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S. HRG. 111–701, PT. 6

DEPARTMENT OF DEFENSE AUTHORIZATION FOR APPROPRIATIONS FOR FISCAL YEAR 2011

HEARINGS

BEFORE THE

COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

ON

S. 3454

TO AUTHORIZE APPROPRIATIONS FOR FISCAL YEAR 2011 FOR MILITARY ACTIVITIES OF THE DEPARTMENT OF DEFENSE, FOR MILITARY CONSTRUCTION, AND FOR DEFENSE ACTIVITIES OF THE DEPARTMENT OF ENERGY, TO PRESCRIBE PERSONNEL STRENGTHS FOR SUCH FISCAL YEAR, AND FOR OTHER PURPOSES

PART 6
PERSONNEL

MARCH 10, 24; APRIL 28; MAY 12, 2010

Printed for the use of the Committee on Armed Services

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DEPARTMENT OF DEFENSE AUTHORIZATION FOR APPROPRIATIONS FOR FISCAL YEAR 2011

WEDNESDAY, MARCH 10, 2010

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

ACTIVE, GUARD, RESERVE, AND CIVILIAN PERSONNEL PROGRAMS

The subcommittee met, pursuant to notice, at 10:33 a.m. in room SR–232A, Russell Senate Office Building, Senator Jim Webb (chairman of the subcommittee) presiding.

Committee members present: Senators Webb, Hagan, Begich, Graham, and Chambliss.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, counsel; and Gerald J. Leeling, counsel.

Minority staff members present: Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Jennifer R. Knowles and Brian F. Sebold.

Committee members' assistants present: Juliet Beyler and Gordon Peterson, assistants to Senator Webb, Lindsay Kavanaugh, assistant to Senator Begich; Clyde Taylor IV, assistant to Senator Chambliss; and Adam Brake, assistant to Senator Graham.

OPENING STATEMENT OF SENATOR JIM WEBB, CHAIRMAN

Senator WEBB. Good morning. The subcommittee will come to order.

The subcommittee meets today to receive testimony on the Active, Guard, Reserve, and civilian personnel programs in review of the National Defense Authorization Request for Fiscal Year 2011 and the Future Years Defense Program.

We will have two panels today. The first panel's witnesses are the senior civilian officials in the Department of Defense (DOD) and the military departments who are responsible for personnel matters. I welcome The Honorable Clifford Stanley, Under Secretary of Defense for Personnel and Readiness; The Honorable Thomas Lamont, Assistant Secretary of the Army for Manpower and Reserve Affairs; The Honorable Juan Garcia, Assistant Secretary of the Navy for Manpower and Reserve Affairs; and The

Honorable Daniel Ginsberg, Assistant Secretary of the Air Force for Manpower and Reserve Affairs.

Nobody wants to sit in this center seat, here? [Laughter.]

Dr. Stanley, feel free to be the major focal point of the room. [Laughter.]

Our second panel will include witnesses drawn from associations that represent and advance the interests of Active Duty, Reserve, and retired servicemembers and their families. I'll introduce our second panel when it convenes, but I wish to express my appreciation to all our witnesses for joining us this morning.

This is my first hearing as chairman of this subcommittee. The subcommittee's jurisdiction extends to virtually all matters of personnel policy—compensation, military healthcare, military nominations, civilian personnel. I'd like to say, at this point, that I intend for this subcommittee to exercise continuous and active oversight of all our military personnel matters, through hearings, through consideration of the Department's budget and legislative proposals, and also through day-to-day interaction with you and people who work with you, and with our committee staff, as well. This hearing is one part, and one part only, of that process.

There's no greater responsibility for Congress and military leaders, as our witnesses all know, than to care and provide for our servicemembers and for their families. This is a concept of stewardship that I, and I think all of my compatriots up here, feel about very strongly.

I grew up in the military, as many of you know. I know what it's like to have a parent deployed. I also know what that means, in terms of the responsibilities and the challenges of family members. I can remember, at one point, when—my father was career Air Force—I went to a different school in the fifth grade, sixth grade, seventh grade, three different schools in the eighth grade, the ninth grade, two different schools in the tenth grade, from England to Missouri to Texas to Alabama to California to Nebraska, and I know how that stresses the families, and I know how important it is for us to always keep that in mind.

I had the honor of serving with the Marine Corps infantry in Vietnam. I understand a lot of the stresses of what it means to be deployed in combat. I'm a father of a Marine NCO who had some hard time in Iraq, and also the father-in-law of a Marine infantry sergeant, who is now, at the age of 24, looking to be deployed for the fourth time, coming this July.

That, coupled with the experience that I was able to gain through 5 years in the Pentagon—one as a Marine officer, three having responsibility for our Guard and Reserve programs, about which I feel very strongly, and the other as Secretary of the Navy—we got a very good look, in the 1980s, at the evolution of the total-force concept, where the manpower challenges came from, force-structure issues, and those sorts of things, and they will come to play here, in this subcommittee, as we move forward.

We're very cognizant of the fact DOD, supported by this committee, has instituted many innovative programs over the past several years in order to deal with the challenges that have occurred since September 11, 2001.

I would mention, briefly, since this is my first hearing as chairman of this subcommittee, that the Commonwealth of Virginia has a long history, in terms of taking care of, and being host to, one of the largest Active Duty and retired military populations in our country, and I'm honored to serve in the tradition of John Warner, who is no longer in the Senate, but gave tremendous service to this committee and also to the people of Virginia, in this area.

Our military is now engaged in its 9th year of combat operations since September 11. Our Guard and Reserve components have played critical roles during this period, in ways that were not envisioned at the inception of the All-Volunteer Force and, quite frankly, were not envisioned when I was Assistant Secretary of Defense for Reserve Affairs.

It's also important for us to remember that the All-Volunteer Force is not an all-career force. Sometimes we lose that focus when we have people from the Pentagon coming over here talking to us about programs. The Services do a very fine job of attending to the needs of its career force, but we should always keep in mind our stewardship to those who feel, in the citizen-soldier tradition of this country, that they should come in and obligate themselves for one enlistment, and return to their communities.

The data that we received when we were formulating the GI Bill was that 75 percent of the Army enlisted folks, and 70 percent of the Marine Corps, and roughly half of the other two Services, leave the military on or before the end of their first enlistment. Those numbers may have varied a bit with the economic conditions right now, but those are the people that we should never forget when we come up—in talking about these other programs.

I'm look forward, greatly, to serving with our subcommittee's ranking member, Senator Graham, in addressing these challenges, and to ensure the long-term viability of the All-Volunteer Force, not simply in numbers, but also in quality. Everyone in this room is very familiar with Senator Graham's service, not only on this committee, but also to our country, continuing to serve as a colonel in the Air Force Reserve. He brings valuable perspective, I think, as everyone has seen, as we've attempted to work through the issues of the Guantanamo Bay detainees and many other areas. He's served regularly on Active Duty, and his duties have allowed him to keep his finger on the pulse of the men and women in our military today. He and I have collaborated on a number of important issues over the past 3 years, and I welcome this opportunity to work with him even more closely during the months and years ahead.

The All-Volunteer Force is stressed by the past 9 years of conflict. Having experienced multiple deployments, extended deployments to Afghanistan, Iraq, this is especially true of our ground forces. We're entering uncharted territory, in terms of the long-term consequences of past rotation cycles and an unsatisfactory deployment-to-dwell ratio that is only now beginning to be corrected. Despite authorizing more than 55,000 additional Active-Duty servicemembers in the last year, today's dwell times are still inadequate to ensuring the vital recuperation, revitalization, and reset of the force and their families. I'm concerned about that impact on

the resilience of the force, and we'll have some questions, during your testimony, with respect to those issues.

This subcommittee faces a very clear and immediate challenge, and that is in addressing the rising costs of personnel. The combination of rising end strengths and an increasing compensation package continues to send personnel-related costs soaring. As Secretary Gates recently said, "The costs of healthcare are eating the Department alive." The total personnel-related budget in the Department's fiscal year 2011 request, including the cost of providing healthcare to servicemembers, their families, and retirees, amounts to $178 billion, or 32 percent of the overall DOD base budget. By contrast, when I was Secretary of the Navy in 1987, I think the entire Navy budget was right about $100 billion. Compare that with the fiscal year 2003 total personnel-related spending, including healthcare, amounted to $114 billion. That's an increase of 56 percent from fiscal year 2003 to fiscal year 2011. By all accounts, that growth is going to continue.

Though these challenges are steep, we should also be thankful for the successes that the Department and our Services have enjoyed. The combination of patriotism, a stagnant economy, a robust compensation package, including retirement, healthcare, and education benefits, have allowed the Services to achieve historic highs in recruiting and retention.

The quality of our people has also been sustained. Waivers are down across the Services, test scores are up, and the vast majority of new recruits are high school graduates, a higher percentage than just a couple of years ago. These are all strong indicators of the quality of character and service that our people in uniform exhibit, across the board, day after day.

I look forward to hearing from both panels this morning. I would encourage you to express your views candidly and, in addition relating to what you see going well, to address your concerns in those issues that you believe this subcommittee needs to pay attention to. I, along with Senator Graham and our colleagues, are dedicated to the prospect of ensuring that our military remains the very best in the world.

Senator Graham.

STATEMENT OF SENATOR LINDSEY GRAHAM

Senator GRAHAM. Thank you, Mr. Chairman.

As I listened to your opening statement, it really struck me that, of all of the people in the Senate, you're clearly, I think, the most qualified person to lead this subcommittee right now, in the sense of your understanding the personnel issues and just your personal history.

I want to also acknowledge that Senator Nelson was a complete joy to work with, and he's gone to another subcommittee. But, Mr. Chairman, I promise, when it comes to the troops, we'll be as bipartisan as possible. I think we've proven, between the two of us, that we can disagree, but also find common ground on things that really do matter.

I was on a plane not long ago, and on that one plane I had a young man come up to me who had just gotten out of the military, he's going to Harvard, and he mentioned the GI bill that you au-

thored and we worked together to pass. It really is working. There's a lot of implementation problems, but the fact that this young man is able to get most of his college education paid for, if not all, for serving 4 years, going to Harvard, I think, is a testament to that bill. The guy sitting right by me was a 28-year service Air Force colonel who is going to transfer his benefits to his youngest daughter going to college, and he was just telling me how much that meant to his family. So, what we're able to accomplish there, with your leadership, is really helping people.

The one thing I would suggest is, the President's budget—I'm going to try to support as much as possible. The 1.4-percent pay raise is the least we can do. We all wish it would be more, but we do have budget problems up here. The sustainability of healthcare is the issue, I think, for us on this committee, and maybe the Congress as a whole, because, as you talked about your time with the Navy, the budgets have grown, the obligations are great, so few people are doing so much for so long. Here we are, 9 years almost into this war, and we're growing the military. I think that's a wise thing to do. Personnel costs are 30-something percent of the budget, but the healthcare component is 8 percent of the budget, growing, it's going to be hard to sustain that. We haven't had a premium increase in TRICARE since 1995. I want to do everything I can to help the families and retirees and military members, but eventually we're going to have to deal with that problem: How do you sustain the growth of TRICARE and other medical benefits within the budget before you start taking away from the warfighter? That means some hard decisions are to come.

When it comes to "Don't Ask, Don't Tell," I think we all are waiting to see what this survey shows, and try to make an intelligent decision based on input from the military, and I would just urge my colleagues to let that run its course.

With that, Mr. Chairman, I will listen to the witnesses and look forward to working with you. Again, I think, between the two of us and the members of this committee, we can do some good things for our men and women in uniform.

One last thought. Senator Chambliss has a bill that I've been working with to lower retirement age for Guard and Reserve members who have served on Active Duty since September 11, 2001. For every year they would serve, or 90 days they would serve, they could retire a bit earlier, all the way down to 55. That has a cost associated with it, but I think it's an idea whose time has come, and I look forward to working with you to see if we can make that possible.

Mr. Chairman, I look forward to being your ally and colleague on this. Now is the time for me to shut up and let the people who are in charge talk.

Senator WEBB. Let me say that I can't think of a better person to be working with than Senator Graham on these issues, as well.

Senator GRAHAM. Thank you.

Senator WEBB. We've received statements for the record from the Fleet Reserve Association, the Reserve Officer Association, and, without objection they will be included in the record at this point.

We've also received a statement for the record from Senator Bill Nelson, who could not be here, and, without objection, that will be

included in the record after the principal statements of our witnesses.

[The prepared statement of Senator Bill Nelson follows:]

PREPARED STATEMENT BY SENATOR BILL NELSON

Mr. Chairman, thank you for allowing me to speak about one of the last injustices plaguing the veterans' benefits system. I am talking about the offset between the Department of Defense (DOD) Survivor Benefit Plan (SBP) annuity and the Department of Veterans Affairs (VA) Dependency and Indemnity Compensation (DIC) benefit.

SBP is an annuity paid by the DOD to survivors when either a military retiree pays a premium as income insurance for their survivors or when a servicemember dies on active duty. DIC is a survivor benefit paid by the Veterans Administration. Survivors receive DIC when military service caused the servicemember's death.

There is a longstanding problem in our military survivor benefits system, the requirement for a dollar-for-dollar reduction of survivor benefits from the SBP paid by DOD by the amount of DIC received from the VA. I have fought for 9 years to eliminate the offset for SBP beneficiaries whose loved ones purchased or earned this annuity.

Following the bloodiest of America's wars, President Abraham Lincoln, in his second inaugural address, said that one of the greatest obligations in war is to "finish the work we are in; to bind up the Nation's wounds; to care for him who shall have borne the battle, and for his widow, and his orphan."

To truly honor our servicemembers, we all agree that the U.S. Government must take care of our veterans, their widows and orphans. In keeping with that moral principle, we must repeal the unjust offset that denies widows and orphans the annuity their deceased loved ones have earned on active duty or purchased for them.

In the 2008 National Defense Authorization Act, we cracked the door to eliminating the offset. In conference negotiations with the House, we made some progress when we got a "special payment" of $50 per month, which will increase to $310 per month by 2017 because of money savings found in Tobacco Legislation passed last year.

Our efforts have been important steps in the right direction, but they are not enough. We must meet our obligation to the widow and orphan with the same sense of honor as was the service their loved one had rendered. We must completely eliminate the SBP–DIC offset.

I commend many of the organizations represented by the witnesses today for the support they have shown and hard work put in for full repeal of the offset. I ask DOD to work with Congress to honor the retirees, the fallen, and their families, and budget for full repeal of the SBP–DIC offset.

Thank you, Mr. Chairman.

Senator WEBB. With that, we would begin with Dr. Stanley, and then move to Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, in that order.

Dr. Stanley, welcome.

STATEMENT OF HON. CLIFFORD L. STANLEY, UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

Dr. STANLEY. Good morning, Senator Webb and Senator Graham and other distinguished members of the subcommittee.

First of all, let me just say I'm honored to be here, and particularly with colleagues and, in some cases, just meeting today.

As I speak to you concerning DOD's personnel programs and readiness, for the past 3 weeks, as the Under Secretary of Defense, I've had the honor of working and interacting with some of the greatest men and women in uniform, DOD civilians, contractors, and their great families. It is truly a privilege to serve them in this position.

I first want to thank you for your support of these men and women over the years. They have fought our wars, protected our interests and our allies around the globe. I look forward to working

closely with this committee to improve support for those in uniform, the civilian employees of the Department, and their families.

Just a few short months ago, I appeared before you as President Obama's nominee to be the Under Secretary of Defense for Personnel and Readiness. At that time, I emphasized several top priorities: the All-Volunteer Force, support to wounded warriors, personnel readiness, family programs, and the stress that is affecting our military today.

In terms of military personnel, the Services are experiencing historic success in recruiting and retention. It is a tribute to both the dedication of our military personnel and to the patriotism of our Nation's citizens that we continue to maintain an All-Volunteer Force of unprecedented quality after more than 8 years in active combat operations.

I am happy to report that in fiscal year 2009, the Services have had the most successful recruiting year of all the All-Volunteer Force era. All four Active Services and all six elements of the Reserve component achieved both numerical and recruit quality targets for the first time, which is a banner year. To continue to secure sufficient personnel for the Armed Forces, the Department must provide a compensation package comparable and competitive to the private sector at the same time we balance the demands of an All-Volunteer Force in the context of growing equipment and operational costs.

The Department continues this commitment through the President's request for a 1.4-percent increase in military pay for all servicemembers in the fiscal year 2011 budget, an amount that equals earning increases in the private sector, as measured by the Employment Cost Index. Of note, from the January 1, 2002, through the January 1, 2010, pay raises, military pay rose about 42 percent, and the housing allowance rose by 83 percent. During the same period, private-sector wages and salaries rose only 32 percent.

While there is little question that those increases were necessary in the past, rising personnel costs could dramatically affect the readiness of the Department. We are at a point where discretionary spending offers the best ability to target specific skills, and the quality and quantity of those filling such positions. I believe the Services still require the use of special pay and bonuses to ensure sufficient operational readiness and our mission.

Our military forces maintain an exceptionally high level of readiness, but multiple deployments to Iraq and Afghanistan have certainly increased the stress on our servicemembers and their families. We have a number of initiatives underway to address this stress, and have set clear limits and goals for the deployment lengths and the amount of time, or "dwell," between deployments.

To that end, we have limited our unit deployments to 1 year in theater, a minimum of 1 year between deployments for our Active component. Our goal is to increase the time between deployments to 2 years for every year deployed, commonly called a 1-to-2 dwell ratio. For the Reserve component, we have limited the mobilization period to 1 year, and we strive to have a minimum 3-year break between mobilizations. The goal of the Reserve component dwell ratio is 1 year mobilized, with a 5-year break between mobiliza-

tions, or a 1-to-5 dwell ratio. Although we are not there yet, we are making progress toward those goals.

The Department is focused on care for our wounded, ill, and injured military members. As Secretary Gates stated last month, aside from winning the wars themselves, this is the Department's highest priority. Initiatives are currently underway to achieve a seamless transition from Active Duty to veteran status, and to increase cooperation between DOD and the Department of Veterans Affairs (VA). In addition, efforts to create a Disability Evaluation System that is simpler, faster, fairer, and more consistent are underway.

Finally, in support of President Obama's commitment, the Department is partnering with the VA to establish Virtual Lifetime Electronic Records that will improve veteran care and services through increased availability and administrative and health information.

We are also committed to further improving support to our military families. For fiscal year 2011, we have requested for a 41-percent increase in family assistance baseline funding across the Department to ensure that we are on target, in the sense of investing in programs that are needed by servicemembers and their families. We have initiated an extensive strategic planning process to address the current issues facing family readiness programs. This begins with a thorough assessment of existing needs, programs, and related issues.

Unfortunately, we have had stumbles in this area. As I'm sure you're aware, we announced a temporary pause to the My Career Advancement Account (MyCAA) program on February 16, 2010. Due to unforeseen, unprecedented, but welcome, demand in enrollments that overwhelmed the infrastructure, we nearly reached the budget threshold. While it was necessary to pause the program immediately, we failed to communicate properly the reasons for the pause. Over the past few weeks, DOD has worked tirelessly on mapping out solutions, for both the short and long term, that honors our commitment to our military spouses while accounting for fiscal realities.

Our proposals are in the final stage of approval and we hope to restart the program very soon. We know we must make a concerted effort to restore our credibility and confidence with our military spouses, servicemembers, and the American public.

Our military has proven its resilience during the most challenging of times, but the stress on the force is obvious. The Department's civilian and military leadership remain focused on employing numerous strategies to reduce the incidence of suicide in the Armed Forces. In calendar year 2009, there were a total of 312 suicides, 285 Active component and 26 in the Reserve component, marking an increase, up from 268 in 2008. I know this committee shares our belief that even one suicide is too many.

There are many other critical issues facing the Department and this Nation, and I am exceedingly grateful to this Congress and this committee for their continuous commitment to supporting our men and women in DOD.

I look forward to your questions and thank you for your time.

[The prepared statement of Dr. Stanley follows:]

PREPARED STATEMENT BY HON. CLIFFORD L. STANLEY

Mr. Chairman and members of this distinguished subcommittee, thank you for inviting us to testify before you.

As I humbly assume my role as the new Under Secretary of Defense for Personnel and Readiness, I am resolute in my determination to honor, protect and improve the lives of U.S. airmen, soldiers, sailors, and marines. I am here today to describe our mission as I see it and share my thoughts on how compassion, excellence and heightened sense of urgency will help me and my organization fulfill our duty.

I am mindful we are at war and we must prevail. We win when we help our troops succeed in combat, and be healthy and happy with their families when at ease. We win when our troops can be confident their families have easy access to the resources and support they need while their loved ones are deployed. Maintaining our incredible All-Volunteer Force is our highest priority as we strive to recruit, attract, retain, and reward American's best and brightest, and their families.

ACTIVE DUTY

Recruiting

After more than 5 years of the most challenging recruiting environment since the inception of the All-Volunteer Force (AVF) in 1973, the Services emerged in fiscal year 2009 with the most successful recruiting year of the AVF era—all four Active Services and all six Reserve components achieved both numerical and recruit quality targets for the first time, a banner year. Previous years were marked by a growing economy, low unemployment, reluctance of influencers of youth to recommend military service, propensity among youth themselves at an all-time low, and recruiting goals of the Army and Marine Corps increasing. Yet since 2005, the Services met or exceeded recruiting goals—the AVF concept has proven itself amidst some of the greatest stressors it could face.

The recruiting environment has now changed. Unemployment has risen considerably. Generally, times like this make recruiting less challenging, and a regrettable trend in national unemployment operates to the advantage of those who are hiring, including the U.S. military. In addition, interest in the military among young people has increased.

On the other hand, challenges remain—the lower likelihood of influencers of youth (e.g., parents and teachers) to recommend service, a large and growing proportion of youth population who are ineligible to serve in the military principally as a consequence of rising obesity, high numbers of youth going to college directly from high school, and the continuing concerns about overseas contingency operations with its concomitant high operations tempo, particularly the announced increases in force levels in Afghanistan. Therefore, we are in uncharted waters—with significant factors, both negative and positive, directly affecting military recruiting efforts.

As a result, we continually review our recruiting programs to align funding and policies with current realities, recognizing that stable and adequate investments in recruiting resources are necessary to maintain success, especially in the long term. These reviews have allowed the Services to reduce recruiting resources in fiscal year 2010 and 2011. While this results in a decreasing reliance on bonus incentives to meet recruiting goals, each Service knows it must be judicious in its cuts—reducing budgets gradually, and in the right places—using those targeted incentives to ensure we attract high quality youth into our most critical skills. We are mindful of the past, when fluctuating resources—up in tough recruiting environments, down in favorable ones—jeopardized recruiting missions, often resulting in sporadic failures.

The recruiting environment is less challenging today, but we know that a tough recruiting environment will return. If we enter those difficult recruiting periods with insufficient resources and inexperienced recruiters, it will only exacerbate the problem and contribute to the "boom and bust" recruiting cycle which has characterized the past. Such a cyclical resourcing strategy also ignores the ongoing and significant role recruiting resources—particularly advertising—have on both youth and influencer awareness, attitudes, and propensity. Therefore, it is imperative that we stabilize necessary recruiting resources. We appreciate this committee's untiring support of our recruiting programs and look forward to working together to ensure future success.

As previously stated, fiscal year 2009 was a banner year for active duty recruiting. Altogether, the Services exceeded their goal of 163,880 accessions by 5,088, accessing 159,374 first-term enlistees and an additional 9,594 individuals with previous military service.

Fiscal year 2010 active duty recruiting efforts, to date, are even better. Through December, all Services met or exceeded both quantity and recruit quality objectives

for the active force, with the Army achieving 13,977 of its 13,716 recruiting goal, for a 102 percent year-to-date accomplishment (Table 1). Especially notable is the fact that for the second year in a row, after 4 years of falling below the 90 percent DOD Benchmark for High School Diploma Graduates, the Army is now exceeding that measure, with an impressive 99.9 percent of new recruits holding that credential.

Table 1. FY 2010 Active Duty Enlisted Recruiting Through December 2009

	Quantity			Quality	
Active Duty Enlisted Recruiting Through December 2009	Accessions	Goal	Percent of Goal	% High School Diploma Graduate (HSDG); *DoD Benchmark = 90 percent*	% Scoring at / above 50th Percentile on Armed Forces Qualification Test; *DoD Benchmark = 60 percent*
Army	13,977	13,716	**102%**	**99.9%**	**65%**
Navy	6,217	6,217	**100%**	**96%**	**78%**
Marine Corps	4,640	4,623	**100%**	**99.5%**	**71%**
Air Force	5,092	5,092	**100%**	**99%**	**84%**
DoD Total	29,926	29,648	**101%**	**99%**	**72%**

We should not lose sight of the fact that, although the overall youth population is large, only a relatively small proportion of American youth is qualified to enlist. It is an unfortunate fact that much of the contemporary youth population is currently ineligible to serve. Medical disqualification, with obesity a large contributing factor, removes 35 percent, drug or alcohol abuse removes 18 percent, and another 23 percent do not meet our standards for reasons such as criminal misbehavior, have more dependents than can reliably be accommodated in the early career, or low aptitude scores. Another estimated 10 percent are qualified, but are attending college.

To expand the recruiting pool and assist the Services in meeting a special category of critical readiness needs, the Department initiated a 1-year pilot program, Military Accessions Vital to National Interest (MAVNI), allowing the enlistment of up to 1,000 of a select group of non-U.S. citizens who had been in the United States for at least 2 years. Enlistments under this pilot are open only to health care professionals in critically short specialties and individuals with language skills and cultural backgrounds in a limited list of languages. We are currently reviewing results of this pilot program.

But, given the overall limited pool of eligible youth, our continuing recruiting success does not come easily. It remains the result of long hours and hard work by the 15,100 dedicated and professional, active-duty military recruiters. These recruiters often are the sole representative of our military forces in local communities, and they have both my and the Department's most sincere respect and gratitude.

This past August, we implemented the post-September 11 GI Bill—the most extensive restructuring of post-service education benefits since the introduction of the original World War II GI Bill. As I am sure you are aware, the Montgomery GI Bill (MGIB) has been a cornerstone of our active-duty military recruiting efforts since 1985. There is little doubt that the MGIB has met or even exceeded the expectations of its sponsors when it was enacted, and has been a major contributor to the success of the All-Volunteer Force.

This new post-September 11 GI Bill should enhance our recruiting efforts even more. However, we remain cautious about the impact of such a major, new benefit on retention, particularly first-term retention. We hope that the provision in the new program that allows career servicemembers to share or transfer their GI Bill with immediate family members, long requested by both members and their families, will mitigate negative retention impacts. Early results look favorable, with over 100,000 career servicemembers already requesting authority to share their earned educational benefits with their family members. We are monitoring the effects of this implementation very closely.

Military Decorations and Awards

The Department continues to work in concert with the Services to appropriately recognize and laud the accomplishments, both valorous and non-valorous, of our soldiers, sailors, marines, and airmen. In the AVF, appropriately recognizing the accomplishments of our servicemembers is fundamental to maintaining esprit-de-corps and a motivated force. It is most important that the Services recognize the significant acts and achievements of our servicemembers while simultaneously maintaining the time-honored prestige of our most revered military decorations such as the Medal of Honor, Distinguished Service Cross, Navy Cross, Air Force Cross, and Silver Star. I am aware of the concern from some Members of Congress in regard to the award of valor decorations and will closely examine the results of the ongoing review and report on the Medal of Honor awards process as requested in the House Armed Services Committee report language that accompanied the National Defense Authorization Act of Fiscal Year 2010.

Leave and Liberty Enhancements

Given the ongoing operations tempo associated with Operations Iraqi Freedom and Enduring Freedom, the Department is acutely aware of the need to provide all soldiers, sailors, marines, and airmen with adequate leave and liberty opportunities, especially during and after deployments, for respite and reintegration, respectively. servicemembers serving in Iraq and Afghanistan are provided a much needed break from combat through the Rest and Recuperation (R&R) leave program. This vital program provides servicemembers, who are on long deployments, government funded transportation to the airport closest to their leave destination, and allows them to take 15 days of respite leave in an area of their choosing. For those servicemembers serving in the most dangerous and arduous areas of the combat zone, the R&R leave is not chargeable which not only recognizes their stressful duty but also provides more accrued leave to utilize upon redeployment for reintegration into their family and community. Additionally, the Post Deployment/Mobilization Respite Absence (PDMRA) program provides Active and Reserve component members who are deployed or mobilized above and beyond the Secretary of Defense's established deployment—dwell time ratios with respite nonchargeable administrative absence upon return from deployment or mobilization.

I thank Congress for passing legislation, through the NDAA for Fiscal Year 2010, which allows our servicemembers to temporarily increase, from 60 to 75, the number of leave days authorized for carry over from 1 fiscal year to the next. This provision will reduce the frequency of lost leave for those servicemembers who have fewer opportunities to take longer leaves due to the persistent operational demands. The Department continues to monitor leave balances and lost leave to preclude avoidable loss of the benefit.

Retention

For fiscal year 2009, the Department was very successful in attaining enlisted retention goals. All Active components met or exceeded their respective retention goals in every measurable category. The Services and the Department anticipate continued success in the upcoming year and are already meeting or exceeding the monthly goals for early fiscal year 2010.

Despite the overall strength of enlisted retention over the last few years, there remain critical shortages in many low density/high demand skills and other "hard-to-retain" skills, such as explosive ordnance disposal specialists, linguists, intelligence and counterintelligence analysts, and pararescue operators, that justify the continuation and application of the statutory bonus authorities. The Selective Reenlistment Bonus (SRB) and the Critical Skills Retention Bonus (CSRB) are among the most effective and are authorized by 37 U.S.C. 308 and 37 U.S.C. 355, respectively, as incentives to attract/retain qualified personnel in critical military specialties.

The Department's process to manage bonuses is very well defined. A skill is critical if it meets one or more of the following: (a) technical skills requiring high training and/or replacement costs; (b) skills in high demand in the civilian sector; (c) challenging to recruit into; (d) crucial to combat readiness or capabilities; and (e) low density/high demand (those skills that are in high demand for current operations yet are low density due to less requirements during peacetime). All requests from the Services must have a rigorous business case that clearly outlines the need for the bonus for that skill, payment amount and method, and expected retention results. Designations do not exceed 3 years, subject to congressional extension of the statutory bonus authority. The complementary authority of the CSRB is the Selective Reenlistment Bonus (SRB). The SRB is under the authority of the Service Secretaries and is not centrally managed by the Department. However, applications of

the bonus authorities are reviewed at the Department and sent as an annual report to Congress.

Stop Loss

The Army is the only Service with members currently extended under the Stop Loss authority. From a peak of 15,758 in 2005, the Army reduced the number of soldiers affected by Stop Loss to approximately 8,000 at the end of December 2009. The Department is progressing as planned to completely end the use of the Stop Loss authority. Army units deploying after January 1, 2010, are no longer using the Stop Loss authority. The Department further expects to reduce the number of servicemembers on Stop Loss to less than 6,600 by June 2010. This is a 50 percent reduction from February 2009 (date that the Secretary of Defense announced the milestones to end Stop Loss). All use of the Stop Loss authority will end by March 2011.

