43% were abandoned due to administrative exhaustion**.
- **63% Denied Independent Review: 63% of families** were never offered an Independent External Review by a neutral physician.

4. Financial Cost-Shifting & Personal Impact

- **88% Treatment Forfeiture: 88% of respondents** were forced to delay or completely forfeit necessary medical treatment due to TRICARE denials.
- **Out-of-Pocket Strain: 63% incurred out-of-pocket medical expenses**, with **38% paying $5,000 to $10,000+** annually.
- **Cost-Shifting to Taxpayers: 57% of families** were forced to enroll their dependent in state Medicaid waivers to receive care, shifting an estimated **$6,383 annual net tax burden per child** directly onto local state taxpayers for care a federal defense program should cover.

SECTION 4: LEGISLATIVE SOLUTION

Military Health Care Accountability and Parity Act of 2026

To eliminate administrative loopholes and hold the Defense Health Agency accountable, Congress must pass targeted statutory amendments to Title 10, U.S. Code:

Key Draft Provisions (Section-by-Section)

- **SEC. 2(1) Full Parity & Market Reform Mandate:** Strips TRICARE's legacy "grandfathered" posture under ACA Section 1251 and Title 10, requiring full compliance with federal health insurance market reform standards, including Non-Quantitative Treatment Limitation (NQTL) parity, external independent appeals, and essential health benefits.
- **SEC. 2(2) Prohibition on Care-Setting Exclusions:** Statutorily prohibits the Secretary of Defense from denying or restricting reimbursement for medically necessary care based on the geographic, educational, or community setting in which the care is delivered, or non-clinical classifications that conflict with established diagnostic standards (e.g., DSM-5).
- **SEC. 2(3) Permanent Benefit Integration:** Mandates that any care offered under a temporary pilot or demonstration project for more than 5 consecutive fiscal years shall automatically integrate as a standard, permanent benefit under the TRICARE Basic program.

CONCLUSION

Closing TRICARE's statutory loopholes does not require new entitlement spending; it holds defense health contractors accountable to the same market standards required of private commercial insurers. Enacting the *Military Health Care Accountability and Parity Act of 2026* protects active-duty warfighter retention, stops improper cost-shifting to state taxpayers, and ensures military families receive evidence-based healthcare.

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