Two Stop Loss Special Pays have been enacted which allow a payment of up to $500 per month for members whose active duty (retroactive to September 11, 2001) is or was extended by use of the Stop Loss authority. These pays were appropriated and authorized by the Congress, with the Department's support, to mitigate the impact and disruption that extensive use of Stop Loss had and has on the lives of servicemembers and their families. The Department implemented both pays, active and retroactive, and appreciates the support of Congress to compensate members for the unique circumstances presented by the use of this policy, while still preserving our ability to react with discretionary authority as dictated by future circumstances.

Separation Policy

The Department continues to improve military discharge policies in response to conditions of the current war and its effects on those who serve. As we reported to Congress earlier, one such improvement is the addition of increased rigor when using a personality disorder as the basis for administratively separating servicemembers who had deployed to imminent danger areas. This more rigorous process now includes a review by the Surgeon General of the Military Department concerned, yielding greater confidence that servicemembers who should be separated due to post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI) are appropriately processed for disability separation as opposed to personality disorder. The immediate evidence of the positive effect of the increased rigor is that the number of personality discharges has decreased from 81 at the policy's promulgation in September 2008 to an average of 16 per month in 2009. Also, in response to section 512 of the NDAA for Fiscal Year 2010, the Department is prescribing policy regarding a more in-depth medical examination to assess whether the effects of PTSD or TBI relate to the basis for an administrative separation for those servicemembers who are pending discharge or who were discharged under conditions other than honorable.

End Strength Management

Meeting end strength is a priority of the Department. The table below depicts the fiscal year 2009 Active Duty authorizations (prescribed and actual) and fiscal year 2010 authorized levels which the Department intends to achieve. The Secretary of Defense has authority granted under the terms of the President's national emergency declaration to increase statutory strength levels prescribed by the National Defense Authorization Act if needed. The Services have implemented recruiting, retention, and force shaping policies and programs to achieve end strengths for fiscal year 2010. The Department appreciates the congressional support of the fiscal year 2010 end strength levels. These end strengths will provide the ground forces to meet strategic demands, eliminate the need for the use of Stop Loss, and mitigate persistent capability shortfalls which will reduce stress and demands on servicemembers and families by increasing dwell time.

Table 2. Active Component End Strength Summary

Component	FY 2009 NDAA/SecDef Prescribed End Strength	FY 2009 Actual End Strength	FY 2010 NDAA End Strength
Army	547,400	553,044	562,400
Navy	326,323	329,304	328,800
Marine Corps	202,000	202,786	202,100
Air Force	330,000	333,408	331,700

Force Development

The Department continues to emphasize joint officer development and has made great strides in implementing the extraordinary authorities authorized in the 2007 NDAA. Active and Reserve component participation continues to grow, and the adjudication of over 3,200 joint experiences from nontraditional joint duty assignments attests to the Department's ability to recognize joint experiences whenever and wherever they occur.

Joint officer management is not the only area of significant improvement for the officer corps. We appreciate the authorities provided by Congress in the fiscal year 2009 and 2010 NDAAs that allow the development of general and flag officers with the joint knowledge and skills necessary to lead and counter emerging threats. This landmark general and flag officer management legislation apportioned general and flag officer authorizations between internal and external Military Service requirements, ensuring the statutory responsibilities of the military departments and the joint warfighter can be met.

The enactment of conforming legislation from the Department's 2010 legislative package is also serving to dramatically accelerate the development of joint experience in the Reserve components. The legislation expanded on the previously enacted statutory framework affording the Military Departments the opportunities to purposefully develop officers from the Reserve components for senior posts in joint warfighting organizations. This delivered on the promise of the charter Goldwater-Nichols legislation by institutionalizing joint officer development through the senior officer grades regardless of component.

Compensation

The Department and Congress continue their strong commitment to provide a secure standard of living and quality of life to those who serve in uniform. Today, we find ourselves empowered with a never before seen set of flexible and targetable pay authorities which enable the Department to dynamically address recruiting and retention and achieve specific and desirable effects. We also find ourselves with large fixed costs encompassed in our entitlements, and the prospect of continued growth in that area. To secure sufficient personnel for the Armed Forces, the Department must provide a compensation package comparable and competitive in the private sector while at the same time balancing the demands of an All-Volunteer Force in the context of growing equipment and operations costs.

The Department continues this commitment through the President's request for a 1.4 percent increase in military pay for all servicemembers in the fiscal year 2011 budget—an amount that equals earnings increases in the private sector as measured by the Employment Cost Index. Of note, since January 1, 2002 through the January 1, 2010 pay raise, military pay has risen by 42 percent, the housing allowance has risen by 83 percent, and the subsistence allowance has risen by 40 percent. During this same period, private sector wages and salaries have only risen by 32 percent. Government Accountability Office (GAO) is currently auditing the overall adequacy of military pay, as well as the appropriateness of the benchmarks used to measure any gaps relative to the private sector and its report is due April 2010. We are confident regular military compensation will compare favorably with pay in the private sector. While there is little question that those levels of increase were necessary in the past, the Department now finds itself at a point where discretionary spending offers the best ability to target specific skills, and the quantity and quality of those filling such positions.

Collateral to the GAO review, the President recently commissioned the eleventh Quadrennial Review of Military Compensation. The four themes he has asked the panel to focus on continue the thesis of tailoring pays beyond entitlements to target groups and behaviors. This review, in general terms, will be looking at the compensation package for service performed in combat of hostile areas; compensation for our Reserve components in light of current and planned utilization; compensation benefits available to our wounded, those who care for them and the survivors of those fallen; and the pay and incentives for some of our most critical fields, including mental health professionals, special operators, operators of remote systems and those with specialized linguistic skills. With the recently consolidated pay authorities, I am confident in saying Congress has given us the tools we need to address each of these areas; what remains is identifying the best combination of the pays to achieve the ideal combination of outlay to impact. The Department, as always, welcomes the continuance of these authorities, but would be generally opposed to continued entitlement growth beyond indexed levels in the absence of specific goals and outcomes supported by studies such as those just discussed.

Similar to our efforts to target and define the impacts of each pay with our active personnel, we must continue to ensure we support those who have already served,

but again, we must do so in an equitable manner and one that is consistent with the overall demands of the Department. As an example, the Department continues to oppose efforts to eliminate the offset between the Survivor Benefit Plan (SBP) and Dependency Indemnity Compensation (DIC) programs. Allowing concurrent receipt of SBP and DIC without offset would create an inequity with one select group receiving two survivor annuities, while survivors of most military retirees and survivors of veterans who died of service connected cause, but were not retired, would receive only one or the other. At the same time, in seeking that broader equity and Department-wide impact, we see a win-win opportunity in expanding the concurrent receipt program to include military disability retirees with less than 20 years of service regardless of disability rating. This expansion would cover our most challenged retirees by allowing them to receive retired pay for their years of service performed and VA disability compensation for their future reduced earning capability.

Overall, the state of military compensation is healthy. We have improved our overall entitlements to the point that all of our personnel are paid at or above the 70th percentile of their civilian counterparts. We have eliminated out-of-pocket expenses for housing to fully cover, on average, the costs of comparable civilian housing.. We have gained a new and dynamic set of authorities which we are in the midst of implementing. For the first time, we truly have the ability to target pay with pinpoint accuracy to achieve desired aims and maximize effects of dollars spent. Our challenge today is to maintain this position without imposing greater long term bills, while using our targetable tools to shape and manage our force.

Legislative Fellowship Program:

The Legislative fellowship program is a unique and excellent opportunity for members with great potential to serve to learn the day-to-day functions of the Legislative Branch of Government and is a valuable experience in the professional development of career military members or civilian employees in the Department. The Services and Components assign their Legislative Fellows to appropriate follow-on tours, which the Department monitors for each Fellowship cycle. Typical of the follow-on assignments are positions in: the House and Senate Liaison Divisions of the Services; the Office of the Secretary of Defense (Legislative Affairs); the Combatant Command Headquarters with duties associated with interacting with Congress; Service primary staffs responsible for legislation development and interaction with Congress; and the Staffs of senior leaders. The Secretary of Defense established the maximum number of Legislative Fellows at 100. The 100 Legislative Fellowships are broken out in calendar year 2011 as follows:

	Military	Civilians	Total
Army	24	1	25
Navy	20	2	22
Marine Corps	13	2	15
Air Force	32	4	36
Defense Agencies	0	2	2

Legislative Fellows serve no more than 12 months in the House or Senate. The Legislative Fellowship Program is the only program that authorizes Department of Defense personnel to work in Congress on a more than temporary basis and the program and policies are clearly promulgated in a DOD Instruction. Legislative Fellows are selected under Service competitive selection process and approved by the OUSD (P&R).

RESERVE COMPONENT

Achieving the defense strategy articulated in the Quadrennial Defense Review (QDR) requires a vibrant National Guard and Reserve seamlessly integrated into the Total Force. National Guard and Reserve units and individual members are heavily utilized across the full spectrum of current military operations, ranging from combat missions in support of the global war on terror to homeland emergencies. The Guard and Reserve have demonstrated their readiness and ability to make sustained contributions, and to prevail in today's wars, the Reserve components must serve in an operational capacity—available, trained, and equipped for predictable routine deployment—as well as a strategic capacity. Preventing and deterring conflict will likely necessitate the continued use of some elements of the Reserve Component (RC) in an operational capacity well into the future, especially in high-demand skill sets. Accordingly, the Department will use the Guard and Reserve where needed as an operational Reserve, rather than the "force of last resort," to fulfill requirements for which they are well suited in the United States and overseas. To-

day's Citizen Warriors have made a conscious decision to serve, with full knowledge that their decision means periodic recalls to active duty under arduous and hazardous conditions.

Consistently averaging about 140,000 National Guard and Reserve members mobilized to support ongoing operations on a daily basis, the Reserve components continue to make significant contributions to the national defense. The fiscal year 2011 budget provides about $50 billion for pay, training, equipping, and facilities to support the Reserve components of the Army, Navy, and Air Force in their respective Reserve components as operational Reserve Forces. The budget includes an across-the-board pay raise of 1.4 percent, along with pay and allowances for over 1 million personnel. Operating funds support necessary training requirements to ensure deploying personnel are fully mission-ready.

The fiscal year 2011 budget request supports the Department's Ready Reserve totaling about 1.1 million members contributing about 43 percent of the total military end strength at a cost of about 9 percent of the total base budget. The Ready Reserve consists of the Selected Reserve (about 838,300), the Individual Ready Reserve (IRR) about (250,000), and the Inactive National Guard (ING) (about 2,000). This budget request includes about $53.3 billion to fund pay and allowances and costs of Reserve component training, incentives, equipment operation and maintenance costs, and readiness training costs for eligible military personnel. This amount includes $5.5 billion for Reserve component equipment procurement, which is funded by the military departments as a subset of their Active component procurement budget.

Managed as strategic and operational forces, the total Reserve component structure operates across the continuum of military missions performing both strategic and operational roles in peacetime, wartime, contingency, domestic emergencies and homeland defense operations. As such, the Services organize, resource, equip, train, and utilize their Guard and Reserve components to support mission requirements to the same standards as their Active components. The budget supports preparation of both units and individuals to participate in missions, across the full spectrum of military operations, in a cyclic or periodic manner that provides predictability for the combatant commands, the Services, servicemembers, their families, and civilian employers, while potentially increasing the Department's overall capacity and reducing costs.

To help reduce Active component "dwell to deployment" ratio, all Reserve components are moving towards a more rotational process, characterized by a period of active service thereby relieving active force burden, and then followed by an extended period at home. The current mobilization policy issued in January 2007 by the Secretary of Defense mandated involuntary mobilizations be limited to no more than 12 months, which does not include individual skill training days required for mobilization or deployment or terminal leave. The Secretary of Defense also set a goal of not more than 1 year mobilized in any 6 year period for the Reserve components. The Services are moving toward this goal as quickly as possible given current operational requirements. Unlike before, when the RCs were usually funded at less than full readiness because they were not first to fight, specific units now must be fully resourced in any given year. This new train-mobilize-deploy construct means that the RCs must be ready, manned, trained, medically and dentally prepared, and equipped when their scheduled availability comes up, and they must be funded accordingly.

Resourcing Operational Reserve Forces

Managing the Reserve components as operational forces affects training schedules and funding requirements, including medical readiness. In the past, normal training profiles meant training about 2 days per month plus 14 to 15 days of active duty for training annually, during which time Reserve component personnel were required to train to the same standards as their Active counterparts. While that training profile remains for some units, current Department policy states that for those with planned deployments, training days prior to mobilization must increase. This training profile, with more training pre-deployment and less post-deployment, minimizes mobilized time away from families and civilian jobs and will require a different resourcing approach. In general, the land based (Army and Marine Corps) Reserve components train according to this new profile, meaning that funds which had been consumed after mobilization from the active accounts are now required and expended prior to mobilization from the Reserve accounts. This change in training profiles means a simple comparison to prior year execution funding models can be misleading. For fiscal year 2011, Congress has authorized Reserve component military personnel budgets to be consolidated into a single budget activity, allowing much improved management of Reserve component assets and more agile fund allocation.

This flexibility is especially crucial for managing funds for the new operational Reserve, and the Department greatly appreciates this Congressional approval.

Equipping and Basing Operational Reserve Forces

The fiscal year 2011 budget requests $5.5 billion for Reserve component equipment, and provides greater transparency and more robust funding for vital equipment needs as the Department continues to ensure that deployed and next-to-deploy units, whether in the active or Reserve component, receive the highest equipping priority. Effective and realistic readiness training at home requires that the National Guard and Reserve have access to equipment compatible with the active components and used in the assigned operational environment. Modernization, mission transformation, equipment replacement due to the war losses, and homeland defense are all catalysts for a new approach to equip the Reserve components.

In the past, the Reserve components often relied on cascaded or "hand-me-down" equipment from the Active components and they often were short in their equipment inventories. The fiscal year 2011 budget contains funds needed for Reserve component equipment procurement to continue that transition, repair and replace war-damaged equipment, and to correct longstanding deficiencies. The budget request includes funds for equipment that will not only improve combat readiness but will also allow the National Guard to further improve its ability to respond to local domestic emergencies.

Additionally, the Guard and Reserves previously have been a low priority for receiving new equipment. But today that standard has changed and these Forces receive the same equipment as their Active counterparts. We have achieved major progress in programming funds and equipping our Reserve components for an operational role. With this operational role comes the requirement for equipment transparency in form of increased visibility and accountability for the National Guard and Reserve in the programming and budgeting process. Institutionalizing this process will ensure an adequate mission capability for foreign and domestics responses and we are proceeding in that direction.

The Reserve components request $1.4 billion for military construction (MILCON) projects. These projects will meet both current and new mission requirements for RC operations, readiness, and training facilities.

READINESS AND TRAINING

Deployment and Dwell

Multiple deployments to Iraq and Afghanistan have certainly increased the stress on our servicemembers and their families. We have a number of initiatives underway to address this stress, and have set clear limits and goals for deployment lengths and the amount of time or "dwell" between deployments.

To that end, we have limited unit deployments to 1 year in theater, with a minimum of 1 year between deployments for our Active component. Our goal is to increase the time between deployments to 2 years for every year deployed, commonly called a 1:2 "dwell" ratio. For the Reserve component, we have limited the mobilization period to 1 year, and strive to have a minimum 3 year break between mobilizations. The goal for Reserve component dwell ratio is 1 year mobilized with a 5 year break between mobilizations, or a 1:5 dwell ratio.

Dwell time is driven by the number of forces deployed for missions around the world against the supply of available forces. We have increased the supply of forces by increasing the end strength for the Army, the Marine Corps, and Special Operations Forces. We also expect to make progress toward meeting the dwell goals as we drawdown forces in Iraq.

Defense Mishap Reduction Initiative.

As Chair of the Defense Safety Oversight Council (DSOC), I have been chartered to ensure that the Department is making steady progress toward the Secretary's goal of a 75 percent reduction in all accidents. The Department has made considerable progress to date due to the tremendous effort of our military and civilian leaders. From our 2002 baseline, we have reduced our civilian lost workday rate 41 percent, are down 31 percent in our private motor vehicle fatality rate, and dropped our Class A aviation accident rate 56 percent.

The DSOC is supporting the Military Departments' pursuit of the Occupational Safety and Health Administration's (OSHA) Voluntary Protection Program (VPP) at more than 200 DOD installations and sites. We have 30 sites that have already attained OSHA's Star recognition and we expect 17 more sites by the end of 2010. Their OSHA Star status designates them as exemplary worksites with comprehensive, successful safety and health management systems, and improved labor/management relations.

We recently completed a comprehensive, data driven assessment to further prevent aircraft crashes, save military lives, and reduce the need for replacement aircraft. The task force, consisting of a variety of experts from across the Department, recommended that the military aviation communities acquire technologies for collision awareness, crash survivability, and risk management. As a result of this important work, the military departments are making further investments in hardware and software that will avert aircraft crashes. With your continued support, we can make further progress in preventing injuries, fatalities, and aircraft crashes; and be well on our way towards attaining the Secretary's accident reduction goal.

MILITARY HEALTH SYSTEM

Health Budgets and Financial Policy

The fiscal year 2011 budget reflects several areas of continued emphasis, including the modernization of our medical infrastructure and full funding and support of our Wounded, Ill and Injured programs. The Unified Medical Budget, the Department's total request for health care in fiscal year 2011, is $50.7 billion. This includes the Defense Health Program, Military Personnel, Military Construction, and Medicare-Eligible Retiree Healthcare. Major increases in the budget request include $0.8 billion for medical and general inflation; $1.2 billion for private sector care costs due to an increase in users of TRICARE and an increase in utilization of the TRICARE benefit; $0.6 billion for enhancements for the Direct Care system; and $0.3 billion for modernizing the Department's electronic health record to enable data compatibility for the Virtual Lifetime Electronic Record, and correcting critical system problems, increasing user satisfaction, and improving system reliability and availability.

Our primary and enduring responsibility is to provide the highest quality care to our beneficiaries, using the most current medical evidence to drive our clinical decisionmaking; and one of our fundamental tenets is that quality of care is also cost-effective. In addition, there are a number of actions we have undertaken and will continue in fiscal year 2011 to continue to provide value to the Department and the taxpayer. The ways we are addressing cost effectiveness in fiscal year 2011 include:

- continued implementation of Federal Ceiling Pricing of retail pharmaceuticals ($842 million savings);
- continued implementation of the Outpatient Prospective Payment System, which reduces the reimbursement paid for outpatient care at inpatient private sector care facilities ($366 million savings)
- standardization of medical supply chain management across the full range of military health care operations ($27 million savings);
- increasing efforts to identify and detect fraud, waste, abuse, and overpayments to civilian medical providers ($68 million savings); and
- additional VA and DOD facilities sharing—most notably the first fully integrated Joint DOD/DVA healthcare collaboration consisting of the North Chicago Veterans Affairs Medical Center and the Navy Ambulatory Care Center, Great Lakes, IL.

Health Affairs/TRICARE Management Activity Strategic Direction

In 2002, the assistant Secretary of Defense for Health Affairs (ASD/HA) aligned policy and program execution strategies under Health Affairs/TRICARE Management Activity (HA/TMA). In HA/TMA, as in most organizations, the bridge from strategy to execution was challenging, and the organizational alignment, still in effect today, was intended to streamline processes for faster and more effective execution of policies and programs. Under this arrangement, HA is setting clear strategic direction for the Military Health System (MHS) in partnership with the Services.

For the past 12 months, HA/TMA has worked closely with the Service Surgeons General on initiatives that have coalesced around a strategic initiative known as the "Quadruple Aim." Borrowing liberally (and with permission) from the nonprofit Institute for Healthcare Improvement's (IHI) "Triple Aim," the Department is focusing on four strategic imperatives:

- Readiness - Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.
- Population Health - Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.

- Experience of Care - Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe, and always of the highest quality.
- Responsibly managing the total health care costs - Creating value by focusing on measuring and enhancing quality healthcare; eliminating inefficiencies; reducing unwarranted variation; and emphasizing investments in health that reduce the burden and associated cost of preventable disease in the long term.

There are many important initiatives that will emerge from this strategic direction. One of the most vital, because it will have effects across all four components of the Quadruple Aim, is the "medical home" concept being piloted by all three Services. This approach takes the existing construct of a primary care manager and enhances it through improved access to care. Features will include 24/7 access to a provider through multiple avenues—that will include leveraging technology to avoid unnecessary visits or emergency room visits. More importantly, it will enhance continuity of care and greatly improve satisfaction with service. The early results from pilot sites are very encouraging, and we are applying lessons learned from these sites to improve the program as we proliferate it across the Department.

With the shared vision of the Quadruple Aim and a revised decision-making process, the MHS is laying the groundwork for a smooth transition under the BRAC-directed co-located medical headquarters in the National Capital Area (affecting HA/TMA and the Services' Surgeons General staffs). The co-location initiative offers significant opportunities to achieve even greater unity of effort.

Mental Health Professionals

Significant effort has been made to recruit additional mental health personnel in order to meet the growing demand for behavioral health services in the Department. Since 2007, the number of active-duty mental health providers has remained relatively constant, yet we expect the Consolidation of Special Pay language (10 U.S.C. § 335) recently implemented will have a significant effect on retention of psychologists and social workers.

Our work to recruit civilian mental health providers has been very effective. Table 3 shows the Services total mental health needs/requirements as compared to the number of providers on-hand as of the third quarter of fiscal year 2009. The Navy and the Air Force compare assigned personnel versus requirements. The Army's growing needs are not completely reflected by official requirement documents yet, and thus they are identified as "needs." Table 4 shows the significant improvements in total Mental Health personnel that have been made since 2007, including in the TRICARE Network.

Table 3: Mental Health Personnel Gap analysis

Army	Needs	Authorized	Assigned	Assigned/Needs
Psychologist	1,013	595	926	91%
Psychiatrist	474	243	408	86%
Social Worker	1,297	520	1,123	87%
MH Nursing (including NP)	288	152	285	99%
Other Licensed MH Provider (Marriage Family	48	-	46	96%
Tech/Counselor	716	654	586	82%
Total	3,836	2,164	3,375	88%

Navy	Requirements	Authorized	Assigned	Assigned/Requirements
Psychologist	331	331	300	91%
Psychiatrist	176	176	166	94%
Social Worker	176	176	166	94%
MH Nursing (include NP)	130	130	143	110%
Other Licensed MH Provider (OT)	39	39	35	90%
Tech/Counselor	507	507	433	85%
Total	1,359	1,359	1,243	91%

Air Force	Requirements	Authorized	Assigned	Assigned/Requirements
Psychologist	372	372	342	92%
Psychiatrist	145	145	149	103%
Social Worker	405	405	373	92%
MH Nursing (including NP)	102	102	74	73%
Other Licensed MH Provider	0	-	-	0%
Tech/Counselor	828	828	778	94%
Total	1,852	1,852	1,716	93%

Table 4: Total Mental Health Staffing

Location	2007	2008	2009*
Military Facilities**	4,129	4,373	6,061
TRICARE Network Providers***	39,587	45,215	49,807

***Data as of 2nd Qtr 2009**
****Military, Civilians, and Contractors FTEs in MTFs**
*****Represents expansion of mental health providers in TRICARE network including psychiatrists, psychologists, social workers, licensed mental health counselors, and psychiatric nurse practitioners (community based providers)**

Suicide Prevention

The Department's civilian and military leadership remain focused on employing numerous strategies to reduce the incidence of suicide in the Armed Forces. In calendar year 2009, there were a total of 312 suicides—285 in regular components and 26 in Reserve Components—marking an increase from 268 in calendar year 2008. Suicides within the Regular Components increased from 235 in calendar year 2008 to 285 in calendar year 2009. Demographic risk factors are: male, Caucasian, E–1 to E–2, younger than 25 years old, GED/less than high school education, divorced, and in the Active Duty component. Other factors associated with suicide, which are consistent with data from the civilian population, are: substance abuse, relationship problems, legal, administrative (article 15), and financial problems. Although the impact of role of deployment on suicide risk is still under investigation, a majority of suicides do not occur in the theaters of operation.

Table 5: Total Suicides

	2001		2002		2003		2004		2005		2006		2007		2008		2009		Year Total
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	
Total/Year	160	10.3	171	10.3	190	11	194	11.3	189	11.3	213	13.1	224	13.8	268	16.3	311	18.5	1920
Regular	125	10.5	146	10.3	158	11	171	12	148	10.7	187	13.5	197	14.3	235	16.9	285	20.3	1652
Reserve	15	9.3	25	10.6	32	11.1	23	8	41	14.8	26	10.7	27	10.8	33	12.7	26	9.5	248
OEF	1	*	3	*	4	*	2	*	4	*	3	*	5	*	4	*	6	*	32
OIF	0	*	0	*	27	*	20	*	25	*	31	*	41	*	38	*	35	*	217

When a servicemember has a problem, he or she can, in most cases, receive confidential help from military and other mental health providers. However, if the individual is unable to perform his/her duties, is homicidal or suicidal, or is in a sensitive duty, the commander will be notified for safety reasons. Resources available to servicemembers and their families include: confidential problemsolving counseling through Military OneSource, online information and tools at militarymental-

health.org and afterdeployment.org, confidential pastoral counseling with chaplains, Military Family Life Consultants (active duty and families), military mental health providers, Service-level counseling centers, and access to information and referral to mental health professionals through the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Outreach Center.

The Department and Services recognize suicide prevention begins long before an individual exhibits suicidal ideation. Comprehensive programs focus on enhancing resilience and early identification designed to reduce psychological health issues or disorders that may contribute to suicide risk. Leadership at every level receives training on warning signs, resources, healthy lifestyle choices, and actions to take if an intervention is deemed necessary. The Suicide Prevention and Risk Reduction Committee (SPARRC) is a forum for developing/expanding partnerships among the Services, VA, Federal and civilian partners. The SPARRC's goal is to improve policies, programs and systems across the Department while providing support for medical, line, and community leaders. Chaired by DCoE, the SPARRC includes representatives from all Services, VA, SAMHSA, Center for Disease Control, Medical Examiners, Chaplains, Telehealth/Technology and National Guard/Reserves.

The Department also collaborates with VA and the Substance Abuse and Mental Health Services Administration (SAMHSA) on suicide prevention efforts. This includes an annual joint DOD/VA conference on reducing the rate of suicides in the Active Duty components, Reserve components, and veteran populations. The January 2010 DOD/VA Suicide Prevention Conference, "Building Strong and Resilient Communities," brought together over 900 servicemembers, family members, and mental health professionals throughout DOD, VA, and other Federal agencies. The conference highlighted practical tools, personal stories, and ongoing efforts in supporting the community.

The Department's mental health initiatives dovetail with both the Readiness and Population Health components of the Quadruple Aim. We have developed metrics that we closely monitor to determine if our programs are effective and if our policies are being effectively implemented. We are also broadening our view of readiness, to include perspective on the "readiness" of an entire family for a servicemember's deployment. In 2010, we will expand our measures to include this more expansive view of readiness—and consequently, better manage pre-deployment, deployment, and post-deployment activities for the Total Force.

We recognize the number of suicides continues to increase and suicide has a multitude of causes, and no simple solution. There are many potential areas for intervention, and it is difficult to pinpoint the best approach because each suicide is unique. Recognizing this, DOD is tackling the challenge using a multi-pronged strategy involving comprehensive prevention education, research, and outreach. We believe in fostering a holistic approach to treatment, leveraging primary care for early recognition and intervention, and when needed, providing innovative specialty care. The areas of focus to reduce risk include: (1) conducting data collection and analysis to detect contributing risk factors; (2) facilitating partnerships across DOD, Federal, and civilian organizations to increase collaboration and communication; (3) reducing stigma and increasing access to resources to provide needed care; and (4) using research to close gaps and identify best practices.

Health Informatics

The DOD's Electronic Health Record (EHR) continues to be a key enabler of military medical readiness; giving healthcare providers secure, 24/7, worldwide access to medical records of our highly mobile patient population. Across the enterprise, the EHR supports uniform, high-quality health promotion and healthcare to more than 9.5 million MHS beneficiaries. Using the EHR, our healthcare providers access the electronic medical records of MHS beneficiaries from any point of care throughout the direct care system.

The MHS Information Management/Information Technology Strategic Plan for 2010—2015 provides the roadmap for improving the EHR, and lists EHR improvement as a top IM/IT priority. Using this roadmap, MHS will effectively execute its action plan to stabilize the current system while transitioning to a suite of EHR applications and supporting infrastructure that will improve reliability, speed, user interface and data integrity, and achieve higher satisfaction from all users. These improvements will enhance IT interoperability within the MHS and support planned improvements in electronic health data sharing with VA and our private sector care partners.

For future years, ICIB will prioritize additional health related sharing capabilities or usability enhancements to continue the advancement of DOD/VA interoperability in a manner that supports clinicians in healthcare delivery. The Departments will

continue to work together to improve and expand upon the interoperability of appropriate healthcare data as appropriate and necessary.

Virtual Lifetime Electronic Record (VLER)

On April 9, 2009, President Obama announced that DOD and VA would work together to create of a "virtual lifetime electronic record" (VLER) for servicemembers and veterans. While the Department and VA already share an unprecedented amount of health care information between the two systems, a very large portion of health care to our beneficiaries comes from private sector contract providers. The DOD, VA, and the Department of Health and Human Services are working together to promote access of electronic health care information for care provided in DOD, VA, and private sector facilities while DOD and VA continue to leverage work already done to improve our capabilities for sharing information.

VLER will rely on the Nationwide Health Information Network (NHIN) as the mechanism to share standards-based health data between DOD, VA, and private sector partners. Well-defined standards are the essential foundation for interoperability among systems. These standards will be guided by the Department of Health and Human Services (HHS) and will be consistent with the NHIN model based on the Federal Health Architecture.

DOD and VA have been active participants and among the leaders in the development of the NHIN working with the HHS Office of the National Coordinator for Health Information Technology. The NHIN will tie together health information exchanges, integrated delivery networks, pharmacies, government health facilities and payers, diagnostic laboratories, providers, private payers, and other stakeholders into a "network of networks." The NHIN provides a national standards-based mechanism for previously unconnected electronic health records and other sources of healthcare information to share information securely while respecting and enforcing mandates for guarding patient privacy.

Working together with HHS and private health care providers, DOD and VA are creating a capability that will take a huge step towards modernizing the way health care is delivered and services are administered for our Nation. VLER will allow health care providers access to servicemembers' and veterans' military medical records, providing the information needed to deliver high-quality care. VLER will do all of this with the strictest and most rigorous standards of privacy and security, so that our servicemembers and veterans can have confidence that their medical records can only be shared at their direction.

VLER is not a large acquisition program nor will VLER result in one single DOD/VA Information Technology (IT) system. Rather, VLER builds on the electronic health care systems already in place in DOD, VA and the private sector. Even if DOD and VA were to embark on a huge acquisition program to implement a single system, they would still not be able to access the critical information captured by the private sector. The VLER solution is viable for the entire health care community and enables each individual entity to develop and maintain their own internal systems. It creates an opportunity for competition since it uses well-documented standards that can be implemented through a variety of electronic health initiatives that can be linked to the NHIN.

MILITARY FAMILY SUPPORT AND WOUNDED WARRIOR CARE

This past year, due to the high level interest in supporting military families, resources were increased to institutionalize servicemember and family support programs across the Department. A 41 percent increase in the Defense-wide family assistance baseline funding in fiscal year 2011 from fiscal year 2010 will provide lifelines of support for servicemembers and their families through outreach to Guard and Reserve members and families, Military OneSource 24/7 accessible family support assistance, referrals for counseling, financial education and training, and access to education, training certification opportunities leading to a portable career for spouses.

To ensure we are on-target in investing in programs needed by servicemembers and their families, we initiated an extensive strategic planning process to address the current issues facing family readiness programs, beginning with a thorough assessment of existing needs, programs, and related issues. A variety of methods were used to gain input from key players across the system, including family members, support professionals, non-governmental organizations, land-grant universities, and senior DOD leadership.

Child Care

Access to child care remains a top priority for the Department. Efforts are ongoing to meet the needs of our deployed families, including National Guard and Reserve

families. We have expanded respite child care options through the YMCA program, offering opportunities for geographically isolated families to help mitigate the stress experienced by the parent at home. These efforts augment the respite child care provided by the Military Services.

We continue to reduce the unmet need for child care, yet are cognizant of the ongoing need to recapitalize our aging child and youth facilities. We need to eliminate barriers to hiring practices key to expanding our partnerships with community child care providers. The temporary program to use minor military construction authority for the construction of child development centers provided a means to increase the availability of quality, affordable child care for servicemembers and their families. This authority expired at the end of fiscal year 2009, and we have proposed legislation to reinstate the authority. The legislation would also expand age limit requirements from 5 years old to 12 years old to include children in school age care programs, broaden the authority to include other family support initiatives (e.g., family center, fitness facilities, etc.), and increase the funding authority to $15 million for all projects.

Youth Programs

We are also deeply committed to addressing the needs of our military youth. More than 350 dynamic, innovative and successful youth programs serve more than 500,000 military connected children and youth between the age of 6–18 worldwide. Programs promote positive youth development and prepare pre-teens and teenagers to meet the challenges of military life, adolescence, and adulthood. Partnerships with other youth-serving organizations enable the Department to offer resources in a variety of domains, including physical fitness and sports; arts and recreation; training in leadership; life skills; career/volunteer opportunities; mentoring; intervention; and support services. Programming supports character and leadership development, sound education choices, healthy life skills, the arts, and sports and recreation. Many programs offer summer day camp and youth employment opportunities. Twenty-two youth facilities were funded in 2008 and 2009, totaling $145.6 million in non-appropriated funds; this support constitutes a critical aspect of family support. Six youth facilities are funded for fiscal year 2010 and fiscal year 2011, totaling $49.7 million.

Family Advocacy Programs

The DOD Family Advocacy Program (FAP) plays a key role in addressing familial physical, sexual, and emotional abuse and neglect involving military personnel in the active component as victims and abusers. On each military installation with command-sponsored families, there is a FAP that provides services in prevention, identification, intervention and treatment of child abuse and neglect and domestic abuse. Two key programs, the New Parent Support Program and treatment programs for substantiated spouse abusers have been tied to outcomes for prevention.

Casualty and Mortuary Affairs Programs

The Department remains committed to providing the highest quality of compassionate and caring assistance to families of fallen servicemembers for as long as they determine assistance is needed. After which, additional assistance can be obtained by a simple phone call or letter written to the appropriate Service Casualty Office. Since early 2006, the Department has worked extensively with the Military Services; the Department of Veterans Affairs; the Social Security Administration; family support organizations; nonprofits groups, and more importantly, survivors, to ensure our policies and procedures are standardized to the maximum extent possible, more customer focused, and flexible enough to address unique situations.

While the Department has made many enhancements to the Casualty Assistance Program, we recognize there is always room for improvement and therefore we strive every day to make it better, simpler, more respectful, and more compassionate. As the Secretary stated, "When young Americans step forward of their own free will to serve, they do so with the expectation that they and their families will be properly taken care of should anything happen to them." We listen to those we serve and to those organizations who have dedicated their existence to providing valuable support and services to survivors of the fallen. Together, our collaborative efforts will ensure our program will continue to be enhanced and our families provided the very best assistance possible.

Military OneSource

Military OneSource (MOS) continues to have a positive impact on servicemembers and their families. OneSource offers a 24-hour/365-day centralized assistance program to provide diverse information and referral services by credentialed counselors to Active Duty, Guard, Reserves and their family members, regardless of physical

location or activation status. Assistance can be provided in many languages. Since inception, Military OneSource has experienced exponential expansion. Over 739,000 telephone calls were received in fiscal year 2009, more than doubling the number of calls received in fiscal year 2008. The website received over 4 million visits, almost doubling the number of visits received during the prior year. Nearly one in three servicemembers uses Military OneSource.

In general, the most common reasons for which a person sought MOS counseling were marital and intimate relationships, stress management, family relationships, and anger management. In addition, MOS financial counseling support is offered in-person and telephonically. In fiscal year 2009, MOS conducted 4,501 financial counseling sessions. The most common reasons for which a person sought financial counseling support from MOS were budgeting and money management, overextension with bills, credit management, loans and consolidating loans, and mortgages and refinancing. In fiscal year 2009, OneSource assisted members and families with almost 600,000 tax filings at no cost to the family.

The Wounded Warrior Resource Center (WWRC), accessed via Military OneSource, provides immediate assistance to the wounded and their families with issues related to health care, facilities, or benefits. The WWRC works collaboratively with the Military Services' wounded warrior programs and the Department of Veterans Affairs to ensure callers are promptly connected to the resources that can help address their needs. In fiscal year 2009, 1,200 cases for wounded warriors were handled.

Dependents' Education Programs

A key quality of life issue is the education of military children. Servicemembers often make decisions about assignments based on the availability of quality educational opportunities for their children. The Department of Defense Education Activity (DODEA) provides quality pre-kindergarten through 12th grade educational opportunities and services to eligible military dependents around the globe where DODEA schools are located. Of the approximately 1.2 million military dependent children, DODEA educates nearly 85,000 in 192 schools in 12 foreign countries, 7 States, Guam, and Puerto Rico with 8,700 educators. DODEA also assists eligible military dependent students through a tuition reimbursement program for military assigned to overseas locations without a DODEA school.

The ongoing relocation of military dependent students through force structure changes created a need to enrich and expand partnerships with military-connected communities to ensure the best possible educational opportunities for military dependent children. Through its Educational Partnership Initiative, DODEA was given expanded authority to assist local education agencies (LEA's) who educate military dependent students through efforts focused on highest student achievement. DODEA works collaboratively with the Department of Education to ease the transition of military students by sharing experience and expertise with LEAs who educate larger populations of military dependent students.

Data from the Department of Education reports that there are 300 LEAs with a military child enrollment of 5 percent or more. Of the 300 LEAs with 5 percent military child enrollment, 153 of the LEAs are not meeting the State academic standards in reading/language arts and/or math using annual tests aligned to academic indicators. In addition, there is significant research surrounding the psychosocial effects of multiple deployments on school performance and student behavior. In fiscal year 2009, DODEA extended support through grants focusing on enhancing student learning opportunities to 44 school districts serving approximately 77,000 military children in over 284 schools.

Through new technologies, DODEA is developing additional academic opportunities for its students. The focused efforts are to expand access to education and provide curricular options to eligible students within DODEA through the expanded use of distance learning. DODEA plans to transition its distance learning program into a virtual school program beginning with the implementation of fully accredited virtual high school in School Year in 2010–2011. These tools include real-time audio and video, document sharing, screen sharing and web collaboration to stimulate active teacher-student, student-student and student-content interaction. A "virtual hub" model has been put into place that puts the teachers in locations closer to the students to facilitate interaction that simulate traditional classroom discussion and one-on-one tutoring.

Beginning in 2008, DODEA implemented a new process for advising decision-making that focuses on highest student achievement and a thorough review of data, implementation, and effectiveness of programs. Part of the advisory process includes educator-led task groups which review and analyze data. DODEA task groups are convened for various reasons such as instructional and curricular topics, issues of

interest from the field, or management needs. All task groups spend considerable time reviewing and analyzing information and data on a specific issue and then, through consensus, developing systemic recommendations sent to the Director to guide future educational actions. Currently, DODEA has seven on-going task groups.

Korea Tour Normalization

United States Forces Korea (USFK), through the Tour Normalization Program, is aggressively increasing command-sponsored military families on the Korean peninsula for the primary purpose of establishing a higher quality of life for military families. In addition to the housing needs, this impacts educational needs. DODEA anticipates adding 25 schools in Korea over the next 10 years, providing an end state program by 2020 of 31 DODEA schools in Korea. Student growth is expected to grow from 4,422 DODEA students currently in the Republic of Korea to 21,758 at the end state. This is approximately a 500 percent increase in the student population. DODEA is actively working programmatic details with USFK and local Military Service communities to support this effort.

MWR Support to Troops in Combat

The ability to communicate with family and friends is the number one factor in being able to cope with longer and more frequent deployments. We continue to balance the most effective use of available bandwidth between mission and personal requirements, including wireless access. Currently, servicemembers have free access to the non-secure military Internet by using their military e-mail address, including aboard ships. They also have free Internet access at over 1,008 MWR Internet Cafes in Iraq and Afghanistan with 9,241 computers and 4,101 Voice Over IP phones (with call rates of less than 4 cents a minute). Another 197 cafes, 2,191 computers and 1,154 phones have been funded for fiscal year 2010 for use in Afghanistan. To enhance MWR provided services, the Exchanges provide personal information services for a usage fee for this customer convenience. Back home, computers and Internet service located in our family support centers, recreation centers, libraries, and youth centers help ensure families can connect.

DOD-State Initiatives

The Department continues to work with State governments to educate their policymakers on the life-challenges faced by servicemembers and their families and to ensure that state-level policies do not disadvantage military families' transient life style. States have addressed several key quality of life issues, to include the impact of frequent school transitions experienced by military children, the loss income by military spouses as a result of military moves, and the enforcement of the congressionally-mandated DOD predatory lending regulation. The response from states has affirmed their commitment to supporting the well-being of the Nation's fighting force. For example, 27 States have joined the Interstate Compact on Educational Opportunity for Military Children, 36 States now provide eligibility for unemployment compensation to military spouses, and 30 States enforce the DOD predatory lending regulation. The Department is continuing this effort in the 2010 session and has added child custody to the slate of issues. In this regard, the Department is asking States to appropriately balance the interests of servicemembers who are absent due to military service with the best interests of the child by ensuring absences caused by military deployments are not the sole basis for permanent custody decisions and addressing delegation of visitation rights while the servicemember is deployed.

Special Needs

The establishment of the Office of Community Support for Military Families with Special Needs was mandated by NDAA 2010. The purpose of the Office is to enhance and support Department of Defense support for military families with special needs to ensure parity across the Services. The Office will be headed by a member of the Senior Executive Services. It will be staffed with personnel in the fields of medicine, education, early intervention, social work, personnel and information technology, as well as members of the armed services to ensure appropriate representation by the military departments. Currently, plans are underway to identify the specific mix of staff and to create an umbrella Office of Community and Family Support with an emphasis on special needs, which will synchronize all family support needs with those of families with special needs.

Disability Evaluation System

The Disability Evaluation System (DES) Pilot simplifies and restructures how servicemembers are evaluated for continued service and compensation as a result

of a wound, injury, or illness. Based on the recommendations of several commissions and task forces, DOD and VA implemented the DES Pilot on November 26, 2007, at three National Capital Region (NCR) locations (Walter Reed, Bethesda, and Malcolm Grow). Since November 2007, this program has been administered jointly by the DOD and VA. The Pilot eliminates duplicate disability examinations and disability ratings by the Departments. The DOD determines fitness for duty; the VA examines and rates for disability. The rating is used by DOD for unfitting conditions and by VA for all service-connected or aggravated conditions. After March 2010, the DES Pilot will operate at 27 locations across the continental United States and Alaska and encompass 47 percent of all potential servicemembers' cases. Compared to the legacy system, case processing time has been nearly cut in half (46 percent decrease) for Active and Reserve component servicemembers. The Pilot will be expanded to encompass 100 percent of the DES by December 2012. The DES Pilot Final Report which includes the results and recommendations for the DES Pilot-model worldwide implementation will be forwarded to Congress by May 31, 2010.

Transition Initiatives

The Department has several initiatives relating to the Department of Defense (DOD) Transition Assistance Program (TAP). We began this fiscal year by convening the first Joint Interagency Strategic Working Group on the Transition Assistance Program in November 2009. We are also working on several employment initiatives with our partners at the Department of Labor. As an ex-officio member of the Secretary of Labor's Advisory Committee on Veterans Employment, Training and Employer Outreach (ACVETEO), the Department is looking at more efficient ways to connect employers with transitioning Services members, veterans and their spouses. We are also looking at revamping the Department of Labor (DOL) TAP Employer Workshop to make it more dynamic and ensure it is meeting the needs of our warriors. Finally, we continue to collaborate with DOL on how to ensure our wounded, ill and injured are being prepared for and get meaningful jobs.

In addition to our work with DOL, this office assisted with the Office of Personnel Management (OPM) strategic plan as well as an executive order signed by the President in November 2009, which directed all Executive Branch Federal Agencies to increase the hiring of veterans. We are pursuing other initiatives like our work with the U.S. Interagency Council on Homelessness. The Department is assisting the council in developing a Federal Strategic Plan on Homeless. The plan will address ideas and ways to end homeless for our veterans, families, and youth.

One of our most exciting initiatives was joining the social network community with the launching of the DOD TAP Facebook. We are taking advantage of the popularity of social media as another communication resource to promote transition services and benefits to military personnel and their families.

Finally, we are working to improve outreach and education to all servicemembers to increase their participation in the Benefits Delivery at Discharge and Quick Start Programs. These programs allow eligible servicemembers to submit their application for disability compensation prior to separation or retirement.

CIVILIAN PERSONNEL

National Security Personnel System Transition

The National Defense Authorization Act for Fiscal Year 2010 (NDAA 2010) repealed the authority for the National Security Personnel System (NSPS) and requires the Department to transition out all employees and positions from NSPS to the appropriate non-NSPS personnel and pay system no later than January 1, 2012. The law provides no employee will suffer any loss of or decrease in pay upon conversion from NSPS.

Planning for terminating NSPS is well under way with the goal of transitioning employees and organizations from NSPS back into their pre-NSPS personnel and pay system during fiscal year 2010. The rules of the gaining pay and personnel system will be followed in determining placement of NSPS employees. Since the majority of the 226,000 employees covered by NSPS will transition to the General Schedule system, government-wide rules issued by the Office of Personnel Management (consistent with title 5, U.S.C.) are applicable. Until the transition takes place, organizations and employees currently covered by NSPS will continue to follow NSPS regulations, policies, and procedures. While the Department did not transition any bargaining unit employees into NSPS, approximately 900 employees organized after their organizations moved into the system. The Department plans to meet with representatives of national unions representing these NSPS bargaining unit employees to discuss transition issues and will ensure that local collective bargaining obligations are fully satisfied as these employees transition from NSPS back to the Gen-

eral Schedule. Transition timelines are being determined based on organizational readiness as evidenced by avoidance of undue interruption to mission and hardship to employees; established processes to classify NSPS positions into the appropriate non-NSPS personnel system; existence of an appropriate performance management system; and information technology capability. Prior to their transition out of NSPS, employees will be informed of their position classification under the non-NSPS personnel system. With limited, approved exceptions, no new appointments to NSPS will be made after March 1, 2010. The Department is tracking transition costs as it did with NSPS implementation costs. The organization that is guiding and directing transition planning and execution is the National Security Personnel System Transition Office (NSPSTO). The Director, NSPSTO is responsible for the development, coordination, and dissemination of supporting procedures, policies, and tools; and for developing training products and services for use by the Components in training employees and supervisors on all aspects of the transition. In addition, the Department is committed to providing open and frequent communications during the transition. The NSPSTO has redesigned its Web site to publicize up-to-date information on the transition, including transition toolkits that contain a variety of products such as conversion guides, fact sheets, brochures, articles, frequently asked questions, performance management guidance, timelines, and town hall briefings on the transition. The website and communications will be updated periodically as new information becomes available and new products are developed. In addition, the Department will deliver a report to Congress at the end of April 2010, as required by NDAA 2010, that covers the steps taken for the reclassification of NSPS positions and the initial plan for transitioning employees and organizations from NSPS; semi-annual reports that cover transition progress will also be provided until all organizations and employees are out of NSPS.

Civilian Strategic Human Capital Planning and Forecasting

With over 760,000 civilian employees, in over 600 occupations, supporting a myriad of critical missions, it is essential the Department have a structured plan to ensure civilian talent is in place to meet current and future mission requirements. To meet this demand, the Department is leading an enterprise-wide effort to establish a more structured, standard approach to Strategic Human Capital Management (SHCM), based on a combined effort of competency assessment and workforce analysis trending. The Department recognizes the need for a civilian workforce with the attributes and capabilities to perform seamlessly in an environment of uncertainty and surprise, execute with a wartime sense of urgency, and create tailored solutions to multiple complex challenges. We are institutionalizing an updated, integrated human capital strategy for the development of talent, that is consistent with 21st century workforce demands and a new generation of workers, and that is competency-focused, performance-based, agile, responsive to mission impacts, and focused on employee engagement and respect.

Civilian Expeditionary Workforce

The Department is working to better employ the talents of our civilian workforce to meet expeditionary mission challenges, especially those not directly related to warfighting. Global security challenges require adequate civilian capacity to conduct complex operations, including those missions that require close military-civilian planning and cooperation in theater. Since 2001, more than 43,000 Department civilians have been involved in contingency operations around the globe. Currently, approximately 5,100 civilian employees are serving in theater. In response to these imperatives, the Department institutionalized the Civilian Expeditionary Workforce (CEW) to provide deployable civilian experts to support military operations, contingencies, emergency operations, humanitarian missions, disaster relief, and stabilization and reconstruction operations. The CEW is designed to enhance the Department's ability to work alongside and help build the capacity of partner defense ministries and provide surge support where needed. The CEW encompasses a pre-identified subset of the Department's emergency essential and volunteer civilian workforce by skill sets and capabilities, who are trained, ready, cleared, and equipped for rapid response and quick assimilation into new environments.

Civilians deployed under the CEW receive general and theatre-specific, urban training, and are eligible for the same health care benefits as deployed military personnel, including medical evacuation and access to hospital services in-theatre. With the support of Congress, the Department has obtained important incentives and benefits to help compensate for the inherent risks of deployment. The Department continues to identify pertinent issues and propose fully integrated solutions to ensure force health protection, surveillance, deployment benefits, and medical care for civilians who have been injured, wounded, or have contracted diseases while de-

ployed in support of contingency operations. We have worked in partnership with the Office of Personnel Management, the Department of State, and the Department of Labor to ensure all similarly-situated Federal civilians receive consistent and equitable benefits commensurate with the risks of deployment.

Civilian Leadership Development

The Department is currently working on the recruitment and development of entry-level leaders in conjunction with Section 1112 of the NDAA for Fiscal Year 2010, which requires the establishment of a DOD Civilian Leadership Program. The Department recognizes the need for an improved model to attract, retain, and deliberately develop civilian leaders to support pipeline readiness and enhance bench strength. In fiscal year 2010, the Department will fully develop the entry-level program to grow emerging leaders. We will launch an initial program pilot in fiscal year 2011 and expand the pilot and implementation in fiscal year 2012. Our communities of initial focus for this effort include acquisition and finance specialists to meet the Department's needs.

Recruitment for Critical Positions and Competencies

The Department has an aggressive approach for identifying mission critical recruitment requirements, to include health, acquisition, linguists and emerging mission-essentials such as IT specialists in cyber warfare. We have a plan in place and a robust forecasting model that indicates those areas where recruitment surges may be needed. Where such surges are indentified, we craft staffing strategies, such as expedited hiring authority and scholarship programs, to meet those needs. Our integrated approach to Strategic Human Capital Management (SHCM) will prove to enhance our ability to analyze demographic trends, forecast requirements, assess gaps, and further define recruitment and hiring strategies.

Increasing Veterans Opportunities

The Department values the experience and commitment of our servicemembers and places special emphasis on supporting transitioning servicemembers, wounded warriors, and veterans in their search for employment. We continue our efforts to actively reach out to our veterans to assist them in their civilian employment search with aggressive outreach programs, transition assistance programs, career and job fairs, and benefits counseling and assistance.

The Department continues this tradition in support of Executive Order 13518, the Veterans Employment Initiative. In January 2010, the Department stood up the DOD Veterans Employment Program Office to promote veterans recruitment, training and development throughout the Department. We are promoting the Veterans Initiative through DOD's Hiring Heroes Program, through which we conduct eight to ten Hiring Heroes Career Fairs throughout the U.S. for wounded, ill and injured servicemembers, transitioning military, veterans, and their families.

In-sourcing

The Department is on track to reduce the level of contracted support service from the current 39 percent of our workforce to the pre-2001 level of 26 percent, and perform those services with full-time government employees. Over the next 5 years, DOD expects to hire up to 33,400 new civil servants to fill positions established as a result of insourcing contracted services. This includes 5,000 acquisition personnel over fiscal year 2010/2011 and 10,000 through fiscal year 2014. On January 4, 2010, the Department submitted to Congress a report on "fiscal year 2010 Insourcing Initiative and Plans." DOD Components estimated they would establish nearly 17,000 new civilian authorizations in fiscal year 2010 to perform currently contracted work.

There are no artificial limits placed on DOD Components' identification of insourcing candidates (i.e., contracted services that would more appropriately be performed by government employees). The Department considers insourcing as a well-reasoned part of Total Force management that:

- Rebalances the workforce and rebuilds organic capabilities.
- Ensures that inherently governmental functions that support the readiness/management needs of the Department are performed by government employees.
- Implements Congressional direction on in-sourcing (NDAA for Fiscal Year 2008).

Contractors remain a vital part of the Department's Total Force. The Department is not "replacing" or "converting" contractors but rather in-sourcing contracted services—contractors remain a vital source of expertise to the Department and are an integral part of our Total Force.

OTHER PERSONNEL CONCERNS

Foreign Language, Regional, and Cultural Capabilities

The Department is continuing its work to ensure our commissioned and noncommissioned officers are prepared for a full range of varying and complex missions that our current and future security environment requires which includes building expertise in foreign languages, regional and cultural skills. The fiscal year 2011 budget focuses on sustaining gains achieved in previous years and continuing to build a solid infrastructure in which to meet future demands. Baseline funding of $793 million in fiscal year 2011 supports redirected language and culture instruction to achieve higher proficiencies for the Total Force in these skills. During the most recent programming cycle, the Department committed an additional $29 million in fiscal year 2011 to establish Language Training Detachments to provide and sustain commanders' needs, support the Afghanistan/Pakistan Hands program, and expand the role of English language training for partner nation personnel. The Department's continuing efforts feature the following significant initiatives and accomplishments.

Military Leadership Diversity Commission

As mandated by NDAA 2009, the Department established the Military Leadership Diversity Commission (MLDC) to conduct an independent review and comprehensive evaluation and assessment of policies that provide opportunities for the promotion and advancement of minority members of the Armed Forces, including minority members who are senior officers. Led by General Lester Lyles (ret.), the Commission consists of 26 appointed members to include retired and active duty officers, enlisted, and civilian representation from all the Service components and the Coast Guard. The Commission will expand to 32 members.

The Commission conducted its first meeting in Washington, DC in September 2009. Several monthly meetings are planned throughout the country during the independent review, culminating with a written report to the President and Congress no later than September 2010. The report shall include the Commission's findings and conclusions, recommendations for improving diversity within the Armed Forces, and other relevant information and proposals considered appropriate.

Sexual Assault Prevention and Response

The Department's position on sexual assault is a simple one: Sexual assault is a crime that is incompatible with service in the U.S. Armed Forces. It undermines core values, degrades military readiness, subverts strategic goodwill, and forever changes the lives of victims and their families. To address this crime, the Department has put numerous broad-based programs in place to achieve our vision of enhancing military readiness by establishing a culture free from sexual violence.

The Department's goal is to prevent sexual assault through institutionalized prevention efforts that influence the knowledge, skills, and behaviors of servicemembers to stop a sexual assault before it occurs. We have developed a comprehensive prevention strategy built around the concept of bystander intervention. Throughout the Department—from the newest recruits to the most senior leaders—servicemembers are getting educated on the role they can play as individuals in preventing this crime.

In conjunction with prevention, we are working to increase awareness so when a crime does occur, it is reported. We want any victims within the military to come forward, first and foremost, to get treatment, and if so desired, provide details of the crime so the perpetrator can be held accountable.

The Department is committed to ensuring the sexual assault prevention and response program works as intended. This "system accountability" is achieved through data collection, analysis, and reporting of case outcomes. In order to improve data collection, analysis, and case management, the Department initiated the development of the Defense Sexual Assault Incident Database (DSAID). In January 2010, a Request for Proposal was issued to identify a vendor for the database, with selection expected by the fall.

The Department has participated in several external reviews in recent years, most recently by the Government Accountability Office (GAO) and the Defense Task Force on Sexual Assault in the Military Services (DTF–SAMS). DTF–SAMS released their report in December 2009 and GAO released their report in February 2010. We are currently reviewing and responding to their recommendations.

Child Custody

The Department believes the States are in the best position to balance the competing interests within the context of their own domestic relations laws. Approximately 30 States have passed legislation that addresses the special circumstances

facing military parents who have custody of children but who are not married to the other parent.

The American Bar Association, National Military Family Association, and the Senate support the Department's position. Although the Senate has continued to reject Federal child custody legislation, it did include language in the NDAA for Fiscal Year 2010 that requires a report to Congress on military child custody issues by March 31, 2010. Senate Armed Services Committee staff indicate this report will form the basis for hearings anticipated in April 2010.

The Department has committed to several efforts to address the unique challenges facing military members who have custody of a child but are not married to the other parent. The Department is working with its State liaisons to encourage those 20 States who have not addressed military child custody issues in their domestic relations laws to do so. The Department is also looking for opportunities to increase participation in and support of the American Bar Association's Military Pro Bono project, which provides free in-court representation to military members for domestic relations cases (and other cases). Finally, the Department is updating and reissuing its Family Care Plan instruction, which can, if used properly, significantly reduce custody problems without the detrimental effects of the proposed Federal law.

Federal Voting

The Department vigorously assists our men and women in uniform, their voting-age dependents and U.S. citizens residing overseas to successfully participate in the 2010 primary and general elections. Initial indications are that the Department's programs are having a significant impact: for the 2008 general election, the active duty military voter registration rate exceeded that of the general population's: 77 percent for the military as compared to 71 percent for the general population.

Unfortunately, while more than 91 percent of absentee ballots were successfully returned by general electorate voters in the 2008 general election, only 67 percent of uniformed services and overseas voter absentee ballots were successfully returned. Unsuccessful return of ballots represents the single greatest point of failure for military and overseas voters, and is largely due to absentee ballots being sent out too close to the election, with insufficient time for the voter to successfully receive, vote and return the ballot by the States' mandated deadlines. In fact, more than 81 percent of all the voting failure suffered by military and overseas voters was because of ballots transmitted to them, but never returned.

The Department is focusing its voting assistance programs to address the overwhelming point of failure by focusing on those programs that will expedite both the delivery and return of ballots from military and overseas voters. First, the Federal Voting Assistance Program is developing an online wizard that will allow military and overseas voters to receive and mark their complete Federal, State, and local ballot online, and then print it out for voter verification, signature of the voter's oath, and postal mail return of the paper ballot. Second, the Military Postal System is also preparing an expedited ballot return system which will return ballots by Express Mail, as well as provide the voter with an online tracking system all the way to delivery to the local election official. The Military Postal System's desired delivery time is no more than 7 days from receipt of the ballot from the voter to delivery to the local election official.

The Department is also taking full advantage of the authority granted it under the Military and Overseas Voter Empowerment (MOVE) Act of 2009 to designate all military installation voting assistance offices as National Voter Registration Act voter registration agencies. This will allow the Department to also collect from and mail in for those voters (who desire the assistance), the FPCAs or other registration forms completed by those voters.

The Department has been working closely with States to identify those changes in State law necessary to achieve the requirements of the MOVE Act, and to provide sufficient opportunity for military and overseas voters to successfully complete the absentee voting process.

CONCLUSION

We face two fundamental, and related, challenges. First, we must continue to attract and retain high quality, motivated individuals for Active and Reserve military service and we must maintain an enthusiastic and skilled civilian workforce. Second, we must weigh sufficiency against the risks of an uncertain future. As we invest in our human capital, we must do so judiciously. While our future challenges may often seem without bounds, our resources are not. We must make hard choices, as a Department and as a Nation, of allocating our resources the best we can to win the war at hand while taking care of our most valuable asset—our men and women in uniform. I look forward to working with this Congress in this effort.

Senator WEBB. Thank you very much, Secretary Stanley.

Secretary Lamont.

STATEMENT OF HON. THOMAS R. LAMONT, ASSISTANT SECRETARY OF THE ARMY FOR MANPOWER AND RESERVE AFFAIRS

Mr. LAMONT. Chairman Webb, Senator Graham, distinguished members of the committee, thank you for the opportunity to appear before you today.

I appear before you on behalf of 1.1 million men and women serving here and abroad in peaceful, as well as hostile, environments. This combat-seasoned force is resilient and professional, yet strained and out of balance. More than 1 million of this Nation's finest citizens have deployed, over the past 8 years, into harm's way. We realize, very well, that there are costs associated with this conflict, both visible and invisible.

Our current programs to relieve stress on the force are critical to maintaining a healthy, balanced, and prepared force. These programs help us defend our country against some of the most persistent and wide-ranging threats in our Nation's history. The success of these programs is due, in large part, to the support Congress has given us since this Army went to war in 2001.

First and foremost, you have enabled us, through appropriate resources, to meet a temporary end-strength increase for our agile Army. As a result, this will, in part, alleviate the stress and strain on the total Army. This is a step in the right direction to get our personnel structure back in balance.

Congress has also given us the means to improve the quality of life for our soldiers and their families. Soldiers remain in the Army based on the established incentive programs, such as an excellent healthcare system, educational opportunities, financial stability with sufficient bonuses, general vacation time, soldier and family services, and frankly, out of a true sense of duty to our country. This Congress has embraced our needs, and for that, we are very grateful.

The Army continues to face challenges, which we will encounter today and well into the future. Armed with lessons learned, it is our intent to stay in front of those challenges, anticipate them, develop strategies and programs to address them, and hopefully, keep them from becoming problems in the future.

Specifically, one of the challenges that we are addressing is the concept of the Operational Reserve. The Army's Reserve component continues to transition from a strategic Reserve to an operational force. The Army will require recurrent, assured, and predictable access to the Reserve component to meet operational requirements. This transformation of the Reserve component into an operational force will provide an opportunity for the Army to provide the most cost-effective total force by investing resources in the most cost-efficient portion of the Army's total force.

Our focus this year centers on restoring the balance, resilience, and sustainment of the force, growth in talent, and our ability to meet the Nation's needs with the highest-quality force available. The Army will continue to work hard to attract and retain the best, but we need your help in taking on this larger problem. The chal-

lenging environments that our soldier's serve in demand that we maintain the standards as set, and we must remain ever-vigilant that our force is manned with both physically and mentally qualified soldiers, as it is today.

As you are well aware, we have some tough challenges ahead of us. I'm confident, however, that with the operational and institutional agility this Army has developed over the past 9 years, we will meet all the challenges that will come our way. It is always easy to commit to a plan of action when we know that Congress supports us. Your leadership and your support have been unwavering.

I appreciate this opportunity to come before the committee, both now and in the future, and I look forward to your questions.

Senator WEBB. Thank you very much, Secretary Lamont.

[The prepared statement of Mr. Lamont follows:]

PREPARED STATEMENT BY HON. THOMAS R. LAMONT

INTRODUCTION

Chairman Webb, Senator Graham, distinguished members of this subcommittee, thank you for the opportunity to appear before you on behalf of America's Army. Our greatest heroes are America's most precious resource—our soldiers. These soldiers and their families, backed by our civilian workforce, represent the very best of America's values and ideals and faithfully shoulder the load that our Nation asks of them. This fighting force of 1.1 million soldiers is continually tested at home and abroad. Repeatedly our Nation's men and women step forward and pledge to serve. They recognize the challenges facing our Nation, answer the call, and become part of something larger than themselves. Their dedicated service and sacrifice are deserving of the very best services, programs, equipment, training, benefits, lifestyle, and leadership available. Our focus this year centers on restoring the balance, resilience, and sustainment of the force, growth in talent, our ability to meet the national challenges, and the importance of maintaining this strength to meet the demands now and for the future. Thank you for your steadfast commitment to ensuring our soldiers, their families, and our civilian workforce by supporting our personnel initiatives to ensure growth, sustainment and well being of our All-Volunteer Force.

STRATEGIC OVERVIEW

America's Army, strained by over 8 years of persistent conflict, remains a resilient force. Our Army, however, is also stretched and out of balance while demand has continued to grow. The Army has added nearly 100,000 more soldiers since 2004. More than one million of our country's finest men and women have deployed to combat, with over 5,000 lives sacrificed in the line of duty. The Army appreciates your recent support in providing the Army with temporary end strength increase of 22,000 to provide some relief to our stressed force. We will complete the initial ramp of 15,000 by the end of fiscal year 2010 and will evaluate the need to complete the remaining amount later this year. Even with this temporary increase, we face many challenges ahead, but must remain vigilant and supportive to the needs of our people. We must continue to address these needs and find a way to get our Army back to a balanced force.

END STRENGTH

To alleviate the stress and strain on the force, the Department of Defense authorized the Army a Temporary End Strength Increase (TESI) of up to 22,000 Active Duty soldiers. Currently the plan is to use 15,000 of the 22,000 with a decision on the remaining 7,000 expected at the end of the second quarter, fiscal year 2010. This temporary increase provides additional, primarily skill level one, soldiers within highly deployed Military Occupational Specialties (MOSs) to combatant commanders. TESI has already increased unit readiness and will provide increased manning and readiness until fiscal year 2013 when the Army returns to its base end strength level of 547,400 in the Active component. While the majority of these additional soldiers are enlisted, the officer ranks will also experience a slight increase.

Another advantage of TESI is a reduction in the use of Stop Loss. The Army expects to achieve a 50 percent reduction in the number of soldiers affected by Stop Loss by June 2010. As of January 2010, 7,861 soldiers were affected by Stop Loss, a 41 percent reduction from the January 2009 baseline of 13,217. By January 2011, the Army will have no soldiers deployed under Stop Loss. However, soldiers in post-deployment reintegration or demobilization may still be in Stop Loss until early spring 2011. TESI and the implementation of voluntary stabilization programs for each component have made significant contributions to the Army's ability to eliminate Stop Loss, while minimizing the potentially detrimental impact to unit readiness.

We continue to make significant progress in our efforts to restore balance. Increasing time between deployments for our soldiers and building greater predictability for soldiers and families continues to be one of our key concerns. Despite the short term impact of the recent surge of troops to Afghanistan, we expect the ratio of Boots on Ground (BOG) time to dwell time at 1:2 for the Active Force and 1:4 for the Reserve component to improve as demand decreases. Eventually, increased dwell time will be achieved by lowering the demand on our forces while increasing the size of the active Army. This will ease the constant pressures on our forces as we move into the rotational cycle of the Army Forces Generation (ARFORGEN) model. The Army Senior Leadership remains committed to meet these deployment goals while eliminating Stop Loss, and without any increase in tour length for our soldiers.

RECRUITING AND RETENTION (OFFICER AND ENLISTED)

Our soldiers are the Army's most important resources, and our ability to meet the challenges of the current and future operational environments depends on our ability to sustain the All-Volunteer Force. The pace and demand of the operational environment over the last several years has caused us to dedicate our focus to reaching a high volume of recruits. The shift in the economy, however, has allowed us to demand even higher quality recruits. Despite the challenges of an Army engaged in two protracted conflicts, the Army exceeded its enlisted recruiting and retention missions for fiscal year 2009 and is confident it will meet its goals for fiscal year 2010. The Army met 104 percent of its recruiting goals for fiscal year 2009, while at the same time, meeting its quality benchmarks for new recruits. Successfully meeting these critical benchmarks moves us closer to restoring balance. As we dedicate ourselves to the fiscal year 2010 recruiting mission, we will continue to monitor trends and make adjustments as required.

In fiscal year 2009, with congressional support, the total Army spent $4.9 billion on recruiting and retention. In fiscal year 2010, these programs received $4.4 billion due to a more favorable recruiting and retention environment. Our $4.6 billion, fiscal year 2011 request is based on the need to continue funding for contracts written between fiscal year 2006 and fiscal year 2009 and to ensure the success of the total Army's recruiting and retention missions. The amount budgeted for contractual payments is anticipated to decrease in fiscal year 2012 and subsequent years.

Because of this funding, the Army is now a higher quality All-Volunteer Force. For example, the Army's percentage of "high quality" enlisted soldiers with a high school diploma have increased by 2.1 percent since the end of fiscal year 2009. Additionally, recruits scoring in the upper range (50–99 percent) on the Armed Forces Qualification Test (AFQT) increased 2.0 percent; and recruits who scored poorly (30 percent and below) on the AFQT decreased 0.4 percent. The Army was able to decrease the amount of ineligibility waivers previously provided for enlistments and appointments. Also, the Army was able to repair mid-grade officer shortages in the Regular Army, which provided the opportunity to aggressively target mid-grade shortages in the Reserve components.

Overall, the Army's programs are effective in recruiting and retaining both officers and enlisted soldiers with critical skills. For enlisted soldiers, the Enlistment Bonus (EB), the Selective Reenlistment Bonus (SRB), Critical Skills Retention Bonus (CSRB), Army College Fund (ACF), and the Student Loan Repayment Program (SLRP) remain as proven and effective tools for filling critical skills. The ACF and SLRP are especially effective in attracting quality recruits who have some college experience or plan to attend college after the Army.

To assist in recruiting critical skills, the Army launched the "Military Accessions Vital to the National Interest" (MAVNI) Pilot Program which the Secretary of Defense authorized on November 25, 2008 and Army launched on February 23, 2009. The purpose was to attract high quality individuals with exceptional skills in health care professions or native speaking skills in at least 1 of 35 critical foreign languages. MAVNI recruits are non-U.S. citizens who have been legally present in the

United States for 2 or more years and speak a critically needed foreign language or are U.S. licensed health care professionals who meet or exceed all requirements for military service but for U.S. citizenship. They do not have permanent residency (i.e. Green Cards). We recruited 788 MAVNI with language skills and 143 health care professionals during the 12 months since the program launched. Without spending a single dollar on marketing or advertising, Army received over 12,000 leads for the MAVNI program and positive media coverage. Of the foreign language speakers recruited, 66 percent have a bachelor's degree or higher, and 30 percent have at least a master's degree. Half the MAVNI recruits speak and comprehend the foreign language for which they were recruited at the 3/3 level or higher which is akin to a college graduate. Their loss from the Delayed Entry Program (DEP) is one-third that of non-MAVNI recruits and their attrition rate once in the Service is virtually nil. We reached the cap for this program established by the Secretary of Defense so until the program is extended we are unable to recruit the many applicants waiting to be processed.

Through a separate program, the Army has recruited more than 1,600 soldiers as military interpreters and translators under the MOS O9L Program. This MOS enlists native speakers of Arabic, Pashtu, Dari, Farsi, and Kurdish into all components of the Army to serve as interpreters in uniform. Combatant Commanders have found them to be force multipliers as they bring high levels of proficiency in these languages as well as firsthand cultural knowledge.

In fiscal year 2009, all components exceeded the annual retention goal. The Active Army achieved 124 percent of the annual goal, the Army Reserve achieved 105 percent, of the annual goal, and the Army National Guard achieved 106 percent of the annual goal. During fiscal year 2009, retention bonuses were carefully monitored and adjusted to achieve the maximum result, ensuring the Army met its retention goals while remaining fiscally responsible. The economic environment allowed the Army to reduce incentive levels as well as the number of occupations offering bonuses, while focusing on our most critical skills. In addition, use of the Army's Critical Skills Retention Bonus greatly assisted in retaining very experienced senior enlisted soldiers with invaluable leadership and combat experience. Retention of combat experienced veterans remains critical to current and future readiness. In fact, 39 percent of all reenlistments occurred while soldiers were deployed. The Active Army also continued to support and encourage Active Duty soldiers who elected not to reenlist to transfer to the Reserve component upon completion of their Active Duty tour.

The Army retention mission is also on track to meet the goals set for fiscal year 2010. The Active Army has reenlisted 41,262 soldiers for 68 percent of the annual goal, the Army Reserve has reenlisted 4,291 for 42 percent of the annual goal, and the Army National Guard has reenlisted 10,771 soldiers for 35 percent of the annual goal. In all components, the Army expects to finish successfully in every category.

The Post-September 11 GI Bill, which took effect August 1, 2009, provides a significantly enhanced level of educational benefits for Active Duty servicemembers. Additionally, it serves as a valuable incentive to attract and retain quality soldiers of all ranks. The Army expects the Post-September 11 GI Bill to serve as an inducement for college oriented teens to join the Army, while transferability should increase retention within our mid-career (6–10 years of service), category of soldiers. Although it is too early to fully determine the impact of the Post-September 11 GI Bill on both recruiting and retention, initial signs are positive. In particular, we've kept a watchful eye on the retention of our initial term soldiers who some feared might separate under expiration of their term of service in order to use their educational benefits. However, the Army exceeded its retention goals for first-term soldiers in fiscal year 2009 and continues to do so in fiscal year 2010.

Shortages remain within our officer corps due to overall structural growth of the Army. To correct this, the Army initiated the Captains' Retention Incentive Menu in September 2007. The Army spent $443.6 million from fiscal year 2007 to present on this incentive program. The goal of the program was to recruit, retain, and manage critical skills to increase the retention of lieutenants and captains for 3 years. The Captains' Retention Incentives Menu program included a cash option based on the officer's branch, resident graduate school attendance for up to 18 months, or attendance at the Defense Language Institute for 1 year. As a result, the Army's retention rate for Captains increased in fiscal year 2008 to 89.1 percent and again in fiscal year 2009 to 89.9 percent over the 10-year average of 88 percent. The program guaranteed retention through fiscal year 2011 for over 16,000 of the 23,000 captains who were eligible to participate. The timing of our Captains' Retention Incentives Menu program, concurrent with the dramatic downturn of the economy and job market, helped support our retention goals. The cash and Defense Language Institute options ended in November 2008. The remaining retention incentive, the Expanded

Graduate School Program, has been funded at $7.5 million in fiscal year 2010. Overall, the single most effective retention incentive for junior officers was the cash bonus. Over 94 percent of the more than 16,000 officers who took incentives in fiscal year 2008 elected to take the cash bonus. Department of Defense survey data analysis showed that most officers who intended to separate or were undecided, took the incentive and committed to further obligated Army service.

The U.S. Military Academy (USMA) and ROTC both continue to offer pre-commissioning incentives. These consist of offering new officers their Post or Branch of Choice or Graduate Schooling. In fiscal year 2006 through fiscal year 2009 there were approximately 6,000 participants. These incentives have increased longevity by 40 percent for newly-commissioned, high-performing USMA and ROTC officers.

In spite of a dramatically changed recruiting climate, based on the economy, our message to our soldiers and their families must resound with assurance that they will be cared for in a manner commensurate with their service and sacrifice. Incentives, bonuses, and pay are only part of the equation in creating balance in our soldiers and families lives. In the event of a life changing injury or the loss of life, our soldiers are assured that their families will receive financial and programmatic support for their loss and sacrifice. This support includes full-earned benefits and disability compensation. The Army is working closely and aggressively with soldiers and their families to streamline access to assistance from other Federal agencies, such as the Social Security Administration, Department of Labor, and Department of Veterans Affairs.

In direct support of President Obama's Veteran's Day Executive Order on employment of veterans in the Federal Government, we have begun a Veterans Employment Transition Initiative to streamline, synchronize, and integrate existing policies, programs, and initiatives to assist soldiers and their families as they transition out of the military. The intent is to ensure that they have timely visibility of every opportunity available to them as they transition to civilian life, whether as Federal workers or as contributing members of the private sector.

The Army carefully manages its resources, reviewing and adjusting incentives at least quarterly to ensure we attract and retain quality individuals in needed occupations, while remaining fiscally responsible to avoid excessive payments. The economic environment has allowed us to reduce incentive amounts and the number of occupations offered bonuses or education incentives. Enlistment Bonuses are at the lowest levels since the 1990s drawdown. However, we must retain the flexibility to apply incentives as necessary to retain soldiers with critical or specialized skills. The continued authorities and funding of these programs by Congress remain critical to the sustainment of the Army.

INDIVIDUAL READY RESERVE MOBILIZATION

The Individual Ready Reserve (IRR) is a category of the Ready Reserve, and is composed of those members of the Ready Reserve who are not serving in Selected Reserve units or assignments, or in the Inactive National Guard. The availability of IRR soldiers is critical to the Army's mission of providing properly trained and equipped units of sufficient strength to meet contingency operation or mobilization requirements. As of February 28, 2010, there are 59,413 soldiers in the IRR. Since September 11, 2001, a total of 29,997 soldiers received mobilization orders and a total of 12,018 soldiers deployed to the CENTCOM Area of Responsibility. The Army applies specific screening criteria and a tiered systemic approach regarding involuntary mobilization of the IRR. These actions align with the January 2007 DOD policy on Utilization of the Total Force and take into account a soldier's dwell time, Military Service Obligation (MSO), and previous deployments in support of OCONUS Contingency Operations (OCO).

An effective IRR program is based on several factors, including the soldiers' understanding of their obligations, access to benefits and support, and time to adjust personal affairs prior to mobilizations. In an ongoing effort to validate the readiness of the IRR, the Army continues to implement the IRR Muster program. Approximately 5 months after entering the IRR program, soldiers will be ordered to muster duty. Afterward, soldiers are required to muster each year they remain in the IRR. Through the muster program, the Army established a partnership with the Department of Veterans Affairs to use VA medical centers as muster sites for the added opportunity of connecting soldiers to VA services. During fiscal year 2009, the Army spent approximately $3.6 million to muster 13,500 soldiers, contributing to 3,300 soldiers returning to Army Reserve formations. The Army plans to muster 14,000 IRR soldiers at an estimated cost of $4.2 million in fiscal year 2010 and expect to impact 3,500 soldiers returning to Army Reserve Formations.

OPERATIONAL RESERVE

As the Army continues to institutionalize the Operational Reserve, our first and greatest challenge is to effectively and efficiently deliver ready and trained soldiers. Transforming the Reserve components (RC) into an operational force in the near-term (fiscal year 2012–2014) will provide a means for RC forces to provide proportional support to the Army's Force Supply model of a Corps Headquarters, 5 division headquarters (4 Active component (AC), 1 RC), 20 Brigade Combat Teams (15 AC, 5 RC), and 90,000 enablers (41,000 AC, 49,000 RC) to support combatant command requirements through 2014 time period. It is important to note that programming decisions are required in the near term to ensure RC forces are sufficiently ready to support the Army's force generation plans. Without sufficient resources in unit management, collective training and medical/dental readiness, the RC will not be ready to support the planned 1/5/20/90 force supply construct.

The Army will require recurrent, assured and predictable access to the RC to meet operational requirements as requirements increase for Army forces to conduct overseas engagement activities over the remaining years of the program period (fiscal year 2015–2017). During this period, RC forces will be mobilized and employed in full spectrum operations at rates proportional to AC forces within force utilization goals of 1:3 (AC) and 1:5 (RC). Continued investments in RC unit management, collective training and medical/dental readiness are required to achieve required readiness levels in accordance with these ARFORGEN goals. Moreover, these investments are required within the base funding to ensure the RC achieves a level of institutional transformation that cannot be achieved through the year-by-year allocation of resources from overseas contingency operations funds.

Finally, transforming the RC into an operational force provides an opportunity for the Army to provide the most cost-effective Total Force and mitigate any decline in resources by investing now in the most cost-efficient portion of the Army's Total Force. The Army National Guard (ARNG) and the U.S. Army Reserve account for 51 percent of the Army's military end strength for 16 percent of the base budget. When comparing the cost per soldier, the relative value of the RC is even greater. A 2008 comparison of AC/RC manpower by HQDA G–8 identified the approximate total costs per Regular Army soldier in manpower, training, equipping, organization costs and operating costs as $135,000, compared to $36,000 for ARNG soldiers and $35,000 for Army Reserve soldiers. Given the relative value is a reasoned investment for the Army's Total Force, this will make targeted investments improve RC readiness. Moreover, such investments in the near-term (POM 2012–2017) will position the Army to better manage the risks of declining resources for the Army, should such a reduction be required in the next 2 to 5 years. However, delays in these investment decisions reduce the Army's flexibility to consider strategic alternatives to a larger Active Force structure model in the long-term.

QUALITY OF LIFE

Recognizing that the strength of our Army comes from the strength of our Army families, the Secretary of the Army and Chief of Staff of the Army initiated the Army Family Covenant in October 2007 and reaffirmed this commitment by resigning the Covenant this past October. The Covenant institutionalizes the Army's commitment to provide soldiers and families a quality of life commensurate with the quality of service they provide our Nation. The Army Family Covenant incorporates programs designed to build strength and resilience in our families. These improved services and programs help to mitigate the stress from mutiple deployments and frequent military moves.

The Covenant focuses on the following: standardizing soldier and family programs; increasing access and quality of health care; improving soldier and family housing; ensuring excellence in our schools, youth and child care services; expanding the education and employment opportunities for family members; improving soldier quality of life in recreation, travel, and the Better Opportunities for Single Soldiers program; and improving relationships with local communities and marketplaces.

From fiscal year 2007 to fiscal year 2010, the Army more than doubled its investment in family programs. To ensure they remain enduring, these increases have been included in the fiscal year 2010 base budget. Furthermore, this funding will increase from $1.7 billion in fiscal year 2010 to $1.9 billion in fiscal year 2015.

We must never forget that we are one Army made up of Active Duty, National Guard, and Army Reserve components and must often reach "beyond the gates of the garrison" to ensure we support our geographically dispersed families. We are thankful for all the citizens and community based organizations that have stepped up to support our soldiers and their families, regardless of their location.

CIVILIAN PERSONNEL AND WORKFORCE DEVELOPMENT

Department of the Army civilian employees provide vital support to soldiers and families in this era of persistent conflict. They share responsibility for mission accomplishment by delivering combat support and combat service support—at home and abroad. More than ever, Army civilians are an absolutely essential component of readiness and a key element in restoring balance. Today, the Army Civilian Corps has nearly 300,000 employees with 3,832 currently serving in harm's way in the U.S. Central Command area of operations.

Since September 11, 2001, we increased the civilian workforce from 222,000 to 263,169 (plus 24,357 Civil Works) due to overseas contingency operations, Defense Health Program increases, Family and Soldier Support initiatives, acquisition workforce growth, in-sourcing contracts associated with inherently governmental functions, military technician increases, and military-to-civilian conversions. Future Civilian employee growth is critical to supporting current plans to rebalance the Army to 73 brigade combat teams and associated combat support/combat service support units by fiscal year 2011.

In fiscal year 2009, the Army saved significant resources by in-souring more than 900 core governmental functions to Army civilians. We plan to in-source 7,162 positions in fiscal year 2010, and are programmed to in-source 11,084 positions during fiscal year 2011–2015, of which 3,988 are acquisition positions. These positions were identified in the Army's on-going contractor inventory review process.

Current workforce development programs, such as the Army Intern Program; the Army Fellows Program; the Presidential Management Fellows Program; the Senior Fellows Program, and the Army Senior Leader Development Program, to name a few, are helping the Army to "build a bench", of future Army leaders. In an era of persistent conflict, however, the operational and budgetary realities of fighting terrorism on multiple fronts have simultaneously increased the requirements for development and decreased the available funding. Simply put, the Army's resources to develop our Civilians have not kept pace with the need. While current training and development programs provide highly competitive growth opportunities, better incentives for self-development and professional development are needed to ensure the Civilian cohort is as prepared to meet future missions as their military counterparts. The Department of the Army also has several initiatives to focus and invigorate development of the civilian workforce, which complement the strategic workforce plan requirements outlined in the National Defense Authorization Act for Fiscal Year 2010.

The Army is developing a Civilian Human Capital Strategy to better focus on the full life-cycle needs of Civilian Workforce, from recruitment to replacement. Because of the increasing complexity of today's operational environment, the Army must invest more resources into recruiting, sustaining, and developing its Civilian workforce. The Initial emphasis of our Civilian Human Capital Strategy will be on identification of the competencies needed by employees in mission critical occupations, assessment of the current competency levels of the workforce, and strategies for closing the gaps. This focus will enable the Army to develop competency-based civilian recruiting and hiring strategies as well. This approach will help ease the transition from one generation to the next as we implement Base Realignment and Closure and begin to experience the next wave of baby boomer retirements.

ARMY EQUAL OPPORTUNITY POLICY

The Army leads the Nation in Equal Opportunity (EO) policy and practice. Commanders at all levels are responsible for sustaining positive EO climates within their organizations to enhance Army Readiness. Remaining applicable and relevant within the ever-changing environment in which we operate, the Army is transforming EO policy/program by integrating and institutionalizing equal opportunity and diversity goals, objectives and training practices. This effort will strengthen the foundation of the Army's Human Capital Strategy. Since fiscal year 2008, the Army has invested $3.4 million and expects to invest another $0.9 million in fiscal year 2010 for EO personnel and services support, database and survey systems, outreach support, and training contracts.

SEXUAL ASSAULT AND HARASSMENT PREVENTION

The Army's goal is to eliminate sexual assault and harassment by creating a climate that respects the dignity of every member of the esteemed band of brothers and sisters. The Secretary of the Army (SECARMY) and the Chief of Staff (CSA) remain personally involved in reinforcing to all soldiers and leaders the importance of preventing sexual assault and harassment. Under their guidance and leadership,

the Army launched a comprehensive sexual assault prevention strategy that requires leaders to establish a positive command climate where sexual assault is clearly not acceptable. The strategy further encourages soldiers to execute peer-to-peer intervention personally, and to not tolerate behavior that could lead to sexual assault.

The cornerstone of the Army's prevention strategy is the "I. A.M. Strong" campaign, where the letters I, A, and M stand for Intervene—Act—Motivate. The "I. A.M. Strong" campaign features soldiers as influential role models and provides peer-to-peer messages outlining the Army's intent for all its members to personally take action in the effort to protect our communities. Leaders have embraced "I. A.M. Strong" initiatives and are motivating soldiers to engage proactively and prevent sexual assault.

The Army's sexual assault prevention strategy consists of four integrated phases and extends through calendar year 2014 as we work to be the Nation's leader in sexual harassment and sexual assault prevention.

The SECARMY introduced the "I. A.M. Strong" campaign at the Sexual Assault Prevention Summit in September 2008. The Summit served as a platform to launch Phase I (Committed Army Leadership) by providing training on best practices and allowing commands the opportunity to develop prevention plans to support the Army strategy.

Phase II of the prevention strategy (Army-wide Conviction) includes educating soldiers to understand their moral responsibility to intervene and stop sexual assault and harassment. Phase II began at the 2009 Sexual Assault Prevention Summit (6–10 Apr 09) during which the SECARMY, CSA, and Sergeant Major of the Army addressed attendees, which included over 100 sergeants major and 50 general officers.

Phase III culminates the dedicated effort of leaders and soldiers under Phase I and Phase II by "Achieving Cultural Change" that truly reflects Army values and fosters an environment free from sexual harassment and sexual assault.

The final phase is "Sustainment, Refinement, and Sharing," during which the prevention program continues to grow while motivating national partners to support our efforts to change generally accepted negative social behaviors; thus eliminating the crime of sexual assault.

With the implementation of the strategy, a likely near-term consequence will be an increase in the number of reported cases as soldiers' and other victims' propensity to report increases. This increase in cases will require more sexual assault responder support, specifically: victim advocates, healthcare personnel, investigators, and prosecutors.

SUICIDE PREVENTION PROGRAM

The loss of any soldier is a tragedy, particularly when it could have been prevented. There were 160 suicides by active-duty soldiers during 2009, continuing the 5-year trend of increased suicides within the Army. As a result, we have instituted a multi-level, holistic approach to health promotion, risk reduction and suicide prevention. Although the total number and rate of suicides in the Army remains of deep concern, we should remember each of these suicides represents an individual and a family that has suffered an irreparable loss—-and, as a result, our suicide prevention efforts are focused on directly assisting soldiers, their families, and our Army civilians.

On 16 April 2009, the Vice Chief of Staff of the Army (VCSA) signed the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention, a comprehensive plan setting in motion unprecedented changes in Army doctrine, policy, and resource allocation, as well as immediate guidance to commanders, in order to address the problem of suicides in the overall context of risk reduction and health promotion.

The Army Suicide Prevention Task Force has addressed more than 240 different tasks related to suicide prevention doctrine, organization, training, materiel, leadership, personnel, and facilities. Over 90 percent of these tasks have been implemented.

To build on the Army Campaign Plan's accomplishments during calendar year 2009, the Army Suicide Prevention Task Force is leading an effort to review and assess the effectiveness of Army Health Promotion, Risk Reduction and Suicide Prevention programs at all levels. Army has partnered with National Institute of Mental Health to conduct a long-term study (Army Study to Assess Risk and Resilience on Servicemembers) of risk and protective factors to inform health promotion and suicide prevention efforts. The VCSA Task Force is also reviewing all Army programs at all levels that are related to health promotion, risk reduction, suicide prevention, or were implemented to address soldier, family, or DA civilian stressors to

ensure that the programs provide appropriate levels of support and address current problems, risk factors, and are relevant to today's soldiers' families' and DA civilians needs.

COMPREHENSIVE SOLDIER FITNESS PROGRAM

The Army's Comprehensive Soldier Fitness (CSF) program is a structured, long-term assessment and development program designed to build the resilience and enhance the performance of the Army's soldiers, families, and civilian personnel. The CSF program uses individual assessments, tailored virtual training, classroom training and embedded resilience experts to provide soldiers with the critical skills needed to take care of themselves, their families and their teammates in this era of persistent conflict. By developing the five dimensions of strength—physical, emotional, social, spiritual, and family—CSF equips soldiers with the skills to become more self-aware, fit, balanced, confident, and competent, and ultimately better prepared to face the physical and psychological challenges of sustained operations.

ARMY SUBSTANCE ABUSE PROGRAM

The Nation's persistent conflict has created symptoms of stress for our soldiers, including an increase in alcohol and drug abuse. This commander's program uses prevention, education, deterrence, detection, and rehabilitation, to reduce and eliminate alcohol and drug abuse. It is based on the expectations of readiness and personal responsibility.

A team recently returned from deployment to U.S. Army Forces, U.S. Central Command. To support our commanders, clear and effective procedures for random drug testing in theater are under development, such as the implementation of online tools to train unit prevention leaders and to quickly inform commanders of test results. Another area under development is the review of portable prevention education packages for deployed soldiers, soldiers at home, and soldiers in the RC. Additionally, the Army is conducting a pilot program that provides confidential education and treatment to soldiers who self-refer to the Army substance abuse program for assistance with alcohol issues. In addition to the pilot program, we are conducting a broader, more detailed study to determine the exact nature and extent of any stigma in the Army associated with substance abuse treatment. This study will run concurrently with the pilot program. The pilot program and detailed study were concluded on March 1, 2010 and we expect to report to Congress in April 2010. We want to ensure that all soldiers who may need assistance can get assistance without the barrier of stigma.

CONGRESSIONAL ASSISTANCE

Recruiting, retention, and providing for the well-being of the best Army in the world requires a significant commitment by the American people. The Army is grateful for the continued support of Congress for competitive military benefits and compensation, along with incentives and bonuses for soldiers and their families and for the civilian workforce. These are critical in helping the Army be the employer of choice.

CONCLUSION

We must maintain an appropriate level of investment to ensure a robust and high-quality force. The well-being and balance of our force are absolutely dependent upon your tremendous support. The Army is growing and transforming in a period of persistent conflict. We will do so with men and women of the highest caliber whose willingness to serve, is a credit to this great Nation.

Senator WEBB. Secretary Garcia.

STATEMENT OF HON. JUAN M. GARCIA III, ASSISTANT SECRETARY OF THE NAVY FOR MANPOWER AND RESERVE AFFAIRS

Mr. GARCIA. Chairman Webb, Senator Graham, distinguished members of the committee, it's my pleasure to be here today to testify on behalf of our Navy and Marine Corps personnel.

For the past 5 months as an Assistant Secretary of the Navy, I've had the honor of representing and advocating for the nearly 650,000 sailors and marines, both Active Duty and Reserve, and

180,000 civilian employees who, together, are globally engaged across a spectrum of operations ranging from major combat to humanitarian assistance.

Across the Department of the Navy, we are asking our sailors, marines, and civilians to take on extraordinary tasks ranging from combat operations in Afghanistan to unplanned disaster relief in Haiti. The men and women who comprise the Navy and Marine Corps have invariably risen to meet the challenge presented.

Our leadership team—Secretary Mabus, Under Secretary Work, Admiral Roughead, and General Conway—have set a course for the Department of the Navy that drives our human capital strategy, focusing on our greatest asset: our people. In order to achieve our best, we promote an environment in which every person can excel, where each person is treated with dignity and respect, and where all are recognized for the contributions they make.

Both the Navy and Marine Corps are experiencing historic success in recruiting and retention of Active Duty servicemembers. I assess that both Services will continue meeting their recruiting and end-strength goals for the foreseeable future. It's a tribute to both the dedication of our military personnel communities and to the patriotism of our Nation's young men and women that we are able to maintain an All-Volunteer Force of unprecedented quality through more than 8 years of active combat operations.

Recruiting and retention in certain fields—healthcare, Special Forces, nuclear power—continue to pose challenges and will require the use of special pays and bonuses to ensure adequate numbers of qualified personnel are available in those critical specialties.

Despite its high operational tempo, the Marine Corps was able to grow to 202,000 Active Duty end strength 2 years ahead of schedule. This focus on Active Duty recruiting and retention resulted in a slight shortfall of the Marine Reserve component end strength for 2009. For this same reason, 2010 Reserve strength may also be slightly below target.

The health of the Reserve components is of particular concern because of our dependence on them to meet our global obligations. Since September 11, more than 142,000 mobilization requirements have been met by members of the Navy and Marine Corps Reserve.

A high tempo, high stress environment appears to be the new normal for the Department of the Navy. One of the lessons to be learned from recent years is that our people step up and perform superbly in times of greatest need. But, the reality of continuing operations in Afghanistan, combined with our other deployment commitments, undeniably places great stress on our forces. The Department of the Navy is employing every measure available to help identify consequent risks, and we continue to assess and reevaluate these programs daily.

As Secretary Gates has said, apart from the war itself, we have no higher priority than taking care of the wounded, ill, and injured. Through the Marine Corps Wounded Warrior Regiment and the Navy Safe Harbor Program, the sea Services strive to provide the best possible support for our personnel struck down, to include reintegration into society and a new emphasis on post-service employment.

I'd like to thank the committee members for their continuous commitment to the support of our expeditionary fighting men and women, especially to those who have returned from the front line of battle with broken bodies but unbroken spirits, our wounded warriors.

I look forward to your questions.

[The prepared statement of Mr. Garcia follows:]

PREPARED STATEMENT BY HON. JUAN M. GARCIA

Chairman Webb, Senator Graham, and distinguished members of the subcommittee, it is my pleasure to be here today to testify on behalf of our Navy and Marine Corps personnel. For the past 5 months as an Assistant Secretary of the Navy, I have had the honor of representing and advocating for the nearly 650,000 sailors and marines, both Active Duty and Reserve, and 180,000 civilian employees who, together, are globally engaged across a spectrum of operations ranging from major combat to humanitarian assistance. Across the Department of the Navy, we are asking our sailors, marines, and civilians to take on extraordinary tasks ranging from combat operations in Afghanistan to unplanned disaster relief in Haiti. The men and women who comprise the Navy and Marine Corps have invariably risen to meet the challenges presented.

Our leadership team, Secretary Mabus, Under Secretary Work, Admiral Roughead, and General Conway, have set a course for the Department of the Navy that drives our Human Capital Strategy—focusing on our greatest asset—our people. In order to achieve our best, we promote an environment in which every person can excel, where each person is treated with dignity and respect, and where all are recognized for the contributions they make.

Let me address some particular areas of interest and concern related to the Department's manpower and personnel.

In terms of military personnel, both the Navy and Marine Corps are experiencing historic success in recruiting and retention of active duty servicemembers. I assess that both Services will continue meeting their recruiting and end-strength goals for the foreseeable future. It is a tribute to both the dedication of our military personnel communities and to the patriotism of our Nation's young men and women that we are able to maintain an All-Volunteer Force, of unprecedented quality, through more than 8 years of active combat operations.

Recruiting and retention in certain fields—including health care, Special Forces, and nuclear power—continue to pose challenges, and we still require the use of special pays and bonuses to ensure adequate numbers of qualified personnel are available in critical specialties such as these.

The Navy expects to continue to need an additional 4,400 end-strength for Overseas Contingency Operations. In considering that requirement, it is important to remember that the number of active duty sailors has been in gradual decline since the Vietnam war. As recently as 1993 the Navy had half-again as many sailors on active duty, and available for assignments, as it does today.

Despite its high operational tempo, the Marine Corps was able to grow to 202,000 active duty end strength 2 years ahead of schedule. This focus on active duty recruiting and retention resulted in a slight shortfall of the Marine Reserve component end strength for 2009. For this same reason, 2010 Reserve strength may also be slightly below target. The health of the Reserve components is of particular concern because of our dependence on them to meet our global obligations. Since September 11, more than 142,000 mobilization requirements have been met by members of the Navy and Marine Corps Reserve.

Another topic of particular interest is the introduction of female personnel on submarines. On February 19, 2010, the Secretary of Defense notified Congress of our intent to change the policy prohibiting the service of women in submarines. After the requisite notification period has expired, it is the Navy's intent to have the first cadre of female officers commence training on nuclear prototypes and begin a pipeline that will ultimately lead them to qualification as Naval Submariners, removing one of the last gender barriers in the U.S. Navy, and helping to insulate us from the anticipated surge in hiring by the civilian nuclear power industry in the decades to come. Because of the critical mission and demanding environment of the submarine force, we envision a gradual, and measured approach to this integration. Our initial efforts will focus on officers only and will concentrate on our large boats (SSGNs and SSBNs), where the existing infrastructure will accommodate these changes without material alteration. As a measure of extra caution, the Navy will

not reduce the number of male officers trained and qualified for submarine duty until we have experience with successfully placing female officers in those roles.

Some might argue that such initiatives should not be undertaken during a period of high operating tempo and stress on the force. But a high tempo, high stress environment appears to be the new normal for the Department of the Navy. One of the lessons to be learned from recent years is that our people step up and perform superbly in times of greatest need. Yet the reality of continuing operations in Afghanistan combined with our other deployment commitments undeniably places great stress on our forces.

Stress on the force has many causes and manifests in many forms. The Secretary of Defense asked former Secretary West and Retired Admiral Clark to lead an independent review of the tragic events at Fort Hood. Their review produced 86 recommendations for changes in, or reviews of, procedures and policies. Currently, the Department of the Navy is working with the other Services and the Office of the Secretary of Defense to evaluate those recommendations and implement those that seem appropriate. Well before the shootings at Fort Hood, the Department of the Navy had in place its Caregiver Occupational Stress Control Program, which is designed to enhance the resilience of caregivers, including mental health professionals, chaplains, corpsmen, and other counselors and advisers. Additionally, for reservists and individual augmentees returning from mobilization, the Department created the Returning Warrior Workshops (which are a part of the Yellow Ribbon Reintegration Program) to help with the adjustment to life back home.

Stress on our personnel has likely played a role in the heartbreaking increase in suicide rates among the active duty in recent years. The Department of the Navy has employed every measure available to help identify those at risk, encourage them to seek help, and prevent these tragedies. We continue to assess and re-evaluate our programs daily, and will not stop, believing that even a single suicide by those wearing our Nation's cloth is one too many.

As Secretary Gates has said, apart from the war itself, we have no higher priority than taking care of the wounded, ill, and injured. Through the Marine Corps's Wounded Warrior Regiment and the Navy's Safe Harbor Program, the sea services strive to provide the best possible support for our personnel struck down, to include reintegration into society, and a new emphasis on post-Service employment.

Thanks to advances in military medicine, many of our most seriously wounded, who even a few years of ago would have died of injuries, are recovering and, in many cases, able to resume their military jobs. Others will require special accommodations and support for the rest of their lives. We are working in close partnership with the Department of Veterans' Affairs to ensure the best and most dignified treatment possible for those sailors and marines.

Members of our civilian workforce continue their crucial contributions to our mission while coping with two significant transitions of their own.

Consistent with your direction in the National Defense Authorization Act for Fiscal Year 2010, we are currently in the process of moving all of our civilian employees out of the National Security Personnel System. Those who are returning to the General Schedule will be converted no later than the end of the fiscal year. Those who will move to one of the various alternative pay systems will be transitioned during 2011.

While this is occurring, the DOD is also engaged in a significant in-sourcing initiative, expected to add more than 33,000 civilian positions over the next 5 years to perform currently contracted services—the Department of Navy expects to establish 10,000 new civilian positions as part of this effort. This initiative will rebalance our workforce; rebuild organic capabilities; reduce operational risk by ensuring that inherently governmental and functions that support the readiness/management needs of the Department are performed by government employees; and that services are delivered in the most cost effective manner. Nearly a third of these new positions are expected to be part of the crucial acquisition workforce. These insourcing initiatives are consistent with DOD's High Priority Performance Goals in the President's fiscal year 2011 Budget's Analytic Perspectives volume.

Finally, I would like to thank the committee members for their continuous commitment to the support of our expeditionary fighting men and women, especially to those who have returned from the front line of battle with broken bodies but unbroken spirits—Our Wounded Warriors.

I look forward to your questions.

Senator WEBB. Thank you, Secretary Garcia.

Secretary Ginsberg.

STATEMENT OF HON. DANIEL B. GINSBERG, ASSISTANT SECRETARY OF THE AIR FORCE FOR MANPOWER AND RESERVE AFFAIRS

Mr. GINSBERG. Thank you, Chairman Webb, Ranking Member Graham, and members of the subcommittee.

It is my honor to testify before you today about our airmen. They are doing incredible work every day to serve our Nation and accomplish the missions that our Nation has asked of them. Our Air Force has been engaged in continuous operations for over 19 years. We have never been more engaged than today. We have over 38,000 airmen deployed around the world, and thousands more airmen providing direct support to the warfighter through our space systems, global mobility operations, and remotely-piloted operations, to name just a few of the critical capabilities that we provide.

Overall, our force structure is healthy. We are working internal challenges to ensure we meet the increased demand for new and emerging missions, such as our remotely piloted aircraft, cyberoperations, and irregular warfare. We are meeting our total-force recruiting goals, except for a few hard-to-fill specialties in our officer medical specialties.

To address this, we are aggressively pursuing a three-pronged approach to, first, grow our own through expanded scholarship opportunities and commissioning opportunities for our enlisted force; second, increase compensation through special and incentive pays; and third, to improve quality of life.

Although the Air National Guard will meet end strength, we are having challenges recruiting enough officers. That may be related to our high retention rates we are currently experiencing with our Active component. Historically, the Guard and Reserve rely heavily on recruiting prior-service trained airmen who separate from the Active side.

An efficient and smooth transfer between each component and Civil Service allows the Air Force to access and retain important skill sets and balance our mission needs over time. To make this process work even better, we are focusing on our Continuum of Service Program. Through Continuum of Service, we are reviewing all Air Force, Office of the Secretary of Defense (OSD), and statutory requirements to identify areas where we can streamline the transfer between components. When statutory issues are identified, we will work with OSD and our counterparts in other Services to identify and support legislative proposals to you.

Taking care of our airmen and their families is a top Air Force priority. In the spring of 2009, the Air Force renewed its long-standing commitment to our airmen and families by designating July 2009 through July 2010 as "The Year of the Air Force Family." The observance serves two primary purposes. First, we examined our family support services and policies across the Air Force in order to expand or refine them as required to meet the emerging needs and expectations of our airmen, their families, and the larger Air Force family.

Second, we set aside specific time to recognize the sacrifices and contributions of the members of our entire Air Force family—our Active, Guard, Reserve, civilian, spouses, and family members. We

have focused our efforts to ensure we provide robust programs to meet the unique needs of our Guard and Reserve members and their families.

In conjunction with the Year of the Air Force Family, we are also focused on reducing the stressors and mission detractors that impact our airmen and their families. We have taken a holistic approach to addressing airmen resiliency. We are strengthening our Exceptional Family Member Program to ensure we better meet their unique needs. We are dedicated to reducing incidence of sexual assault and suicide among our force. One is too many.

Diversity is an integral part of our mission accomplishment and success in today's Air Force, and will remain in the forefront of that area, as we continue to exclusively attract, develop, and retain highly qualified professionals for the betterment of the total force.

Across all of our programs, we continually strive to improve as we accomplish the Air Force's and the Nation's priorities. I am committed to ensuring we provide the best possible programs that increase our combat capability and take care of our most important asset: our airmen.

I look forward to working with this committee, which has helped shape DOD into the world's premier defense organization. I thank you for the opportunity to appear before you today.

[The prepared statement of Mr. Ginsberg follows:]

PREPARED STATEMENT BY HON, DANIEL B. GINSBERG

INTRODUCTION

Mr. Chairman, members of the subcommittee, thank you for this opportunity to discuss the Air Force's most important resource—our airmen. This diverse group of highly-skilled and dedicated men and women ensure our Air Force remains the most powerful in the world. Our airmen have been continuously deployed and globally engaged in combat missions for over 19 straight years. Approximately 38,800 airmen are currently deployed in support of joint operations across the globe. Of these, over 4,000 airmen are filling Joint Expeditionary Taskings in non-traditional roles in Iraq, Afghanistan and elsewhere. Thousands more are providing critical direct support to our combatant commanders from their home station. These critical capabilities include space systems such as GPS, rapid global mobility of people and supplies, as well as intelligence, surveillance, and reconnaissance from space and remotely piloted aircraft. Our airmen are committed to winning today's fight and prepared for tomorrow's challenges.

As the Air Force's assistant Secretary for Manpower and Reserve Affairs, I am focused on accomplishing the Air Force's priorities by developing and implementing programs and policies to best leverage our total force—Active, Guard, Reserve, and civilians—to maximize our combat capability for the joint commanders. To that end, I have made Continuum of Service (CoS), which will allow for smooth transfer of skilled airmen between components, and increasing the diversity of our force high priorities. I am also attuned to the overall health of our force. We are working essential programs that support our wounded warriors, help airmen reintegrate after deployments, provide families with the support they need and minimize the incidents of sexual assault and suicide to name just a few.

END STRENGTH AND FORCE MANAGEMENT

With the National Defense Authorization Act for Fiscal Year 2010, our current approved total force end strength is 686,944. This includes 331,700 Active component; 179,044 civilians; 69,500 Reserve; and 106,700 Air National Guard. In the fiscal year 2011 budget request, our programmed total force end strength is 702,669. This includes 332,200 Active component, 192,569 civilians, 71,200 Reserve, and Air National Guard end strength remaining at 106,700.

The Air Force's fiscal year 2011 budget request preserved end strength in the face of fiscal constraints, realigned Active component and Reserve manpower within existing resources, and grew civilian end strength to meet Air Force priorities. Major

manpower drivers include initial investment toward remotely piloted aircraft fleet operational capability to 65 combat air patrols; enhancing cyberspace/irregular warfare/command and control capabilities; and resourcing required Air Force priorities to include Acquisition Excellence, further enhancements to Nuclear Enterprise, and developing and caring for our airmen and their families while rebalancing our total force mix for agile combat support.

Maintaining the optimum overall force size as well as balancing critical skill-sets is a routine part of the Air Force's force management efforts. The current downturn in the economy has had a direct impact on the Air Force's lower attrition rates projected in fiscal year 2010. As a result, the Air Force is expected to exceed end strength by about 3,700 airmen (2,100 officers and 1,600 enlisted) in fiscal year 2010. Although this increase would fall under the Secretary of the Air Force's purview of 2 percent over authorized end strength, the Air Force implemented a force management plan to bring this back in alignment. In fiscal year 2010, we made small adjustments in several areas including limited reductions of officer and enlisted accessions, increased service commitment waivers, waived enlisted time-in-grade requirements for retirement, and we are implementing an additional enlisted date-of-separation rollback. We are continually monitoring results from these actions and to date we have achieved about 50 percent of our fiscal year 2010 force management goal. Even with these efforts, we do not expect these actions to fully achieve the reductions targeted for fiscal year 2010. As a result, we will likely continue many of these actions and consider other force management options for the remainder of fiscal year 2010 and in fiscal year 2011 as needed. Utilizing force management tools is a necessary and routine leadership obligation to ensure the Air Force remains within authorized strength levels and get the right balance of grades and skills to meet our evolving mission requirements. However, we strive to use these force management tools in a deliberate manner with the least disruption to the cohesion of the force.

RECRUITING

Even in a time of higher retention and a struggling economy, recruiting the highest quality airmen is as important as ever. Our recruiting force continues to achieve the enlisted accession mission with integrity and excellence. In fiscal year 2009, we met mission requirements for enlisted recruiting in all components (Active, Guard, and Reserve). To date in fiscal year 2010 we have achieved 100 percent of our active-duty accession goals and 100 percent and 112 percent of our Reserve and Guard accession goals, respectively.

Although we have achieved mission goals in our line officer accession programs, we continue to struggle with health professions officer recruitment and retention. In fiscal year 2009, we recruited approximately 70 percent of officer health professions requirements exceeding the fiscal year 2008 production of 62 percent. The ongoing high-demand for medical professionals in the lucrative civilian market makes it difficult for the Air Force to attract and retain fully qualified individuals. As a result, in 2006 the Air Force implemented a long-term "grow our own" strategy by offering more medical school scholarships in student-based markets. In fiscal year 2008, we filled 431 of 437 available scholarships (98.6 percent) and for fiscal year 2009, we accessed 376 of 371 scholarships (101 percent). In fiscal year 2010, we are on track to achieve a 100 percent scholarship fill rate. Our main shortfall in recruiting is attracting fully-qualified medical professionals to come straight into the service particularly in the Biomedical Science Corps. Psychology, Pharmacy, Optometry and Public Health Officers continue to be challenging to recruit. Our continued challenges in the health professions are why we have submitted $85.7 million in this year's budget request for officer bonuses to attract and retain more medical professionals on active duty. We are appreciative of and ask for your continued support in this area.

Although recruitment is also strong in the Reserve and Air National Guard, they face challenges with fewer prior-servicemembers due to lower Active component attrition rates and increased requirements for new and emerging mission specialties. As a result, both the Air National Guard and the Air Force Reserve have had to increase their non-prior service recruitment efforts. In fact, the Reserve non-prior service recruiting requirement has nearly doubled since the end of fiscal year 2007. Increased recruitment of non-prior servicemembers for both Air National Guard and the Air Force Reserve has directly resulted in increased recruitment costs as well as increased training costs over that of already trained prior-servicemembers. The continued support of the Air Force, Department of Defense and Congress will undoubtedly shape the foundation of their success.

RETENTION

Although overall officer retention has remained strong, we have had challenges with retention of rated officers, some critical skills and some health profession specialties. To address our rated officer shortages, we implemented a rated recall program to bring back 500 trained pilots to help fill our rated staff positions allowing more current pilots to return to the cockpit. The Air Force prudently employs Special and Incentive (S&I) pays to compensate for and incentivize the performance of hazardous and arduous duties, the acceptance of duty in hostile or remote and isolated locations, and the recruiting and retention of personnel with specific skills or in specific career fields. Fiscal year 2010 Active component recruiting and retention S&I pays total $465.9 million. For fiscal year 2011, we have requested this be increased to $480.1 million. This increase is due to changing eligible populations, anniversary payments, and the addition of retention bonuses for five stressed officer career fields. Our S&I pays are critical as we shape the force to meet new and emerging missions and support the combatant commanders in today's fight.

The quality of Air National Guard recruits has not declined and their retention rate remains strong at 96.9 percent. The Air National Guard saves on average $62,000 in training costs for every qualified member retained or recruited. Our focus in this area allows us to retain critical skills lost from the Active component and save valuable training dollars. In 2009, through the use of our 14 In-Service Air National Guard recruiters strategically placed at active duty bases, the Air National Guard garnered approximately 896 confirmed accessions of a total of 5,309 accessions. The bonuses and incentive programs are a key component to that success.

Retention for the Air Force Reserve remains solid with first-term airmen retention being the highest in recent history. Likewise, second-term and career airmen retention has rebounded following a drop in recent years due in-part to force structure changes. Although we have not formally studied the causes, we attribute this increase in retention rates primarily to the recent legislative authorizations congress has approved that enhance incentives to remain in the service like inactive duty training (IDT) travel pay, streamlining of TRICARE Reserve Select premiums, enhanced bonuses and the Post-September 11 GI Bill. We anticipate this positive trend in retention will continue for the foreseeable future.

CIVILIAN PERSONNEL

Management of the civilian workforce will continue to be a priority for the Air Force. We are working collaboratively with the Deputy Under Secretary of Defense for Civilian Personnel Policy on Strategic Human Capital Planning efforts, in particular, to address the provisions in NDAA for Fiscal Year 2010 which require reporting by the Military Departments. We support this effort that will result in the Air Force and the Department of Defense (DOD) having the skills and competencies necessary to meet our current and future mission requirements.

In October, 2009, the President signed into law the NDAA 2010 that repeals the authority for NSPS and requires DOD to transition civilian employees from NSPS to the appropriate statutory non-NSPS personnel and pay system not later than January 1, 2012. The Air Force has approximately 44,000 employees in NSPS. We are aggressively planning and preparing to transition these Air Force employees in an orderly and timely manner. We have begun the process of reclassification of positions, where necessary. We will soon issue a conversion plan that will inform and assist our human resource practitioners, supervisors, managers and employees to understand the transition process and to facilitate the transition. The NDAA also provided additional personnel flexibilities which we will be pursuing in conjunction with DOD and the Office of Personnel Management.

DIVERSITY

Diversity is an integral part of mission accomplishment and success in today's Air Force and will remain in the forefront as we continue to inclusively attract, develop, and retain highly qualified professionals for the betterment of the Total Force. The capacity to educate, manage, lead, and train a diverse force is a core competency of Air Force leadership. Currently, we are pursuing collaborative diversity outreach initiatives with Air University, Civil Air Patrol, Junior and Senior Reserve Officer Training Corps, Officer Training School and the United States Air Force Academy. Additionally, strategic plans are being formalized to utilize the Air Force Diversity Champions to promulgate the aims of diversity within the Air Force and the community. Areas of interests and emphasis to cultivate and develop future leaders of the Total Force will include reaching out to students enrolled in science, technology,

engineering and mathematics programs in high schools, colleges and universities across the Nation.

As the demographics of the Nation continue to change, the Air Force must position itself to optimize the true benefits of a diverse force and respectfully request appropriate Congressional funding for the sustainment of the aforementioned outreach initiatives. By incorporating diversity management leadership principles and strategies to leverage the unique qualities and talents of all citizens, the Air Force will achieve mission excellence and sustain dominance in air, space, and cyberspace.

CONTINUUM OF SERVICE

An important aspect of retention is our ability as a Service to allow skilled airmen to easily transfer from one component to another providing the Air Force flexibility while retaining valuable skills. CoS transforms the operating culture and paradigms to shape the future of personnel and manpower delivery throughout the Air Force to meet global mission requirements.

CoS efforts have already positively impacted our Air Force members through a number of initiatives. Through our on-line CoS Tracking Tool (CoSTT), any airman can submit a proposal for a CoS initiative. Our tool was modified for use by the Army and is now being adapted for use throughout the Department of Defense. CoS initiatives have already improved our joint-spouse PCS process, interservice transfer of rated officers and helped facilitate the establishment of the Religious Professional Scholarship Program (RPSP) allowing members to attend seminary and later return to active duty. The RPSP is designed to help fill manning shortfalls within the chaplaincy for underrepresented faiths within the Air Force. This program is now being considered for utilization by my Navy and Army counterparts. In addition, CoS helped modify the chaplain accession age ceiling from 42 to 47.

Some current Air Force CoS initiatives include: (1) aligning the Air Reserve Component pregnancy policy with that of the Army and Marine Corps to allow pregnant women to work until her orders expire; (2) changing Air Force policy on "Lawful Permanent Resident" accessions for critical specialties by utilizing current laws permitting the appointment of a Reserve Component officer who has been lawfully admitted to the United States; (3) evaluating the authority provided in the NDAA for Fiscal Year 2009 by considering a "Career Intermission Pilot Program" to determine whether a more flexible career path will prove to be an effective retention tool; and (4) examining the effects of changes to Air Force policy that would bring fully qualified personnel into stressed career fields faster than traditional methods by recognizing the value of nongovernmental experience.

The Air Force CoS program is an important force multiplier as it not only helps our airmen transition between components, but also balances people and mission to ensure the right airman is in the fight. We greatly appreciate the outstanding support of the Senate Armed Services Committee Personnel Subcommittee on many of our CoS initiatives.

SUICIDE PREVENTION

Preventing suicide among our airmen is extremely important to the well-being of our force. The Air Force developed the basis for its suicide prevention program in 1993 and it is one of ten suicide prevention programs listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices. Although this program resulted in a reduction in the number of suicides among airmen, within the Air Force we have recognized the importance of a multi-faceted approach to meet the varied needs of our people. Since the initial program began, we have placed a strong emphasis on leadership involvement in preventing suicides. Training has been implemented in various professional military education curricula to create awareness among Air Force leaders and frontline supervisors of behaviors that may lead to suicide and to inform leadership of actions they can take to prevent suicide. We have identified specific career fields in which the requirements of the job place enormous stress on airmen and we are developing targeted programs to improve resiliency and encourage airmen to seek help early. To facilitate the seeking of mental health services, we have placed behavioral health specialists in our primary care clinics.

Additionally, we emphasize community involvement in suicide prevention, combining the efforts of chaplains, family counselors, and other non-medical counselors to meet the psychological health needs of airmen. Finally, we collaborate with our sister Services, with the Defense Center of Excellence for Traumatic Brain Injury and Psychological Health, and with the Department of Veterans Affairs to identify best practices and continuously improve our existing suicide prevention program. Recently, the Air Force Surgeon General took the lead in implementing a two-tiered

program to create and enhance psychological resiliency in deploying and returning airmen. This program includes a 2-day decompression program when the airmen return from theater. We believe one suicide is one too many and are strongly committed to preventing suicides and caring for our airmen.

SEXUAL ASSAULT PREVENTION AND RESPONSE

Preventing sexual assault is also a top Air Force priority. Since program implementation in 2005, the Air Force has maintained a multi-disciplinary approach to addressing sexual assault that supports home-stationed and deployed airmen. A robust Air Force response to victims includes dedicated full-time civilian and military Sexual Assault Response Coordinators (SARCs) and more than 2,600 volunteer victim advocates who provide 24/7/365 support. Our robust Air Force Sexual Assault Prevention and Response program budget funds 80 civilian and 29 military officer SARCs at the installation level, who work directly for the Vice Wing Commander. Our military SARCs provide a full-time deployed capability at seven primary deployment locations. The Secretary of the Air Force recently approved the addition of 24 Air Force Office of Special Investigations agents trained and dedicated to investigate sexual assault. Caring and professional response to victims has been a focus of the Air Force program but equally important is our focus to prevent the crime before it occurs.

The primary challenge of addressing sexual assault in the military and society at large is to confront a culture where sexual assault is allowed to exist. It requires a positive, ongoing effort to educate our airmen and others, about the realities of sexual assault, debunking myths that continue to be propagated by media and entertainment, and maintained by peer pressure or other societal convention. The Air Force has developed a prevention-based approach that directly focuses on fostering positive behavior that is in concert with our core values. The approach includes leadership focus from the top down, risk reduction, and bystander intervention training. The later is a strategy that motivates and mobilizes people who may see, hear, or recognize signs of an inappropriate or unsafe situation, to act.

We will be working with Dr. Stanley, OSD (P&R), and our sister Services, to address the recommendations in the report of the Defense Task Force on Sexual Assault in the Military Services. Sexual assault is a crime. The Air Force is dedicated to the elimination of this crime and we recognize the challenges dealing with this very complex issue.

YEAR OF THE AIR FORCE FAMILY

In the spring of 2009, the Air Force renewed its longstanding commitment to taking care of our airmen and families by designating July 2009 through July 2010 as "Year of the Air Force Family." The observance serves two primary purposes. Across the Air Force, we examined our support services and policies in order to expand or refine them as required to meet the emerging needs and expectations of our airmen, their families, and the larger Air Force Family. Second, we set aside specific time to recognize the sacrifices and contributions of all of the members of our Air Force family—our Active, Reserve, and Guard—civilians, spouses, and family members.

We have focused our efforts to ensure we provide robust programs to meet the unique needs of our Guard and Reserve members and their families. The Yellow Ribbon Reintegration Program is one important way we are accomplishing this. The Air Force is working alongside other services in this DOD-wide effort to ensure the Air National Guard and Air Force Reserve airmen and their families are connected with all of the appropriate resources before, during and after deployments. We continue to focus on the reintegration phase after returning home and ensure that commanders are involved and aware throughout. We continue to improve our effectiveness and relationships with other associations such as the Department of Veterans Affairs and the Department of Labor in providing current and relevant information to members. The Air Force remains focused on airmen and their families and will ensure the oversight and success of the Yellow Ribbon Reintegration Program.

Additionally, we are ensuring the Year of the Air Force Family does not overlook our "extended Family" our retirees, parents and the nongovernmental and community partners that support Air Force people every day across the Nation. We are using this year long period to launch our sharper focus on improving support to airmen and families. Under Secretary Donley's leadership, our concerted attention on providing the support that results in stronger, more resilient airmen and families will remain a priority in the years to come.

In April 2010, we will hold a Caring for People Forum that will bring together helping professionals, airmen, and family members to develop an action plan to ad-

dress the pressing and longer term concerns of airmen and families which will be briefed to senior leadership at the end of the forum.

We are working to strengthen all of the partnerships that contribute to the quality of life for our members. These will include close rapport with local school districts (to enhance quality education and garner on-site support for children impacted by repeated deployments), housing privatization projects and agreements between our bases and city or county services.

WOUNDED WARRIOR AND SURVIVOR CARE

The Air Force Wounded Warrior program focuses on the needs of recovering airmen and their families, as well as families of the fallen. We now have 17 Recovery Care Coordinators (RCC) in 15 locations, with an additional 10 RCCs being hired this year. Our RCCs are the primary point of contact for our wounded, ill, and injured airmen and ensure the health care, financial, informational, and personal needs of airmen and their families are available in a timely manner. Because of the range of questions airmen and families have after an injury or illness has incurred, it is critical to the healing process to have relevant and accurate information available to our airmen. Recovery Care Coordinators are in place to ensure those knowledgeable in medical and other areas of expertise are available to provide the requested information. This assistance is provided for as long as the airmen and families want assistance during recovery, rehabilitation, and reintegration. The Air Force also continues to work closely with the Office of Wounded Warrior Care and Transition Policy in the Office of the Secretary of Defense to ensure our programs continue to support all wounded, ill, and injured servicemembers. It is our solemn duty that these airmen receive the utmost support and care.

CONCLUSION

I am continually impressed, but not surprised, by the tremendous hard work and focus our airmen display daily as they accomplish their missions. I am dedicated to providing them the best programs and support, removing any policy barriers and pursuing innovative ways to streamline our processes to allow them to be even more effective. Our Air Force is a critical component to our Nation's defense as we are faced with uncertain and ever changing threats.

We appreciate your unfailing support to the men and women of our Air Force, and I look forward to your questions.

Senator WEBB. Thank you very much.

I thank all of you for your testimony.

I think what I would like to do is—since I took a good bit of time in my opening statement, I think I would like to just start with an 8-minute round, and Senator Graham could begin, and then we could go to Senator Hagan and Senator Begich, and then I'll follow on after you.

Senator GRAHAM. Well, thank you, Mr. Chairman.

Secretary Stanley, when it comes to the personnel part of the budget, we're going to grow the Army and Marine Corps. I think we need to. The healthcare component—how do we get a grip on this? What are some ideas that you all are talking about there?

Dr. STANLEY. Well, Senator, in my 3 weeks, we haven't really talked a lot about details on——

Senator GRAHAM. You mean, you haven't fixed this in 3 weeks? [Laughter.]

Dr. STANLEY. What we have done—in fact, the very first thing I did—and I think we would—working with Congress even then—was to bring someone over with the skills and qualities to at least fill the position temporarily while we wait on the person, who is to be confirmed at some point in the future, to work with. And so, this has been an actual priority from day one, actually, because we recognize the healthcare costs.

Senator GRAHAM. Okay, well, that's fair—and congratulations, to all of you, by the way, for having your job. This time last year we were looking for people like you, and now we have them.

The idea of the Guard and Reserve recruitment and retention—with the economy like it is, it's a good time for the military, but I think the economy's going to get better—I hope it will, and I'm sure it will eventually—TRICARE benefits for the Guard and Reserve—I'd just like to get your impression about how that program has worked, from each of the Services. Secretary Stanley, how is it being received by our Guard and Reserve Force, that they are now eligible for TRICARE? They have to pay a premium.

The second issue, what effect do you believe it would have if we allowed people to retire at 55 if they would do more Active Duty service—earn their way from 60 to 55?

Starting with Secretary Stanley.

Dr. STANLEY. Well, Senator, I know that, the TRICARE programs, all of those programs are under review right now because it's all a part of the gestalt of looking at all of healthcare. I don't have answers for you today.

Senator GRAHAM. Okay.

Dr. STANLEY. But, we look forward to working with Congress on that.

Senator GRAHAM. From the Services' point of view, what are you hearing from the Army, the Marines, and the Air Force?

Mr. LAMONT. From the Army's perspective, TRICARE Reserve has gone over very well. But, we're finding, among particularly our Reserve component, they don't fully appreciate or are educated enough to understand its availability to them. We think it's incumbent upon this to broaden that perspective so they avail themselves of what's out there.

It's an excellent program, and it's a wonderful incentive. On the Reserve side, we may also, at some point in time, need to look at some potential other incentives, from the healthcare side, as we continue operationalizing the Reserve. But, it's a resource issue, of course, as well, for all of us.

Senator GRAHAM. Okay.

Secretary Garcia?

Mr. GARCIA. Senator, I have the opportunity and the honor to continue to serve in the Reserves, and had a Reserve squadron, until coming to take this appointment. I will tell you the—among those circles, the program is—there's a lot of awareness of it, and it's very popular.

The piece that many members have read about, and are very interested in, is what's been called the "gray area" piece; that is, for retired reservists, not yet 60, being able to access TRICARE Select and some of those programs before their retirement.

As Secretary Lamont said, there's a price tag that comes with that. I look forward to wrestling with that, with you. But, I can tell you that, among my circles, on the Navy and Marine side, it's very popular and well thought of.

Mr. GINSBERG. Senator, TRICARE Reserve Select is a very well-liked program. We have good participation rates, as I understand it, within the Air Guard and Air Reserve. It's not just a benefit, it

provides a tool to our airmen to make sure that they're medically ready for deployment.

One of the challenges we need to look at this systematically—is whether—the health of the provider network, and whether maybe a stand-alone Air Guard base, whether we have a sufficient network in place, or we're taking imbursements. It's something we want to look at to ensure that this program is moving along helpfully.

Senator GRAHAM. Well, one last question. The sexual harassment, sexual assault problem is being better identified, and the number of reported cases is growing, which I think is probably an indication, not that there are more activity, it's just getting easier to report it, and people feel more confident about reporting it. But, we're not nearly where we need to be.

Just very quickly, from each Service's perspective, what are you doing in that regard to enhance the ability of a servicemember to report sexual harassment or assaults in a way they feel will not be detrimental to their career?

Mr. LAMONT. From the Army perspective, we're looking at it from a couple of different directions. First, we want to make it easier for them to report. We have initiated programs that allow for the confidentiality of the report. Plus, we're also, as I think we——

Senator GRAHAM. In that regard, do we need to look at changing our laws? Because there's a lot of privileges available maybe in the civilian side, not available to military members. I know you have a priest-penitent privilege and limited medical privilege, but just look at that and see if there are some changes we need to make on the Personnel Subcommittee to expand privileges to healthcare providers. I'd just——

Mr. LAMONT. All right.

Senator GRAHAM. Okay.

Mr. LAMONT. Otherwise, as we try to build resilience within the force, particularly on our Sexual Harassment/Assault Response Prevention situation, we have initiated a program called "I. A.M. Strong"—"I" being "Intervene," "A" being "Act," "M" being "Motivate." Though it's a command-oriented climate that we're trying to address, that would respect the dignity of all of our soldiers, we've looked for this "I. A.M. Strong" program to educate and train our soldiers, on a peer-to-peer basis, to remove any stigma of going forward to make those reports.

We believe it's working, at least as we've seen the number of reports increase. We still believe, unfortunately, that only roughly a third of sexual assaults are being reported.

Senator GRAHAM. Thank you.

Mr. GARCIA. Senator, Secretary Mabus has stood up the Sexual Assault Prevention Response Office. The dedicated officer—civilian SES—reports directly to him for the first time and a network of Sexual Assault Response Coordinators (SARCs) implemented in each unit across the fleet. As you indicated, we are seeing a rise in reported incidents. The challenge is to discern whether that's availability to reporting or whether it's a true spike in incidents. It's something we wrestle with every day.

Mr. GINSBERG. Senator, I think from the Air Force perspective, this is an issue of leadership, it's an issue of investment, and it's

just a leader—an issue of communication. Leadershipwise, it's about showing from the highest levels on down, that sexual assault absolutely won't be tolerated and that from our perspective, goes against everything—all of those core values that we hold dear.

It's about putting in money for a strong, baseline program, a good, strong, healthy organization, along with funding for investigations, and very active and aggressive investigations. It's also a matter of just making sure that those who are victims know that their resources and reporting channels are available to them. We have an ability for somebody who is a victim to come forward and provide limited information about what happened so they'll come forward. It's called restricted reporting, and that's provided a useful channel for victims.

Senator GRAHAM. Thank you, all, for your service. I'm going to have to run to another hearing, but I shall return.

Senator WEBB. Thank you very much, Senator Graham.

Senator Hagan.

Senator HAGAN. Thank you very much, Mr. Chairman.

I do, too, want to thank all of you for your service to our country. I really do appreciate it.

Secretary Stanley, you mentioned, in your opening remarks, about the Military Spouse Career Advancement Account—as it's being referred to MyCAA—and about the stop in the implementation of it. I have a serious concern with that, because, one, neither Congress nor the people who were beneficiaries of this program were given any sort of upfront notification about any of the problems that were being seen in the program. This pause has certainly caused a lot of concern to many people in my State, in North Carolina, because it's an excellent program and a lot of people are taking advantage of it. I think the uncertainty that's been put forth right now has resulted in the Department's decision—has certainly negatively impacted and affected the morale of our servicemembers and their families. It certainly has had, I think, an adverse impact on family readiness.

But, one of the questions I have in the President's fiscal year 2011 budget, which reflects increased funding for this enhanced career and educational opportunities, does it address the longer-term needs of the program?

Dr. STANLEY. First of all, we are addressing the concerns, short-term and long-term. The Secretary is now, at this time, making a decision, looking at options that have been presented to him. But I will say that there are still some unanswered questions on long-term, but I feel confident that they're going to be addressed. I certainly share your concern about what's happened, in terms of the program being stopped. I understand that.

Senator HAGAN. Well, the lack of notification was certainly alarming too, I think, Members of Congress and the people who were the beneficiaries.

As far as improving the implementation of the program, do you need more specialists on staff to help with that? Or is that some of the things you're looking into?

Dr. STANLEY. Actually, in my arrival—just to be very blunt.

Senator HAGAN. Okay.

Dr. STANLEY. I was sworn in on the 16th, and I learned about it on the 16th.

Senator HAGAN. Wow.

Dr. STANLEY. So——

VOICE. Welcome aboard. [Laughter.]

Dr. STANLEY.—I'm going to——

Senator HAGAN. Wow.

Dr. STANLEY. So, we're addressing the issues dealing with MyCAA——

Senator HAGAN. Okay.

Dr. STANLEY.—as we move forward. I'm very optimistic about it working out okay.

Senator HAGAN. Okay.

Another question, concerning the Census. I'm concerned that servicemembers that are deployed during the conduct of the 2010 Census will be counted in a negative way that impacts the communities that host military installations. For the 1990 and 2000 Census, the decision was made to count deployed servicemembers as overseas.

North Carolina currently has approximately 41,200 servicemembers deployed as a part of the overseas contingencies, and in the event that they are counted as prescribed by the Census Bureau, areas with large concentrations of military personnel, I believe, will be significantly undercounted and underfunded for the next 10 years.

What's preventing the Defense Manpower Data Center from providing the Census Bureau with information regarding the base of last assignment or permanent U.S. duty station as the primary response for our deployed servicemembers that are currently engaged in overseas contingencies?

Dr. STANLEY. Senator, I'm going to ask to take that question for the record.

Senator HAGAN. Okay. That's fair.

Dr. STANLEY. Because I'd like to get back to you with a very specific——

Senator HAGAN. Okay.

Dr. STANLEY.—and correct answer.

[The information referred to follows:]

This issue falls under the purview of the Census Bureau, and we must follow its guidance on how to count our personnel. The Census Bureau, in turn, is following what it perceives to be existing Congressional guidance.

We are aware of no law specifying how to count military members deployed overseas. The Census Bureau is using a bill passed in the House in 1990, H.R. 4903, as the methodology for counting overseas servicemembers and their accompanying dependents. This current methodology, used in 1990 and 2000, counts overseas military personnel in this order (where the data is available): State home of record, State of legal residence, and State of last duty station (i.e., base of last assignment).

The Department recognizes the decision to use the current methodology will result in overseas military personnel being assigned to a home State without counting them toward the populations of towns or counties. We also understand counting "last duty station" first would have a beneficial effect on States with a large military population. We have discussed with the Census Bureau methodologies other than using "home of record" first, and these methodologies might provide a more accurate snapshot of the current residence of the military personnel and also the desired town and county specificity. However, the current methodology does have the benefit of consistency over time.

The Department stands ready to discuss all possible methodologies with the Census Bureau. We also look forward to continuing to work with Congress on this important matter.

Senator HAGAN. Well, let me go to one other one. We were talking about suicide. One of you referred to that. So, Secretaries Lamont, Garcia, and Ginsberg, I think we have witnessed an unacceptable number of suicides within our military population, and some of these losses, hopefully, could have been prevented if servicemembers had the ability to access professional care during the early stages of emotional distress. I'm sure we all agree that we have to reduce those numbers. What measures are being taken within the Services to ensure that our military men and women receive and gain easier access to mental healthcare without being stigmatized—that's, obviously, sometimes associated with that—and with going through the chain of command?

Secretary Lamont?

Mr. LAMONT. First, you're absolutely right, we take the loss of any soldier, through any means, very, very seriously. It truly is one of the very highest priorities that we have. We look at it from early identification of risk factors, as well as early intervention when we recognize those risk factors, to move in and encourage, as best we can, to have those individuals who may exhibit those risk factors to seek out help.

We have instituted a program designed to reduce the stigma of reaching out for mental health care. Actually, what we're finding out with some of our younger soldiers, who, for whatever reasons, do not wish to meet personally with a healthcare provider, for instance—we have a software program, that they go online and they self-address——

Senator HAGAN. Right.

Mr. LAMONT.—their issues. It's become a very valuable tool for us. But, it's going to take a lot of effort.

Also, we clearly have to address the resiliency side, and we're making our effort to do that through a program called Comprehensive Soldier Fitness, where we explore, not only just the physical health, but the mental, the emotional and the spiritual well-being of the soldier, as well, to build that mental health resiliency as best we can to address the issues going on in his or her life.

Senator HAGAN. Thank you.

Mr. GARCIA. Senator, I appreciate your question. For the first time, last year, our Marine rate approached that of the national rate; we normed for age and gender. It's an issue we brief daily and constantly look for a correlation that we can zero in on.

We focused much of our training at the NCO level. We feel that they have the most insight and perspective to what our young sailors and marines are wrestling with, those issues. But every marine, every sailor receives training and is made aware that they have access to master's-level counseling. It is confidential unless, in the aftermath of that training, the counselor feels that the individual is suicidal, homicidal, or is unfit for duty. But, everyone is aware of it from boot-camp level on.

Senator HAGAN. Do you think these things are making a difference in the attitude and the health of our men and women?

Mr. GARCIA. I think there is a——

Senator HAGAN. Great.

Mr. GARCIA.—undeniably, a new level of awareness from E–1 to O–10. I've seen the training that takes place at Marine Boot Camp, at Marine Corps Recruit Depot. It's the first time where a Marine drill instructor to—a new boot camp marine sees that drill instructor take his cover off and address him personally, in a way that he has not, yet. It speaks to the importance and the significance, I think, that the Corps and the Department are placing on this.

Senator HAGAN. Okay.

Mr. GINSBERG. Well, Senator, obviously it's a tremendous tragedy even when one servicemember takes their life. We pride ourselves, in the Air Force, being a family, and when one feels so alienated that it becomes a major problem at the highest reaches.

This is a matter—this goes to our staffing—our capacity levels, in terms of having enough psychiatrists and trained psychologists. We, in the Air Force, are doing well, but obviously there's tremendous competition with the private sector for trained psychiatrists and trained psychologists. The bonuses that you provide us are absolutely essential for us to grow our force and to bring in psychiatrists and trained psychologists.

I'd also say that this is—and to address the stigma, one of the things that we're doing in the Air Force is to locate our mental health clinics within military treatment facilities, within regular divisions within the hospital, basically, where somebody who's going in to get treatment is not seen as going to some special clinic, but is just part of—accessing regular care. We want to normalize care.

Senator HAGAN. That's good.

All right, thank you, Mr. Chairman.

Senator WEBB. Thank you, Senator Hagan.

Just to follow on for a moment on that line of questioning, I believe you could show—and, in fact, the Chief of Staff of the Army recently brought me a chart to this effect—that there is a direct correlation between dwell time—the amount of time that people have between deployments—and the percentage of emotional difficulties that are in these units. That's why I introduced this dwell-time amendment in 2007. When the Chief of Staff of the Army called me and said they were going to 15-month deployments, with only 12 months dwell time back in the United States before they redeployed—having spent 4 years as a committee counsel over in the House Veterans' Affairs Committee, when we first started examining the difficulties of people who had served in Vietnam, first of all, I said, "I can't believe you're going to do that. I don't think there's any operational requirement that should cause you, at this point in our history, to put that kind of pressure on our people. You're going to have challenges on the other end of doing this." Quite frankly, we're seeing that.

All of your responses basically go to the means—and I salute these means—of addressing the situation once it occurs, but I don't think there's anything more valuable than putting the right kind of dwell time on our units. Particularly, when you look at the young age of the people who are doing these multiple deployments, and where they are in terms of addressing issues of adulthood.

Mr. LAMONT. If I may——

Senator WEBB. Mr. Lamont, do you want to——

Mr. LAMONT.—just add a comment to that. We have any number of programs that are well intentioned, well resourced, it doesn't matter. There is nothing more important than exactly what you say—is the dwell time of our soldiers, with their families and others, that will help them decompress and serve them so much better in this kind of situation. It is dwell time.

Senator WEBB. I totally agree. Thank you for saying that.

Senator Begich.

Senator BEGICH. Thank you very much, Mr. Chairman.

I want to talk about TRICARE for a second, but then I actually want to get back to the SARC. In Anchorage, in municipal government, we call it SART, a very similar program, I think, but I want—that's what I want to ask you.

But, Secretary Stanley, let me—I represent Alaska. It's very unique when it comes to TRICARE. It's the one that is not managed by a contractor, out of the whole system. We have some very unique situations. Alaska's population, in total, is—about two-thirds has Federal healthcare in some form or another: Medicaid, Medicare, Indian Health Services, VA, Federal employed. So, it's probably the highest percentage, I would bet, or per capita, in the country. So, it has some unique challenges. Then, geographically, the geography of Alaska is very vast, and so we have some great challenges.

I have introduced a piece of legislation to set up a task force for Alaska to bring all the different agencies that deal with healthcare and TRICARE as part of that—and DOD would be at that table—to try to figure out what's the best way to deliver services. I don't know if you've had any chance to see that legislation, have any comment on it. If you haven't seen it yet, I'd be anxious to get your comment for the record, at some point, if you think the task force will be of help for something very unique, I think, in Alaska. I don't know if you have any comment on that.

Dr. STANLEY. Yes, Senator. I haven't seen the legislation, but I've seen what I can best describe now are anecdotal pieces of information that tell me, in Alaska, we have some unique issues that deal with healthcare, as you've already described. So, I look forward to not only looking at the legislation, but working very closely with you to address some very significant issues.

Senator BEGICH. Great, I would love to get your response for the record, I appreciate that.

[The information referred to follows:]

Since two-thirds of Alaskans use a Federal health care program, creating an interagency task force [1] would be helpful in working together to assess and plan improvements to health care access for our Alaskan beneficiaries in a coordinated manner. TRICARE has tested alternate means of reimbursement and other Alaska-unique initiatives to improve access to care, and we are happy to discuss our findings with the task force and learn the successes other Federal agencies have experienced as they face the unique challenges Alaska presents.

Our TRICARE Regional Office-West team has already begun engaging other Federal partners in Alaska in anticipation of establishment of the interagency task force. We look forward to discussing a potential rate schedule that recognizes the uniqueness of the health care system in Alaska.

[1] Note: The creation of the Interagency Access to Health Care in Alaska Task Force was mandated by section 5104 of H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111–148 (124 Stat. 119)).

Senator BEGICH. The other thing I want to say—and the folks from the Federal Government that have been working on the TRICARE, that have been managing it for us, have done a great job. But, I'm also very pleased to see that there is kind of a reexamination. How would a contractor work? Would there be a benefit? Is there some advantage, or maybe not advantage, depending on how it's all looked at? So, I am pleased with that, and that perspective, and I want you to know that. But, do you have, from your view, working with TRICARE contractors, what would you consider some of the advantages that you have seen in the value of delivering that healthcare? From a contractor delivering it, versus the way it's done in Alaska?

Dr. STANLEY. I'm afraid my answer would probably be personal, only because——

Senator BEGICH. Personal is sometimes better.

Dr. STANLEY.—I'm a recipient——

Senator BEGICH. Very good.

Dr. STANLEY.—of TRICARE benefits and the contractor, and from what I've benefited from. It's been pretty transparent to me, in being able to use a system that works very well. But, I don't think that's going to address some of the macro issues we're talking about. I'm also aware of the fact that there are some, already, challenges that exist with the TRICARE system as it's presently presented, with our contractors as we address contracting issues. So, I'm looking into those issues now, but I will tell you that there are some pluses—some significant pluses—but, there are also some—probably some negatives that—as we look at that. But, I don't know what all of those are right now.

Senator BEGICH. As you develop that, will you share it with the committee?

Dr. STANLEY. Absolutely.

[The information referred to follows:]

TRICARE-eligible beneficiaries make up almost 14 percent of the overall population in Alaska. In recognition of the challenges placed on military treatment facilities, we are working with TriWest, the TRICARE West Regional Contractor, to develop a preferred provider listing which would aid in providing more access to civilian providers. Our regional contractors are experienced in the identification and credentialing of qualified providers who are willing to provide care to our beneficiaries. In the future, we plan to identify primary care managers in the civilian community in the Fairbanks area to support beneficiaries assigned to Fort Wainwright and Eielson Air Force Base.

Senator BEGICH. At least my side would be very interested in that.

Dr. STANLEY. I'll look forward to it.

Senator BEGICH. Then, again, as we examine the role of TRICARE, the contractor who delivers TRICARE, as a potential option or augmentation to what we do in Alaska, I'm going to be very interested as we move through this over the next several months.

Two other things. One more on TRICARE, and that is, one of the situations—and I use Alaska, obviously, because I represent Alaska—one of the things we do, if you take Medicare, Medicaid, TRICARE, Indian Health Services, VA, we're always chasing the highest rate, the reimbursement rate. Now, the problem we have in Alaska is, we have very high rates, no matter what. I mean, it's just delivery of care, that cost of care. We don't have a teaching

hospital, for example. We lack a lot of things that other communities can tap into and, therefore, keep their costs more competitive. Ours, we've been very high-cost in. But, we've also been very fortunate, because, under the rules, you've been able to—DOD and—or, the Federal Government has been able to utilize, under a demonstration ability, to have a higher-rate reimbursement in Alaska. It's only been in a demonstration capacity they've been able to do it. Obviously, we're very interested. I know there's a study going on, or at least a potential study, that will talk about how those rates are different; and if they are, how do we make them more permanent? Because, obviously, doctors—and I think some of the comments made here is getting those doctors to perform those services under TRICARE. The reimbursement rate is critical.

In Anchorage, for example, which is the largest provider, or largest city—about 43 percent of the State's population—I think we're down to—on Medicare, for new Medicare patients, I think we're down to less than three or four docs that will accept them. That's it. So, we are the tip of the iceberg of what's going to happen in this country, very rapidly, because our cost differential is now getting to a point where primary-care doctors can't afford to do it; and second, there are less and less of them being produced, in the sense of the system.

So, I would like, if you have any comment on, one, the demonstration project. Again, if you're not familiar, I'd be very interested. Then, how we go about getting some permanency to this, because when docs see a pointer that's not permanent, then they just say, "We're just done waiting, we have to move on to others," honestly, business has to continue for what they do. So, do you have any comment on that? The demonstration project, how do we move it to permanency, and is that a realistic viewpoint?

Dr. STANLEY. Well, thank you, Senator.

Let me just say that I've been briefed on the project, in general.

Senator BEGICH. Good.

Dr. STANLEY. My commitment is to work closely with you, not to study the problem to death——

Senator BEGICH. Now you're talking. [Laughter.]

Dr. STANLEY.—but to move forward with a solution.

Senator BEGICH. Good.

Dr. STANLEY. So, I'm aware of it. Now the issue is, okay, addressing this on the degree of permanency, which is why I put in place someone to help—with expertise, immediately—that's a physician—until we get somebody confirmed. I can't wait that long.

Senator BEGICH. Right.

Dr. STANLEY. Which is the reason we're moving, kind of, like at flank speed, for lack of a better word——

Senator BEGICH. Good.

Dr. STANLEY.—to put things in place and address these issues. There are other issues, too.

Senator BEGICH. Absolutely. We would love to see confirmations happen very rapidly, but don't wait for that. Move forward on progress, and I appreciate your comments.

I will end, Mr. Chairman, just on one—and this is more of a comment to the—as a former mayor, we worked on a project called SART, which is Sexual Assault Response Team, which is a com-

bination public service, police—and they all are centralized into one location. They work with the community hospitals. It's good for investigation purposes. It has a kids' unit. It has a variety of things that—one of the pieces to this equation—and I haven't asked the—and I'm not asking for a response, at this point. I just want you to become aware, if you can, with what we're doing in Anchorage, which is the SART team.

Why I say that, there's a very important component of how the person who has been the victim works through the process, and how that's handled, which is critical to your investigations, conviction rates, as well as to the care that's necessary. Then, if there are family members engaged in this, in the sense of a child who's also been assaulted, there's a whole process that is much different than the adult process.

The SART program has been recognized around the Nation as a very cohesive and—like you, we saw rates go up, in the sense of reporting, but we also saw conviction rates go up, education capacity increasing—and young people, children especially, which is probably the hardest to deal with, with sexual assault or violence in a household or in a home.

I'd just ask you—and we'd be happy to supply you some information—it's very unique and has been very, very successful. In Anchorage, we have two large military bases, literally as far as that door is from our facilities and our population. We have a great relationship with the military that—we know this program has had some impact.

So, I'd just encourage you, as you work through this very troubling issue, to be very frank with you, but one we have to deal with, not only from a sexual assault on the officer, but also so many families are now part of the military family that, 30 years ago, was not the case, but today, it's 70 or 75 percent of the families. So the kids of this population, also, we need to make sure they're getting the services they need, and education they need. So, I would just encourage you to——

Dr. STANLEY. Will do, sir.

Senator BEGICH. Okay, and we'll get you some information from staff.

Dr. STANLEY. Great. Thank you.

Senator WEBB. Thank you very much, Senator Begich.

Senator Chambliss.

Senator CHAMBLISS. Thank you very much, Mr. Chairman.

Gentlemen, first of all, let me just say that I want to thank all of you for what you do. You're charged with managing the most important aspect of our military, and that's the people and the programs that support them.

I know much of what you do deals with numbers, but I also know you have an appreciation for what those numbers represent, in terms of the individual and his or her family, and what it means to our Nation.

You all, along with our second panel, will help give us a sense of how we're doing, and how we can best continue to support the men and women of the Armed Forces and their families. So, I thank you for being here.

Secretary Ginsberg, it's always great to see a Georgian on a panel like this—

Mr. GINSBERG. It's my honor to be here. Thank you, Senator.

Senator CHAMBLISS.—so thanks for your service.

Secretary Stanley, let me just ask you if you are familiar with the situation of the commissary at Dobbins and the one that we're transferring from Gillem to Dobbins. Does that ring a bell at all with you?

Dr. STANLEY. Vaguely. If you keep talking, Senator, I think I might pull something up, here. [Laughter.]

Senator CHAMBLISS. I'm not surprised that you don't, but—

Dr. STANLEY. Okay.

Senator CHAMBLISS.—basically, a BRAC decision was made to close Fort Gillem, in Atlanta, and that's the commissary that has served our retired population for decades. A decision was made, by your predecessor, to construct a new commissary at Dobbins that obviously will continue to operate, and it's going to serve our retired population. And it's in the hands of DeCA right now. That's why I'm not surprised you're not familiar with it. But, I wish you would familiarize yourself with it. At some point, you're going to have some significant input into it, and it may just be an issue of DeCA trying to find the funding for it. But, in any event, it is obviously a critical issue for the retired population, as well as for our active duty folks in the area.

Dr. STANLEY. Yes, sir.

Senator CHAMBLISS. Secretary Lamont, in light of the Fort Hood incident last November, can you elaborate on specific steps that the Army is taking to better recognize the presence of soldiers who may have become radicalized, as Major Hasan was?

Mr. LAMONT. I can tell you this. We are going through a very extensive internal review to look at all components of extremism that may have crept into society and, of course, may touch more and more into our Military Services, and what we can do to address those. We're aware of some apparent shortcomings in our officer evaluation forms and in our enlisted evaluations, and how some of the right questions may just not get asked. Some of the identifying risk factors may not just be exposed, as well.

There is a Defense-wide Fort Hood review in progress right now. As I understand it—and perhaps Dr. Stanley knows more than I—that perhaps sometime this summer there will be a full report, as all of the Services, I believe, are involved in that report. But, certainly the Army is drilling down very deeply to see, what in the world did we miss here?

Senator CHAMBLISS. Let me just mention to all of you—I think Senator Graham may have mentioned this in his opening comments—the Guard and Reserve retirement initiative, early retirement initiative, that we have been successful at having put in place, that we're now looking to extend the retirement date back to service beginning on September 11, 2001. If there are any stumbling blocks out there, I would appreciate hearing from you now, if you're aware of anything. Obviously, funding is an issue. We're going to continue to work that until we, ultimately, have that retirement date, or that service date to qualify for retirement, go back to September 11, 2001, when so many of our men and women

began being called up. Any comments any of you have, relative to any issues that are outstanding, that might be in our way on that issue?

Dr. STANLEY. Senator, I hadn't heard anything, I'm not sure if my colleagues have.

Mr. LAMONT. I've heard very little.

Senator CHAMBLISS. Okay.

Mr. LAMONT. But, as you say, the number one thing that we always look on something like that, of course, is the resource concerns——

Senator CHAMBLISS. Yes.

Mr. LAMONT.—as you are well aware.

Senator CHAMBLISS. Yes. Well, we'll continue to work that from our end.

One other question. Secretary Lamont, I understand that the Vice Chief of Staff of the Army is currently hosting an online virtual conference regarding the future of the U.S. Army Officer Corps. The central premise behind this virtual conference is the recruitment and employment of talent within the Army. This sounds like a great idea, and a great way to look at the caliber of the young men and women who are—who make up our officer corps, from flag officers on down—could you give us any comment on that? Are any of the other Services doing something similar to this, or have plans for it?

Mr. LAMONT. Well, I understand the goal of what the Vice Chief is after, here. Our officer structure is not where we need it to be, given some of the demands that we've had over the past 8 or 9 years, and as we've moved to our modular rotational model in ARFORGEN, it has caused some fairly serious changes in how our officer structure is handled.

I think there is an effort out there, particularly in the grades of major, for instance, or that—there are serious shortcomings there, in the numbers that we have available. I think these—through—what he is trying to do is look for any acceptable options and alternatives to how we identify our officer corps, and where we can move them within the structure that's available now, our other grade challenges, grade-plate challenges, that we have.

Mr. GINSBERG. I'm not familiar with the program, but we work very closely with the Army. I'd love to reach out with my colleague, here, and learn more about it. Certainly provide some formal views to you.

Senator CHAMBLISS. Okay.

Secretary Garcia, Secretary Stanley, anything going on in your branch, similar to this?

Dr. STANLEY. I'm not familiar with the program. I'm, in fact, learning about it as he's talking, Senator.

Senator CHAMBLISS. Yeah. Well, it does sound like a good idea, because everybody has the same issues, relative to the makeup of our officer corps. The Army and the Marine Corps, I guess, have a little bit different situation, just because you've been taxed more than anybody else, but it is an issue that sounds to me like it has a lot of merit to it, and I would encourage every branch to follow suit, there.

Thank you, Mr. Chairman.

Senator WEBB. Thank you, Senator Chambliss.

I'm going to ask a couple of service-specific questions, and then, Secretary Stanley, I'd like to ask you a series of questions.

Let me say, I was a boxer for 8 years. You've been bobbing and weaving for an hour and 15 minutes, here. [Laughter.]

So, I'm going to ask you a series of questions to sort of get us all looking forward, since you just came to this job and I just assumed the chairmanship. But, first, I want to put something in front of the Service Assistant Secretaries.

There was an article in Military Times last week on prescription drug use in the military. I don't know if you all saw that article, or not. But, it pointed out that one in six servicemembers is on some form of psychiatric drug; 17 percent of the Active-Duty Force, and as much as 6 percent of the deployed troops are on antidepressants; and the use of psychiatric medications has increased about 76 percent since the start of these current wars.

First, I would like to express my appreciation to Senator Cardin for having brought this issue to the attention of people here in the Senate. But, these statistics, quite frankly, are astounding to me. I'd like to know if—how familiar the three Assistant Secretaries are with this issue inside your departments, and what your thoughts are. Is this an indication of the overall fatigue of the force, with these constant deployments, or is it an indication of a different approach to medical treatment? Are we on top of this?

I know that last year there was a provision in the Defense bill to require the Department to report on the administration and prescription of these drugs.

But, Secretary Lamont, let me start with you. What are your thoughts on this?

Mr. LAMONT. Well, I'm not specifically aware of the article you're speaking about. I was TDY last week. However, I am well aware of the concerns we have with our pain management program. Those are the prescription drugs that we have found to have really crept into our system in much wider usage than we were ever aware of before.

I'll also suggest to you, drugs like Oxycontin, I understand is used both in pain management and as an antidepressant. That's caused a number of concerns, because—the fear that they may be prescribed by separate healthcare providers.

What we have done to try to address the pain management side, what we found was, depending on where you went for treatment, there could be an entirely different model, if you would, of how pain is treated and how pain drugs are prescribed. There was no consistency there. So, with the various Services, we began a joint task force, this last fall, which is due to report, at any date now, on how we can come together with some kind of consistency in how we handle our pain management problem—pain management equals the drugs—and how we administer the proliferation of drugs in our military system.

Our soldiers are coming back wounded, sore, injured, in need of rehab, and that's—perhaps the easy answer, early on, was pain-managed prescription. But, there are other means. We hope this joint task force report will come to grips with how we can provide some consistency, not just throughout the Army—I mean, we found

that every Army Medical Center was dealing with pain in altogether different ways, all individual to their situation. But, not an Army-wide program at all. I think, with this task force, we'll have the Services all together, and hopefully all in sync, of how we can address this growing problem.

[Additional information supplied by Secretary Lamont follows:]

Pain management has a significant behavioral health component, and drugs like Oxycontin and antidepressants may be simultaneously prescribed by different health care providers for better symptom management. While drugs like Oxycontin are used for pain management, what we have found is that pain has a strong behavioral health component requiring the addition of drugs like antidepressants for better symptom management. These prescription combinations are often managed by different health care providers. The issue of multiple-prescribers exists in our health system and others. It concerns me that patients can receive different agents like narcotics and psychiatric drugs from different sources.

Senator WEBB. Secretary Garcia?

Mr. GARCIA. Senator, I'm familiar with the piece, and, as I understood it, it also posited, or suggested, that there were—elicit drug use, to include in theater. We continue to drug test randomly across the fleet, forward-deployed and at home.

On the prescription side, our Special Assistant for Health Affairs has initiated a working group, generated by the piece, to research this apparent spike, especially on the Marine side. That's where we are. All I can do is continue to keep you posted on the results.

Senator WEBB. Secretary Ginsberg.

Mr. GINSBERG. Senator, I'm not familiar with the article, but I think you raise, obviously, a very important question about the extent of prescription drug use and whether this is an indicator of stress, or is this a new push to medicine? I'd very much like to get some concrete data from our surgeon-general community, and would be more than happy to provide that to you.

[The information referred to follows:]

Thank you for the opportunity to address this concern regarding the health and well-being of our Air Force members and their use of psychotropic medications. Based upon this inquiry we made two distinct efforts to review psychopharmacology utilization data for our active duty servicemembers. The first data set we reviewed was provided by LCDR Joseph B. Lawrence, USN, MSC as the Deputy Director, Department of Defense (DOD) Pharmacoeconomic Center COR, DOD Pharmacy Operation Center. LCDR Lawrence's data pull from the Military Health System (MHS) Pharmacy Data Transaction Service (PDTS) demonstrated that in the U.S. Air Force active duty psychotropic drug prescriptions increased from 58,102 annually in 2005 to 113,010 annually in 2009. The most notable increases related to use of stimulant and sleep medications. Stimulants prescriptions increased from 6,886 in 2005 to 11,522 in 2009. The number of prescriptions for sleep medication went from 33,175 in 2005 to 64,166 in 2009. These two classes of psychotropic medications accounted for approximately 65 percent of the total prescription increase over this time period. While prescription sleep medications do carry a low risk of abuse, they are also highly effective and beneficial when used appropriately for short-term use to address the maintenance of health sleep patterns with international travel and fluctuating operational work schedules.

The second data pull was provided by Air Force Medical Operations Agency, Michael Squires. Mr. Squires extracted data from the PDTS table in the M2 which resulted in all Air Force active duty servicemembers who had received a psychotropic prescription (including antidepressants) between October 2009 and March 2010. The number of unique Air Force servicemembers who had one or more prescriptions for any psychotropic medication, including controlled prescription pain medications during this 6 month period was 81,253 or 22 percent of the Active Force. When controlled prescription pain medications are removed, the number of unique servicemembers on a psychotropic medication changes to 48, 233. This reflects a calculated user prevalence rate during a 6 month period of 1 in 8, or 13 percent , of the Active-Duty Force for psychotropic medications. This figure is a 6-month period

prevalence; point prevalence on a specific day would be lower. Additionally, this data pull illustrated a utilization rate over a 6 month period of controlled pain medications as 51 for every 400 servicemembers (12.75 percent), an antidepressant utilization rate of 23 for every 500 servicemembers (4.6 percent), a sleep medication utilization rate of approximately 19 of every 421 servicemembers (4.4 percent), a stimulant utilization rate of approximately 4 out of every 425 servicemembers (0.94 percent), and an antipsychotic utilization rate of approximately 2 for every 1,000 servicemembers (0.2 percent).

Senator WEBB. I'd just say as an observation, one, we do have a really stressed, young force, because of these deployments. This is an indicator I think we really should be tracking very closely, with repeated deployments and these sorts of things.

The other is, just purely as an observation, from looking at where they are deployed and the restriction of the use of alcohol, I would say it's—having been a journalist in Afghanistan before I started doing this, it is always rather ironic to me that, for reasons of comity with these other countries, we didn't allow our troops to use alcohol, but, I'll tell you, I was in a lot of villages in Afghanistan where everybody had their marijuana patch and their opium patch.

The relief of stress on individuals is handled differently in different cultures, and that may be something you want to look into. It's a very troubling statistic, to me. I hope we can look at it, not simply medically, but in these other ways, as well.

Secretary Ginsberg, can you give this subcommittee, some insight on this decision to provide aviation pay to nonrated pilots in the Remotely-Piloted Aircraft Program, what the justification is and—how does that fit into traditional definitions of flight pay, and those sorts of things?

Mr. GINSBERG. Absolutely. Senator, the Air Force is meeting a very high demand to provide remotely-piloted aircraft—combat air patrols (CAPs) to our combatant command commander in Afghanistan and Iraq. We are currently providing 41 CAPs to the theater. We're working, by the end of fiscal year 2013, to provide 65 CAPs. What we're trying to do is develop a career field, where our airmen, who are providing this critical support to our forces on the ground, our brothers in the Marine Corps and the Army, as well as many are Air Force officers and enlisted on the ground, providing them this direct support. We want to make sure they can grow and develop.

The incentive pays are a critical part of maintaining a robust pipeline of airmen who are operating these systems.

Senator WEBB. Under what category are they paid now?

Mr. GINSBERG. I'm sorry?

Senator WEBB. Under what category are they being paid?

Mr. GINSBERG. Well, this is an OSD-approved—under a—of course, the broad authority that Congress provides, under the—it's the—it's aviation continuation-paylike pay, and it——

Senator WEBB. It's not called "flight pay"?

Mr. GINSBERG. It's not called "flight pay," but it's a—it's a different authority that we're providing under. This about just making—this—these officers and enlisted members are providing absolutely critical direct support to our forces on the ground, and we are putting tremendous stresses on them. Our crew ratios are not sufficient, at this point. They have a hard time getting leave, regular leave. We need to provide them—we're not giving them the op-

portunity to move to new assignments as flexibly as other career areas. We need to provide them pay and bonuses that will help make sure that this career field remains attractive.

I went to Creech early in my tenure, to Creech Airfield, where we have a lot of our operators. It is absolutely astounding, what those airmen are doing to provide day-in and day-out support, truly lifesaving work.

Senator WEBB. Okay, thank you.

Mr. GINSBERG. So, again, it's about making sure that they get the right pay—

Senator WEBB. I think that——

Mr. GINSBERG.—and benefits that they deserve.

Senator WEBB. Secretary Stanley, I believe that this is a good time, with your coming in, to get a strong analytical look at how all of the special incentive pays, bonus pays, reenlistment pays, enlistment—how all of these fit together in a way that is beneficial to the people who are serving, and also to the efficiency of our programs.

What I would like to do in a—rather than taking a great deal of time this morning, what I would like to do is to work with you and your staff to develop a matrix, so that we can fully understand what we're doing in these programs. I believe that the best way to address issues is, first, to assemble, clearly, the facts. So we are going to come to you with some questions about the incentive pays, the special pays, the reenlistment bonuses, the whole panorama, to get an understanding of how they are used, how many people are used, what the criteria are, how many of these are directed by Congress, how many of them are subject to the discretion of the implementers—your staff and the other——

Dr. STANLEY. Yes.

Senator WEBB.—Service departments—so that we can have a clear picture, as we move forward in these programs. I'm not sure of the last time that that's been done. I don't want to go through every one of these and ask for your justifications, but we're going to be having some questions. I don't want these to be considered questions for the record that are going to be answered——

Dr. STANLEY. Yes, sir.

Senator WEBB.—a month or 2 months. I really want to work on this so we can aggressively address it.

There's a couple of other areas that I would like to get some feedback from you on. One of them, I'm sure you're familiar with, this mentor program that there were numerous articles, particularly USA Today, about where retired flag officers are getting up to $2,600 a day to come in and basically give advice. You know the situation, you're a retired flag. A retired four-star can be making in excess of $200,000 a year and then be working for a defense company, and then come in and be getting this sort of pay to give advice that, quite frankly, traditionally, has been a part of having worn the uniform, a sort of a continuing stewardship.

So, there's a lot of questions, here in Congress, about how that reflects upon the dignity of Service, quite frankly. We want to get to the bottom of how that program is run.

Then there's another area which relates to military fellowships, to think tanks. I would like to get some data on this with respect

to the numbers of people who are involved in this and how taxpayer dollars are being spent, beyond regular military compensation, on areas that are called "tuition" for Active Duty military officers to go over and work on a think tank and not only be paid by the taxpayers for their regular military compensation, but actually being paid tens of thousands of dollars into these think tanks for this office space, et cetera. I don't think I have a full understanding of how this works, and we'd like to get specific data from you. Each Service may be doing it differently, but we'd like to assemble that data.

With that, I thank all of you for your testimony, and look forward to working with you on a very close basis. Our door is open for any issues that you want to bring to the subcommittee, or to my office, personally.

Thank you very much.

Dr. STANLEY. I appreciate that.

Mr. LAMONT. Thank you.

Mr. GARCIA. Thank you very much. [Pause.]

Senator WEBB. Our second panel will have members of the military coalition, a consortium of nationally prominent uniformed service and veteran organizations: Master Chief (Retired) Joseph Barnes, National Executive Director of the Fleet Reserve Association; Ms. Kathleen Moakler is the Government Relations Director of the National Military Family Association; Master Sergeant Michael Cline (Retired) is the Executive Director of the Enlisted Association of the National Guard of the United States; Ms. Deirdre Parke Holleman is the Executive Director of The Retired Enlisted Association; and Colonel Steven Strobridge (Retired) is the Director of Government Relations for the Military Officers Association of America.

I mentioned earlier that we had two statements that would be put in the record. Probably more appropriate, they would be put in at this point rather than at the beginning of the hearing.

[The joint prepared statement of the Reserve Officers Association and Reserve Enlisted Association follows:]

JOINT PREPARED STATEMENT BY THE RESERVE OFFICERS ASSOCIATION OF THE UNITED STATES RESERVE ENLISTED ASSOCIATION

INTRODUCTION

On behalf of our members, the Reserve Officers Association (ROA) and the Reserve Enlisted Association (REA) thank the committee for the opportunity to submit testimony on military personnel issues. ROA and REA applaud the ongoing efforts by Congress to address readiness, recruiting and retention as evidenced by incentives in several provisions included in the National Defense Authorization Act (NDAA) for Fiscal Year 2010.

EXECUTIVE SUMMARY

The Reserve Officers Association Calendar Year 2010 Legislative Priorities are:

- Reset the whole force to include fully funding equipment and training for the National Guard and Reserves.
- Assure that the Reserve and National Guard continue in a key national defense role, both at home and abroad. Support citizen warriors, families and survivors.
- Provide adequate resources and authorities to support the current recruiting and retention requirements of the Reserves and National Guard.
- Support warriors, families, and survivors.

Issues supported by the Reserve Officers and Reserve Enlisted Associations are to:

Changes to retention policies:

- Permit service beyond the current Reserve Officers Personnel Management Act (ROPMA) limitations.
- Support incentives for affiliation, reenlistment retention and continuation in the Reserve component.

Education:

- Increase MGIB-Selected Reserve (MGIB–SR) to 47 percent of MGIB-Active.
- Include 4-year reenlistment contracts to qualify for MGIB–SR.

Mobilization:

- Provide differential pay for deployed Federal employees permanently.
- Permit reservists the option of accumulating leave between active duty orders, as well as selling it back.

Pay and Compensation:

- Reimburse a Reserve component member for expenses incurred in connection with round-trip travel in excess of 100 miles to an inactive training location, including mileage traveled, lodging and subsistence.
- Obtain professional pay for Reserve component medical professionals, consistent with the Active component.
- Eliminate the 1l/30th rule for Aviation Career Incentive Pay. Career Enlisted Flyers Incentive Pay. Diving Special Duty Pay. and Hazardous Duty Incentive Pay.
- Simplify the Reserve duty order system without compromising drill compensation.

Spouse Support:

- Expand eligibility of surviving spouses to receive Survivor Benefit Plan (SBP)-Dependency Indemnity Clause (DIC) payments with no offset.

Health Care:

- Improve continuity of health care for all drilling reservists and their families by:
  - Monitoring the implementation of the Department of Defense (DOD) paying a stipend toward employers health care for dependents.
  - Allowing gray-area retirees to buy-in to TRICARE by mid-2010.
  - Providing Continuing Health Benefit Plan to traditional drilling reservists who are beneficiaries of TRICARE Reserve Select but are separated from the Selected Reserve to provide COBRA protections,
  - Permitting active members in the Individual Ready Reserve (IRR) who qualify for a 20-year retirement to buy-into TRICARE.
  - Allowing demobilized retirees and reservists involuntarily returning to IRR to qualify for subsidized TRS coverage,
  - Providing TRS coverage to mobilization ready IRR members; levels of subsidy would vary for different levels of readiness.
  - Improve post-deployment medical and mental health evaluations of returning Reserve component members.
- Fund restorative dental care prior to mobilization.
- Extend military coverage for restorative dental care following deployment to 90 days.
- Evaluate the Post-Deployment Medical Evaluation process.
- Encourage a discussion on health care costs between Congress, DOD, and nonprofits.
- Protect military and veteran's health care from inclusion in national health legislation.

Voting:

- Ensure that every deployed servicemember has an opportunity to vote by:
  - Working with the Federal Voting Assistance Program
  - Supporting electronic voting
- Ensure that every military absentee ballot is counted.

Only issues needing additional explanation are included below. Self-explanatory or issues covered by other testimony will not be elaborated upon, but ROA and REA can provide further information if requested.

READINESS DISCUSSION

Operational versus strategic missions for the Reserve component:

The Reserve Forces are no longer just a part-time strategic force but are an integral contributor to our Nation's operational ability to defend our soil, assist other countries in maintaining global peace, and fight in overseas contingency operations.

National security demands both a Strategic and an Operational Reserve. The Operational Reserve requires a more significant investment of training and equipment resources, and places greater demands on its personnel as compared to the Strategic Reserve. Those serving in Operational Reserve units must be fully aware of the commitment required to maintain the expected level of readiness. A similar awareness and commitment is necessary for those responsible for providing resources to the Operational Reserve.

Planners also must recognize that few individuals can remain in the operational Reserve for an entire career. There will be times when family, education, civilian career, and the other demands competing for their time and talents take priority. Such an approach requires the ability to move freely and without penalty between the operational and strategic elements of the Reserve component as a continuum of service.

Each Service has its own force generation models and the Services organize, train, and equip their Reserve components to a prescribed level of readiness prior to mobilization to limit post-mobilization training and to maximize operational deployment time. ROA and REA urge Congress to continue to support and fund each Service's authority to manage the readiness of its own Reserve Forces as one model does not fit all.

Congress can play an important role by requiring reports from Service leaders to ensure they have a plan for systematic augmentation, that the plan is adequately resourced, and that Reserve training and equipment will permit interoperability with the units they augment and reinforce. In an era of constrained budgets, a capable and sustainable Reserve and National Guard is a cost-effective element of national security.

Junior Officer and Enlisted Drain:

As an initial obligated period draws to the end, many junior officers and enlisted choose to leave, creating a critical shortage of young people in the leadership conduit. This challenge has yet to be solved. ROA and the National Guard Education Foundation published a report suggesting solutions to the problem. Copies can be provided to the committee, or be found at http://www.roa.org/JO-shortage.

End Strength and Preparedness:

It is noted that the only active service component to suffer cuts in the fiscal year 2011 proposed budget was the Coast Guard which will have a reduction of 1,100 personnel.

The other Active components appear to maintain their end strengths with inclusion of temporary increases for the Army and the Navy. It should be remembered that individuals cannot be brought quickly on to active duly on a temporary basis, but it is an accumulation of experience and training that is acquired over years that becomes an asset for the military. Before cuts to the U.S. Coast Guard are made, ROA and REA hope that Congress requests a report from the U.S. Coast Guard, Department of Homeland Security, on the effect in the short and long term.

Traditionally, it has been the Reserve component that has provided the temporary surge to fill-in the active duty numbers. The end strengths included in the President's budget appear to maintain current numbers. ROA and REA are concerned that the ongoing cuts to the Navy's Reserve will continue and this is a trend that needs to be reversed. A new manpower study needs to be done and published by the Navy Reserve to calculate the actual manning level: this study should be driven by readiness and not budgetary requirements.

With pending withdrawals from Iraq and Afghanistan, there is already talk within the beltway about future cuts to military end strength to help offset rising deficits. Many blame the global war on terrorism for our current national debt, but part of high cost of the military is unpreparedness, and the bills borne by trying to create a force to match the need.

Following World War I, Lieutenant General James Guthrie Harbord, USA, General John J. Pershing's chief of staff, was quoted in a 1922 New York Times as saying. "The size of our debt, incurred through unpreparedness, brings a demand for

economy, and we continue unprepared. Thus unpreparedness brings the debt, and the debt continues unpreparedness."

Without external threats, the USA has traditionally reduced the size of its Armed Forces. But since the 1990s the Pentagon has recommended proportional cuts be taken in the Reserve component when taken in the Active Force. This reasoning fails in many ways. It results in a hollowing out of the force and preparedness, undermines morale, and undercuts retention. national security is put at risk. There is a need to maintain a national position of readiness, and the Reserve component is a cost-effective solution of being prepared. Should cuts be taken in the Active component, the Reserve component should grow in size to allow a place for readiness capability.

PROPOSED LEGISLATION

Retirement

ROA and REA again thank the committee for passing the early retirement benefit in the National Defense Authorization Act for Fiscal Year 2008, as a good first step toward changing the retirement compensation for serving Guard and Reserve members, but...

Guard and Reserve members feel that with the change in the roles and missions of the Reserve component, their contracts have changed. Informal surveys keep indicating that earlier retirement remains a top issue asked for by guardsmen and reservists. They ask why so many Guard and Reserve members who have served in the global war on terrorism were excluded from the new benefit; they also ask why even earlier duty is not included: and if faced with the same risks as active duty, why there is a 20 year difference in access to retirement pay?

1. "ROA and REA" endorse S.831. National Guard and Reserve Retired Pay Equity Act of 2009, which is a corrective measure to the National Defense Authorization Act for Fiscal Year 2008 including those Guard and Reserve members who have been mobilized since September 11, 2001. Over 600,000 were unfairly excluded. We realize the expense of this corrective measure scored by CBO is $2.1 billion over 10 years, but hope that offset dollars can be found.

2. ROA and REA don't view this congressional solution as the final retirement plan. The Commission on the National Guard and Reserve recommends that Congress should amend laws to place the Active and Reserve components into the same retirement system. Secretary of Defense Robert Gates refers to the Tenth Quadrennial Review of Military Compensation's comprehensive review of the military retirement systems for suggested reform. The latter report suggests a retirement pay equal to 2.5 percent of basic pay multiplied by the number of years of service.

ROA and REA agree that a retirement plan, at least for the Reserve component, should be based on accruement of active and inactive duty. Early retirement should not be based on the type of service, but on the aggregate of duty. It shouldn't matter if a member's contributions were paid or non-paid; inactive duty, active duty for training, special works or for mobilization. Under a continuum of service, this approach would provide both the Active or Reserve component members with an element of personal control to determine when they retire and will encourage increased frequency of service beyond 20 years within the Reserve.

3. An additional problem arises for O–4 officers who, after a break in service, have returned to the Reserve component. After being encouraged to return a number of officers find they are not eligible for nonregular retirement. When reaching 20 years of commissioned service they find they may have only 15 good Federal years. Current policy allows these individuals to have only 24 years of commissioned time to earn 20 good Federal years.

4. With an ongoing shortage of mid-grade officers (O–2 to O–3), Congress should reexamine the DOPMA and ROPMA laws to permit O–3s without prior enlisted service to be able to retire at 20 years of service. Many of badly needed skills that the Services would like to retain, yet must be discharged if passed over for promotion to often.

ROA urges Congress to make changes in U.S. Code to allow O–3s and O–4s with 14 to 15 good Federal years to remain on Active Duty or in the Reserve until they qualify for regular or non-regular retirement.

Education

1. Montgomery "GI" Bill-Selected Reserve (MGJB–SR): To assist in recruiting efforts for the Marine Corps Reserve and the other uniformed services, ROA and REA urge Congress to reduce the obligation period to qualify for MGJB–SR (Section 1606) from 6 years in the Selected Reserve to 4 years in the Selected Reserve plus

4 years in the Individual Ready Reserve, thereby remaining a mobilization asset for 8 years.

2. Extending MGIB–SR eligibility beyond Selected Reserve Status: Because of funding constraints, no Reserve component member will be guaranteed a full career without some period in a non-pay status. BRAC realignments are also restructuring the RC force and reducing available paid billets. Whether attached to a volunteer unit or as an individual mobilization augmentee, this status represents periods of drilling without pay. MGIB–SR eligibility should extend for 10 years beyond separation or transfer from a paid billet.

Leadership

Both the Army and Air Force Reserve Chiefs may only be selected from general officers from that component's reserve, yet the Navy and the Marine Corps can select its Reserve leadership from either Active or Reserve flag officers. (U.S.C., title 10. section 3038 states that "The President, by and with the advice and consent of the Senate, shall appoint the Chief of Army Reserve from general officers of the Army Reserve . . ." and section 8038 uses similar language for the appointment of the Chief of the Air Force Reserve, while U.S.C., title 10, section 5143, only requires the President to appoint the Chief of Navy Reserve from flag officers of the Navy, and section 5144 only requires the President to appoint the Commander. Marine Forces Reserve, from general officers of the Marine Corps.) The Reserve Chief of a Service's Reserve should have an understanding of both the citizen warriors who are reporting to him or her, and the system through which the report. ROA urges Congress to change sections 5143 and 5144 of U.S.C., title 10 to only permit appointments from the Service's Reserve component.

Military Voting

ROA thanks Congress for the improvements made to absentee voting in the fiscal year 2010 Defense Authorization. Military personnel, overseas citizens, and their families residing outside their election districts deserve every reasonable opportunity to participate in the electoral process. Yet, studies by Congressional Research Service show that 25 percent of military member and family votes were not counted in the 2008 election.

ROA and REA urge Congress to direct the Government Accountability Office to report further on the effectiveness of absentee voting assistance to Military and Overseas Citizens for the 2010 General Election and determine how Federal Voting Assistance Program's efforts to facilitate absentee voting by military personnel and overseas citizens differed between the 2008 and 2010 national elections. ROA and REA also hopes Congress encourages the Secretary of Defense, in conjunction with States and local jurisdictions, to gather and publish national data about the 2010 election by voting jurisdiction on disqualified military and overseas absentee ballots and reasons for disqualification.

HEALTH CARE DISCUSSION

1. ROA and REA hold concerns over the implementation of TRICARE for gray area retirees. Rear Admiral Christine S. Hunter has shared that enrollment could be as early as July or as late as November 2010, and that it might be regionally rolled out. DOD wants to treat Reserve gray area retirees as a separate health care risk group which will likely drive up the cost of health care premiums as well. ROA and REA hope that the committee will ask hard questions at a future hearing about the process, as individuals in the health care industry question the length of time and the approach being taken.

2. Sustaining Reserve Health care. ROA and REA was disappointed to learn that Continued Health Care Benefit Plan is only allowed to members of the Selected Reserve if they have had a tour of active duty within the previous 18 months by DOD. This is denying COBRA protections for traditional reservists who haven't been activated, and even overlooks the Secretary of Defense's directive to mobilize National Guard and Reserve members 1 year out of 6, which would be a dwell time of 60 months between call-ups. There is little cost as the beneficiary pays a premium of 102 percent of TRICARE Cost.

A continuity of health care is needed if a continuum of service is to be seriously considered. Just as an Active Force needs to be provided military health, the Reserve component needs to have a seamless health protection during different duty statuses. As even discharged active servicemembers have the benefit of the Continuing Health Care Benefit Plan, those Guard and Reserve members who have signed up for TRICARE Reserve Select need to have protections when they leave the Selected Reserve.

ROA and REA encourage Congress to work with the Pentagon to open up Reserve component member access to the Continued Health Care Benefit Plan to any TRICARE Reserve Select beneficiary separating from the Selected Reserve under conditions that are not punitive in nature.

3. Employer health care option: The ROA and REA continues to support an option for individual reservists where DOD pays a stipend to employers of deployed Guard and Reserve members to continue employer health care during deployment. Because TRICARE Prime or Standard is not available in all regions that are some distance from military bases it is an advantage to provide a continuity of health care by continuing an employer's health plan for the family members. This stipend would be equal to DOD's contribution to Active Duty TRICARE.

4. Dental Readiness. Currently, dental readiness has one of the largest impacts on mobilization. The action by Congress in the NDAA for Fiscal Year 2010 was a good step forward, but still more needs to be done.

In the first quarter of fiscal year 2009, the Army Reserve was 48.8 percent dental class 1 or 2 Navy Reserve was 92.8 percent, Air Force Reserve 86.6 percent, Marine Corps Reserve 77 percent. Air Guard 91 percent Army Guard 48.2 percent, and Coast Guard Reserve 83.2 percent.

While there has been slight improvement since fiscal year 2007, the Army Reserve and Marine Corps Reserve have actually decreased their dental readiness which is due to large numbers of Class 4 servicemembers. Regardless none of the Services have met the 95 percent dental readiness goal.

The Services require a minimum of Class 2 (where treatment is needed, however no dental emergency is likely within 6 months) for deployment. Current policy relies on voluntary dental care by the Guard or Reserve member. Once alerted, dental treatment can be done by the military, but often times there isn't adequate time for proper restorative remedy.

ROA and REA continues to suggest that the Services are responsible to restore a demobilized Guard or Reserve member to a Class 2 status to ensure the member maintains deployment eligibility.

Because there are inadequate dental assets at Military Treatment Facilities for active members, active families, and reservists, ROA and REA further recommend that dental restoration be included as part of the 6 months Transitional Assistance Management Program (TAMP) period following demobilization. DOD should cover full costs for restoration, but it could be tied into the TRICARE Dental program for cost and quality assurance.

5. TRICARE Health costs: ROA and REA applaud the efforts by Congress to address the issue of increasing Department of Defense health care costs and its interest to initiate dialogue and work with both the Pentagon and the beneficiary associations to find the best solution. The time has come to examine the cost of TRICARE and the level of beneficiary contribution.

ROA and REA are committed to our membership to sustain this health care benefit. We fear that we will be unable to continue to sustain prohibitions on health care fees into the future. We need to work together to find a fair and equitable solution that protects our beneficiaries and ensures the financial viability of the military health care system for the future. Some associations seek to continue to a freeze on premium fees permanently; others are joining ROA and REA by admitting that some increases are necessary.

ROA and REA endorse a tiered enrollment fee and congratulate the Task Force for developing one based on annual income. As most Guard and Reserve members retire at 25 to 30 percent of active duty retirement pay, it makes sense that G–R enrollment fees should be lower. ROA and REA do suggest that if enrollment fees are based on income that it be based just on military retirement income of Active and Reserve retirees.

The ROA and REA do not endorse annual enrollment fees for individuals who don't use the TRICARE Standard plan. Eligibility should remain universal; a one-time administrative enrollment fee might be implemented with first use of the program.

If TRICARE Standard enrollment fees are increased, Congress needs to review the recommended deductibles and current copayment levels. While TRICARE Prime is in the top 90 percent for cost generosity. TRICARE Standard is at a lower level of the spectrum of plan generosity.

6. National Health Care Plan. ROA and REA are concerned that the national health care legislation does not include specific language that preserves military and veteran health care programs under separate authorities. While there have been verbal guarantees from congressional members and the President, getting the pledge in writing would curtail concerns.

CONCLUSION

ROA and REA reiterate our profound gratitude for the progress achieved by this committee by providing parity on pay and compensation between the Active and Reserve components, with the subcommittee also understanding the difference in service between the two components.

ROA and REA look forward to working with the personnel subcommittee where we can present solutions to these and other issues, and offers our support in anyway.

Senator WEBB. Welcome, to all of you.

I suppose we can start with Mr. Barnes and move to Mr. Strobridge.

Welcome, sir.

STATEMENT OF MASTER CHIEF JOSEPH L. BARNES, USN (RET.), NATIONAL EXECUTIVE DIRECTOR, FLEET RESERVSE ASSOCIATION

Mr. BARNES. Good morning, Mr. Chairman, Senator Graham, distinguished members of the subcommittee. Thank you for the opportunity to appear before you today.

The Military Coalition's statement reflects the consensus of coalition organizations on a broad range of important personnel issues and extensive work by eight legislative committees, each comprised of representatives from the coalition's 34 military and veterans organizations.

The five of us will address key issues important to the Active, Guard, and Reserve, retiree, and survivor communities, and military families, and will conclude healthcare concerns which impact everyone within these groups, including our magnificent wounded warriors.

Before proceeding, I wish to thank you and the entire subcommittee and your outstanding staff for effective leadership and strong support of essential pay and benefit program enhancements, and particularly for programs to adequately care for our wounded warriors and their families.

Adequate service end strengths are absolutely essential to success in Iraq and Afghanistan, and to sustaining other operations vital to our national security. The coalition strongly supports proposed Army and Navy end strength levels in 2011. A recent Navy Times story titled "Sailor Shortage" cites too much work to do in the Navy and not enough people to do it, and lists the associated effects, which include little time for rest, fewer people to maintain and repair shipboard equipment, crew members with valuable skills being pulled for other jobs and not replaced, and lower material ship readiness.

As referenced by the first panel, the strain of repeated deployments continues, and is also related to the adequacy of end strengths. Now we're tracking disturbing indicators of the effects, which include increasing drug and alcohol use, more mental healthcare appointments, alarming suicide rates, plus more military divorces. The unrelenting stress on servicemembers and their families is a serious and continuing concern that can lead to very serious morale, readiness, and retention challenges.

Pay comparability remains a top priority, and the Coalition strongly supports the authorization of a 1.9-percent 2011 Active Duty pay hike. We appreciate your past support for higher-than-

ECI pay increases, which have collectively reduced the pay gap to 2.4 percent.

Adequate funding for military recruiting efforts is important. During high retention periods, it's natural to look at reducing these accounts. However, sufficient resources are essential to ensuring continuing recruiting success. It's noteworthy that nearly three-quarters of the optimum recruiting-aged young people do not qualify for Military Service, and the Services must maximize efforts through our military recruiters to recruit optimum-quality personnel across the Armed Services.

The coalition strongly supports the authorization to ship two personal vehicles in conjunction with PCS moves, along with long overdue increases in PCS mileage rates. We appreciate the distinguished Chairman's leadership on the enactment and implementation of the post-September 11 GI Bill and DOD policies on transferability options for personnel nearing retirement. However, technical corrections are still needed to ensure eligibility for members of the U.S. Public Health Service and NOAA Corps.

Adequate programs, facilities, and support services for personnel impacted by BRAC actions, rebasing, and global repositioning is very important, particularly during wartime, which alone, results in significant stress on servicemembers and their families. The coalition notes with concern the 19-plus-percent reductions in military construction and family housing accounts in the proposed 2011 budget request.

Finally, the coalition remains committed to adequate funding to ensure access to the commissary benefit for all beneficiaries. This is an essential benefit, and the Defense Commissary Agency is to be commended for highly cost-effective management of 255 stores in 13 countries.

Thank you again for the opportunity to present our recommendations.

[The prepared statement of Mr. Barnes follows:]

PREPARED STATEMENT BY MASTER CHIEF JOSEPH L. BARNES, USN (RET.)

THE FLEET RESERVE ASSOCIATION

The Fleet Reserve Association (FRA) is the oldest and largest enlisted organization serving active duty, Reserves, retired and veterans of the Navy, Marine Corps, and Coast Guard. It is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA) as an accrediting Veteran Service Organization for claim representation and entrusted to serve all veterans who seek its help. In 2007, FRA was selected for full membership on the National Veterans' Day Committee.

FRA was established in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve or Fleet Marine Corps Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

FRA's mission is to act as the premier "watch dog" organization in maintaining and improving the quality of life for Sea Service personnel and their families. FRA is a leading advocate on Capitol Hill for enlisted Active Duty, Reserve, retired and veterans of the Sea Services. The Association also sponsors a National Americanism Essay Program and other recognition and relief programs. In addition, the newly established FRA Education Foundation oversees the Association's scholarship program that presents awards totaling nearly $100,000 to deserving students each year.

The Association is also a founding member of The Military Coalition (TMC), a 34-member consortium of military and veteran's organizations. FRA hosts most TMC meetings and members of its staff serve in a number of TMC leadership roles.

FRA celebrated 85 years of service in November 2009. For over eight decades, dedication to its members has resulted in legislation enhancing quality of life programs for Sea Services personnel, other members of the uniformed services plus their families and survivors, while protecting their rights and privileges. CHAMPUS, now TRICARE, was an initiative of FRA, as was the Uniformed Services Survivor Benefit Plan. More recently, FRA led the way in reforming the REDUX Retirement Plan, obtaining targeted pay increases for mid-level enlisted personnel, and sea pay for junior enlisted sailors. FRA also played a leading role in advocating recently enacted predatory lending protections and absentee voting reform for servicemembers and their dependents.

FRA's motto is: "Loyalty, Protection, and Service."

CERTIFICATION OF NON-RECEIPT OF FEDERAL FUNDS

Pursuant to the requirements of House Rule XI, the FRA has not received any Federal grant or contract during the current fiscal year or either of the 2 previous fiscal years.

SYNOPSIS

The FRA is an active participant and leading organization in The Military Coalition (TMC) and strongly supports the recommendations addressed in the more extensive TMC testimony prepared for this hearing. The intent of this statement is to address other issues of particular importance to FRA's membership and the Sea Services enlisted communities.

INTRODUCTION

Mr. Chairman, the FRA salutes you, members of the subcommittee, and your staff for the strong and unwavering support of programs essential to Active Duty, Reserve component, and retired members of the uniformed services, their families, and survivors. The subcommittee's work has greatly enhanced care and support for our wounded warriors and significantly improved military pay, and other benefits and enhanced other personnel, retirement and survivor programs. This support is critical in maintaining readiness and is invaluable to our uniformed services engaged throughout the world fighting the global war on terror, sustaining other operational commitments and fulfilling commitments to those who've served in the past.

HEALTH CARE

Health care is exceptionally significant to all FRA shipmates regardless of their status and protecting and/or enhancing this benefit is the Association's top legislative priority. A recently released FRA survey indicates that nearly 90 percent of all Active Duty, Reserve, retired, and veteran respondents cited health care access as a critically important quality-of-life benefit associated with their military service. From 2006–2008 retirees under age 65 were targeted by DOD to pay significantly higher health care fees. Many of these retirees served before the recent pay and benefit enhancements were enacted and receive significantly less retired pay than those serving and retiring in the same pay grade with the same years of service today. Promises were made to them about health care for life in return for a career in the military with low pay and challenging duty assignments and many believe they are entitled to free health care for life.

Efforts to enact a national health care reform coupled with inaccurate and widespread information on the associated impact on retiree health care benefits has created unease and a sense of uncertainty for our members. FRA opposes any effort to integrate TRICARE and VA health care into any national health care program and appreciates the exclusion of TRICARE and VA health care in the House version of the national health care proposal. Military and VA health care services are fundamental to military readiness and serve the unique needs of current and former servicemembers, their families and survivors. Merging these programs into a colossal bureaucracy designed to provide health care to all Americans would broaden their focus and reduce their effectiveness. That said, the Association is concerned about proposed Medicare spending cuts associated with reform initiatives which may negatively impact physician reimbursement rates and access to care for Medicare and TRICARE beneficiaries.

FRA strongly supports Representatives Chet Edwards (TX) and Walter Jones (NC) legislation, "The Military Retirees' Health Care Protection Act" (H.R. 816) that would prohibit DOD from increasing TRICARE fees, specifying that the authority to increase TRICARE fees exists only in Congress.

FRA thanks this subcommittee for resisting past efforts to shift increasing health care cost to beneficiaries and ensuring adequate funding for the Defense Health Program in order to meet readiness needs, fully fund TRICARE, and improve access for all beneficiaries regardless of age, status or location. Adequately funding health care benefits for all beneficiaries is part of the cost of defending our Nation.

CONCURRENT RECEIPT

The Association appreciates President Obama's support for authorizing Chapter 61 retirees to receive their full military retired pay and veterans disability compensation and continues to seek timely and comprehensive implementation of legislation that authorizes the full concurrent receipt for all disabled retirees. The above referenced FRA survey indicates that more than 70 percent of military retirees cite concurrent receipt among their top priorities. The Association strongly supports the fiscal year 2011 budget request of $408 million to cover the first phase of the 5-year cost for concurrent receipt for Chapter 61 beneficiaries that are 90 percent or more disabled.

WOUNDED WARRIORS

FRA appreciates the substantial Wounded Warriors legislation in the National Defense Authorization Act (NDAA) for Fiscal Year 2008. Despite jurisdictional challenges, considerable progress has been made in this area. However, the enactment of legislation is only the first step in helping wounded warriors. Effective oversight and sustained funding are also critical for successful implementation and FRA supports the following substantive changes:

- Establish a permanent and independent office for the DOD/VA Interagency program and expand it's authority to include oversight of all components of achieving a true seamless transition;
- Authorizing full active duty TRICARE benefits, regardless of accessibility of VA care, for 3 years after medical retirement to help ease transition from DOD to VA;
- Extend and make permanent the charter of the "Special Oversight Committee" to ensure improved coordination with DOD and VA initiatives to help wounded warriors;
- Exempt severely wounded medically retired Medicare part B premiums until age 65;
- Providing up to 1 year of continuous habitation in onbase housing facilities for medically retired, severely wounded and their families;
- Eliminate the servicemember's premium for the Traumatic Servicemember Group Life Insurance;
- Ensure the creation and full implementation of a joint electronic health record that will help ensure a seamless transition from DOD to VA for wounded warriors; and
- Establishment of the Wounded Warriors Resource Center as a single point of contact for servicemembers, their family members, and primary care givers.

Achieving an effective delivery system between DOD and VA to guarantee seamless transition and quality services for wounded personnel, particularly those suffering from Post Traumatic Stress Disorder and Traumatic Brain Injuries is very important to our membership. DOD should also make every effort to destigmatize mental health conditions that should include outreach, counseling, and mental health assessment for all servicemembers returning from the combat zone. Family support is also critical for success, and should include compensation, training, and certification, and respite care for family members functioning as full-time caregivers for wounded warriors. FRA supports "The Caregivers and Veterans Omnibus Health Services Act"(S. 1963), and parallel legislation to improve compensation, training and assistance for caregivers of severally disabled active-duty servicemembers.

SUICIDE RATES

FRA is deeply concerned that more servicemembers have taken their own lives by November 2009 than have been killed in either the Afghanistan or Iraq wars. Congressional Quarterly reports that as of November 24, 334 servicemembers have committed suicide in 2009, compared with 297 killed in Afghanistan and 144 who died in Iraq. In response to this, Congress has significantly increased funding for mental health in the DOD and VA budgets that established a suicide hotline. DOD and VA also sponsor annual conferences on this issue. Jurisdictional challenges notwithstanding, it is critically important that Congress further respond and enhanced

coordination between the Veterans Affairs and Armed Services Committees is key to addressing this. As of the above date the Army has had 211 of the 334 suicides, while the Navy had 47, the Air Force had 34 and the Marine Corps (active duty only) had 42. Increases in the number of suicides are not limited to active duty members only, the Department of Veterans Affairs (VA) has indicated that veterans suicides have also been increasing at an alarming rate.

UNIFORM SERVICES FORMER SPOUSES PROTECTION ACT REFORM

The Association believes that the increasing divorce rates among active duty personnel and reservists is related to stress caused by repeated deployments in conjunction with 8 years of fighting a two-front war. According to the Los Angeles Times, "The 3.6 percent rate is a full percentage point above the 2.6 percent reported in late 2001, when the U.S. began sending troops to Afghanistan in response to the terrorist attacks. As in previous years, women in uniform suffered much higher divorce rates than their male counterparts—7.7 percent in 2009. An Army 2009 battlefield survey indicated that 22 percent of married soldiers were considering divorce, compared to 12.4 percent in 2003."[1] The divorce rate for women in uniform is especially troubling, and these numbers do not take into account divorce rates for veterans. The FRA has long advocated introduction of legislation addressing the inequities of the Uniform Services Former Spouses Protection Act (USFSPA) and associated hearings on this issue. The Association believes that this law should be more balanced in its protection for both the servicemember and the former spouse.

The recommendations in the Department of Defense's (DOD) September 2001 report, which assessed USFSPA inequities and offered recommendations for improvement is a good starting point for considering badly needed reform of this onerous law.

Few provisions of the USFSPA protect the rights of the servicemember and none are enforceable by the Department of Justice or DOD. If a State court violates the right of the servicemember under the provisions of USFSPA, the Solicitor General will make no move to reverse the error. Why? Because the act fails to have the enforceable language required for Justice or the Defense Department to react. The only recourse is for the servicemember to appeal to the court, which in many cases gives that court jurisdiction over the member. Another infraction is committed by some State courts awarding a percentage of veterans' compensation to ex-spouses, a clear violation of U.S. law; yet, the Federal Government does nothing to stop this transgression.

FRA believes Congress needs to take a hard look at the USFSPA with the intent to amend it so that the Federal Government is required to protect its servicemembers against State courts that ignore provisions of the act. Other provisions also weigh heavily in favor of former spouses. For example, when a divorce is granted and the former spouse is awarded a percentage of the servicemember's retired pay, this should be based on the member's pay grade at the time of the divorce and not at a higher grade that may be held upon retirement. The former spouse has done nothing to assist or enhance the member's advancements subsequent to the divorce; therefore, the former spouse should not be entitled to a percentage of the retirement pay earned as a result of service after the decree is awarded. Additionally, Congress should review other provisions considered inequitable or inconsistent.

ADEQUATE PERSONNEL END STRENGTH

Insufficient end strength levels and the rigors of supporting Operations Iraqi Freedom and Enduring Freedom are having a negative impact on the quality of life of servicemembers which will ultimately lead to retention and recruitment challenges. FRA urges this distinguished subcommittee to ensure funding for adequate end strengths and people programs consistent with the Association's DOD funding goal of at least 5 percent of the gross domestic product for fiscal year 2011.

ACTIVE DUTY PAY IMPROVEMENTS

Our Nation is at war and there is no more critical morale issue for active duty warriors than adequate pay. This is reflected in the more than 96 percent of active duty respondents to FRA's recent survey indicating that pay is "very important." The Employment Cost Index (ECI) for fiscal year 2011 is 1.4 percent and based on statistics from 15 months before the effective date of the proposed active duty pay increase. The Association appreciates the strong support from this distinguished subcommittee in reducing the 13.5 percent pay gap to the current level during the

[1] Associated Press, November 28, 2009, Divorce Rate Rises in Military, Los Angeles Times.

past decade. In addition, FRA notes that even with a fiscal year 2011 pay increase that is 0.5 percent above the ECI, the result will be the smallest pay hike since 1958. FRA urges the subcommittee to continue the increases at least 0.5 percent above the ECI until the remaining 2.4 percent pay gap is eliminated.

RESERVE EARLY RETIREMENT

The effective date of a key provision in the NDAA for Fiscal Year 2008, the Reserve retirement age provision that reduces the age requirement by 3 months for each cumulative 90-days ordered to active duty is effective upon the enactment of the legislation and NOT retroactive to October 7, 2001. Accordingly the Association supports "The National Guardsmen and Reservists Parity for Patriots Act" (H.R. 208) sponsored by the subcommittee's ranking member Representative Joe Wilson (SC), to authorize reservists mobilized since October 7, 2001, to receive credit in determining eligibility for receipt of early retired pay. Since September 11, 2001 the Reserve component has changed from a Strategic Reserve to an Operational Reserve that now plays a vital role in prosecuting the war efforts and other operational commitments. This has resulted in more frequent and longer deployments impacting individual reservist's careers. Changing the effective date of the Reserve early retirement would help partially offset lost salary increases, lost promotions, lost 401K and other benefit contributions. The Association urges the subcommittee to support this important legislation.

PAID-UP SURVIVOR BENEFIT ANNUITIES

Under current law, retirees are no longer required to pay survivor benefit annuities (SBP) premiums after they have paid for 30 years and reach age 70. This is an inequity for those who may have entered the service at age 17 or 18 and will be required to pay for 33 or 32 years respectively until attaining paid-up SBP status. Therefore, FRA supports changing the minimum age for paid-up SBP from age 70 to age 67 to ensure that those who joined the military at age 17, 18, or 19 and serve 20 years will only have to pay SBP premiums for 30 years.

RETENTION OF FINAL FULL MONTH'S RETIRED PAY

FRA urges the subcommittee to authorize the retention of the full final month's retired pay by the surviving spouse (or other designated survivor) of a military retiree for the month in which the member was alive for at least 24 hours. FRA strongly supports "The Military Retiree Survivor Comfort Act" (H.R. 613), introduced by Rep. Walter Jones (NC) which addresses this issue.

Current regulations require survivors of deceased military retirees to return any retirement payment received in the month the retiree passes away or any subsequent month thereafter if there is a processing delay. Upon the demise of a retiree, the surviving spouse is required to notify the Defense Finance and Accounting Service (DFAS) of the death. DFAS then stops payment on the retirement account, recalculates the final payment to cover only the days in the month the retiree was alive, forwards a check for those days to the surviving spouse or beneficiary. If not reported in a timely manner, DFAS recoups any payment(s) made covering periods subsequent to the retiree's death.

The measure is related to a similar Department of Veterans Affairs policy. Congress passed a law in 1996 that allows a surviving spouse to retain the veteran's disability and VA pension payments issued for the month of the veteran's death. FRA believes military retired pay should be no different. This proposal is also in response to complaints from surviving spouses who were unaware of the notification requirement and those with joint bank accounts, in which retirement payments were made electronically, who gave little if any thought that DFAS could access the joint account and recoup overpayments of retirement pay. This action could easily clear the account of any funds remaining whether they were retirement payments or money from other sources.

To offset some of the costs, if the spouse is entitled to SBP on the retiree's death, there will be no payment of the annuity for the month the retirement payment is provided the surviving spouse.

MANDATE TRAVEL COST REIMBURSEMENT

FRA appreciates the NDAA for Fiscal Year 2008 provision (section 631) that permits travel reimbursement for reservist's weekend drills, not to exceed $300, if the commute is outside the normal commuting distance. The Association urges the subcommittee to make this a mandatory provision. This is a priority issue with many enlisted reservists who are forced to travel lengthy distances to participate in week-

end drills without reimbursement for travel costs. Providing this travel reimbursement would assist with retention and recruitment for the Reserves—something particularly important to increased reliance on these personnel in order to sustain our war and other operational commitments.

FAMILY READINESS

Military deployments create unique stresses on families due to separation, uncertainties of each assignment and associated dangers of injury or death for the deployed servicemember. Further, adapting to new living arrangements and routines adds to the stress, particularly for children.

Fortunately men and women in uniform continue to answer the calls to support repeated deployments—but only at a cost of ever-greater sacrifices for them and their families. Now more than ever before the support of their families is essential to enduring the mounting stresses of the war effort and other operational commitments. This stress has resulted in doubling the number of outpatient mental health visits (1 million in 2003 to 2 million in 2008) for children with an active duty parent.[2] It's most important that DOD and the military services concentrate on providing programs for the families of our servicemembers. DOD should improve programs to assist military families with deployment readiness, responsiveness, and reintegration. There are a number of existing spousal and family programs that have been fine tuned and are successfully contributing to the well-being of this community. The Navy's Fleet and Family Centers and the Marines' Marine Corps Community Services and Family Services programs are providing comprehensive, 24/7 information and referral services to the servicemember and family through its OneSource links. OneSource is particularly beneficial to mobilized reservists and families who are unfamiliar with varied benefits and services available to them.

It's true that "the servicemember enlists in the military service—but it's the family that reenlists." To ensure the family opts for a uniformed career, the family must be satisfied with life in the military.

CONCLUSION

FRA is grateful for the opportunity to present these recommendations to this distinguished subcommittee. The Association reiterates its profound gratitude for the extraordinary progress this subcommittee has made in advancing a wide range of military personnel and retiree benefits and quality-of-life programs for all uniformed services personnel and their families and survivors. Thank you again for the opportunity to present the FRA's views on these critically important topics.

Senator WEBB. Thank you very much, Mr. Barnes.

Ms. Moakler, welcome.

STATEMENT OF KATHLEEN B. MOAKLER, GOVERNMENT RELATIONS DIRECTOR, NATIONAL MILITARY FAMILY ASSOCIATION

Ms. MOAKLER. Thank you. Chairman Webb, Senator Graham, thank you for the opportunity to speak today on behalf of military families, our Nation's military families.

Many families are facing their ninth year of deployment, many have dealt with multiple deployments. We have second-graders who have only known a lifestyle with a parent absent from their lives for months at a time, over and over again. We appreciate the many initiatives and programs supported by this subcommittee in the past. Military OneSource, increased benefits and support for surviving families, and the Yellow Ribbon Program are just a few. We have expanded access to mental health counseling across components, although the need continues to grow.

Now military families expect these programs. They have become part of the overall fabric of family readiness. The challenge that now faces us is making sure that our family readiness programs receive sustained funding and continue to be included in the annual

[2] Military.Com More Troops' Kids Seeking Counseling Associated Press, July 8, 2009

budget process. As the war has progressed, family readiness requirements have evolved. Some new programs have been initiated without evaluating already existing programs to see how they might have been adapted.

The congressionally-mandated Military Family Readiness Council has begun an evaluation process. We endorse this process and hope that it will result in the elimination of repetitive or redundant programs. Existing programs can be improved, such as adding provisions for travel for family members participating in the Reserve-component Yellow Ribbon Program.

With budget cuts and shortfalls looming, we should not randomly reduce funding to family programs, across the board. As redundant programs are identified, their elimination can add to efficiencies. Servicemembers and their families cite MWR programs, like gyms, libraries, and other installation-provided services, as important to their well-being during deployments. Substantial cuts to these programs make them wonder why Services talk about support, yet often cut or reduce the same programs that are identified as the most important by our families.

One of the ways to evaluate the efficacy of programs is research. Our Association has spoken, for several years, concerning research into the effects of continuing deployments on our most vulnerable population: our military children. We appreciate the inclusion of a provision calling for a study in last year's NDAA. In May 2008, we commissioned the RAND Corporation to do a longitudinal study on the experience of 1,500 families. Over the course of a year, RAND interviewed both the nondeployed caregiver parent and one child per family between the ages of 11 and 17. We addressed two key questions: How are school-aged children faring? What types of issues do military children face, related to deployment?

The baseline findings were published in the January issue of the Journal of Pediatrics. The study found, as the months of parental deployment increased, so did the child's challenges. The total number of months away mattered more than the number of deployments. Older children experienced more difficulties during deployment, and there is a direct correlation between the mental health of the caregiver and the well-being of the child. It was interesting to note that in the initial findings, there were no differences in results between Service or components.

What are the implications? Families facing longer deployments need targeted support, especially for older teens and girls. Supports need to be in place across the entire deployment cycle, including reintegration, and some nondeployed parents may need targeted mental health support.

We still hear about needs for childcare. While most traditional childcare needs are being met, innovative strategies for after-hours care and respite care should be explored. These strategies need to be implemented across the Services, as well. Drop-in care for medical appointments, either at the Center for Disease Control or at the military treatment facility itself, can go a long way in improving access to care and eliminating missed appointments.

I, too, must bring up the MyCAA Program, with an underline and an exclamation point. Several years ago, Congress mandated DOD create a program to promote portable careers for military

spouses. The result was a very popular MyCAA program. Recent numbers indicate that 98,000 spouses already are enrolled in the program, an additional 38,000 have applied but have not yet completed the process. Unfortunately, DOD, as we have heard today, has recently had to suspend the program. We have heard, from many concerned military spouses using the MyCAA program, about the loss of funding for courses in which they were enrolled, and how they are scrambling to come up with the funds to continue, be it for an individual course that they are taking online or a semester.

But, I think what bothered them the most was the way the notification was handled. There was no advance notification, information was sent via a press release. This, when the program was in possession of everyone's email address. Many view this as one more frustration in 8 long years of frustrations.

The program may be a victim of its own success. We are unsure as to whether it was the lack of funds or an application overload, or both, that caused the suspension. We ask that the program be resumed as soon as possible, and that it be properly funded.

We thank you for your support of our servicemembers and their families. We urge you to remember their service as you work to resolve the many issues facing our country. Working together, we can improve the quality of life for all these families.

Thank you, and I await your questions.

[The prepared statement of Ms. Moakler follows:]

PREPARED STATEMENT BY KATHLEEN B. MOAKLER

Chairman Webb and distinguished members of the subcommittee, the National Military Family Association would like to thank you for the opportunity to present testimony on the quality of life of military families—the Nation's families. As the war has continued, the quality of life of our servicemembers and their families has been severely impacted. Your recognition of the sacrifices of these families and your response through legislation to the increased need for support have resulted in programs and policies that have helped sustain our families through these difficult times.

We endorse the recommendations contained in the statement submitted by The Military Coalition. In this statement, our Association will expand on several issues of importance to military families:

I. Family Readiness
II. Family Health
III. Family Transitions

I. FAMILY READINESS

The National Military Family Association believes policies and programs should provide a firm foundation for families buffeted by the uncertainties of deployment and transformation. It is imperative full funding for these programs be included in the regular budget process and not merely added on as part of supplemental funding. We promote programs that expand and grow to adapt to the changing needs of servicemembers and families as they cope with multiple deployments and react to separations, reintegration, and the situation of those returning with both visible and invisible wounds. Standardization in delivery, accessibility, and funding are essential. Programs should provide for families in all stages of deployment and reach out to them in all geographic locations. Families should be given the tools to take greater responsibility for their own readiness.

We appreciate provisions in the National Defense Authorization Acts and Appropriations legislation in the past several years that recognized many of these important issues. Excellent programs exist across the Department of Defense (DOD) and the Services to support our military families. There are redundancies in some areas, and times when a new program was initiated before looking to see if an existing program could be adapted to answer an evolving need. Servicemembers and their

families are continuously in the deployment cycle, anticipating the next separation, in the throes of deployment, or trying to reintegrate after the servicemember returns. Dwell times seem shorter and shorter as training, schools, and relocation impede on time that is spent in the family setting.

"My husband will have 3 months at home with us between deployment and being sent to school in January for 2 months and we will be PCSing soon afterwards. . . . This does not leave much time for reintegration and reconnection."—Army Spouse

We feel that now is the time to look at best practices and at those programs that are truly meeting the needs of families. In this section we will talk about existing programs, highlight best practices, and identify needs.

Child Care

At every military family conference we attended last year, child care was in the top five issues affecting families—drop-in care being the most requested need. Some installations are responding to these needs in innovative ways. For instance, in a recent visit to Kodiak, Alaska, we noted the gym facility provided watch care for its patrons. Mom worked out on the treadmill or elliptical while her child played in a safe carpeted and fenced-in area right across from her. Another area of the gym, previously an aerobics room, had been transformed into a large play area for "Mom and me" groups to play in the frequently inclement weather. These solutions aren't expensive but do require thinking outside the box.

Innovative strategies are needed to address the non-availability of after-hours child care (before 6 a.m. and after 6 p.m.) and respite care. We applaud the partnership between the Services and the National Association of Child Care Resource and Referral Agencies that provides subsidized child care to families who cannot access installation based child development centers. We also appreciate the new SitterCity.com contract that will help military families find caregivers and military subsidized child care providers.

Still, families often find it difficult to obtain affordable, quality care especially during hard-to-fill hours and on weekends. Both the Navy and the Air Force have programs that provide 24/7 care. These innovative programs must be expanded to provide care to more families at the same high standard as the Services' traditional child development programs. The Army, as part of the funding attached to its Army Family Covenant, has rolled out more space for respite care for families of deployed soldiers. Respite care is needed across the board for the families of the deployed and the wounded, ill, and injured. We are pleased the Services have rolled out more respite care for special needs families, but since the programs are new we are unsure of the impact it will have on families. We are concerned, however, when we hear of some installations already experiencing shortfalls of funding for respite care early in the year.

At our Operation Purple* Healing Adventures camp for families of the wounded, ill, and injured, families told us there is a tremendous need for access to adequate child care on or near military treatment facilities. Families need the availability of child care in order to attend medical appointments, especially mental health appointments. Our Association encourages the creation of drop-in child care for medical appointments on the DOD or VA premises or partnerships with other organizations to provide this valuable service.

We appreciate the requirement in the National Defense Authorization Act for Fiscal Year 2010 calling for a report on financial assistance provided for child care costs across the Services and components to support the families of those servicemembers deployed in support of a contingency operation and we look forward to the results.

Our Association urges Congress to ensure resources are available to meet the child care needs of military families to include hourly, drop-in, and increased respite care across all Services for families of deployed servicemembers and the wounded, ill, and injured, as well as those with special needs family members.

Working with Youth

Older children and teens must not be overlooked. School personnel need to be educated on issues affecting military students and must be sensitive to their needs. To achieve this goal, schools need tools. Parents need tools, too. Military parents constantly seek more resources to assist their children in coping with military life, especially the challenges and stress of frequent deployments. Parents tell us repeatedly they want resources to "help them help their children." Support for parents in their efforts to help children of all ages is increasing, but continues to be fragmented. New Federal, public-private initiatives, increased awareness, and support by DOD and civilian schools educating military children have been developed. How-

ever, many military parents are either not aware such programs exist or find the programs do not always meet their needs.

Our Association is working to meet this pressing need through our Operation Purple* Summer Camps. Unique in its ability to reach out and gather military children of different age groups, Services, and components, our Operation Purple program provides a safe and fun environment in which military children feel immediately supported and understood. Now in our seventh year, we have sent more than 30,000 children to camp for free with the support of private donors. This year, we expect to send another 10,000 children to camp at 67 locations in 34 States and Guam, and Germany. We also provided the camp experience to families of the wounded. In 2009, we introduced a new program under our Operation Purple umbrella, offering family reintegration retreats in the national parks. They have been well received by our families and more apply than can attend. We are offering 10 retreats this year.

Through our Operation Purple camps, our Association has begun to identify the cumulative effects multiple deployments are having on the emotional growth and well being of military children and the challenges posed to the relationship between deployed parent, caregiver, and children in this stressful environment. Understanding a need for qualitative analysis of this information, we commissioned the RAND Corporation to conduct a pilot study in 2007 aimed at the current functioning and wellness of military children attending Operation Purple camps and assessing the potential benefits of the Operation Purple program in this environment of multiple and extended deployments.

In May 2008, we embarked on phase two of the project—a longitudinal study on the experience of 1,507 families, which is a much larger and more diverse sample than included in our pilot study. RAND followed these families for 1 year, and interviewed the nondeployed caregiver/parent and one child per family between 11 and 17 years of age at three time points over the year. Recruitment of participants was extremely successful because families were eager to share their experiences. The research addressed two key questions:

How are school-age military children faring?

What types of issues do military children face related to deployment?

In December, the baseline findings of the research were published in the journal Pediatrics. Findings showed:

- As the months of parental deployment increased, so did the child's challenges.
- The total number of months away mattered more than the number of deployments.
- Older children experienced more difficulties during deployment.
- There is a direct correlation between the mental health of the caregiver and the well-being of the child.
- Girls experienced more difficulty during reintegration, the period of months readjusting after the servicemember's homecoming.
- About one-third of the children reported symptoms of anxiety, which is somewhat higher than the percentage reported in other national studies of children.
- In these initial findings, there were no differences in results between Services or components.

What are the implications? Families facing longer deployments need targeted support—especially for older teens and girls. Supports need to be in place across the entire deployment cycle, including reintegration, and some nondeployed parents may need targeted mental health support. One way to address these needs would be to create a safe, supportive environment for older youth and teens. Dedicated Youth Centers with activities for our older youth would go a long way to help with this. Our Association, as an outgrowth of the study results, will be holding a summit in early May, where we will be engaging with experts to isolate action items that address the issues surfaced in the study. We will be happy to share these action items with you.

Our Association feels that more dedicated resources, such as youth or teen centers, would be a first step toward addressing the needs of our older youth and teens during deployment.

Families Overseas

Families stationed overseas face increased challenges when their servicemember is deployed into theater. One such challenge we have heard from families stationed in EUCOM concerns care for a family member, usually the spouse, who may be injured or confined to bed for an extended illness during deployment. Instead of pull-

ing the servicemember back from theater, why not provide transportation for an extended family member or friend to come from the States to care for the injured or ill family member? This was a recommendation from the EUCOM Quality of Life conference for several years.

Our Association asks that transportation be provided for a designated caregiver to an overseas duty station to care for an incapacitated spouse when a servicemember is deployed.

Military Housing

In the recent RAND study of military children on the home front commissioned by our Association, researchers found that living in military housing was related to fewer caregiver reported deployment-related challenges. For instance, fewer caregivers who lived in military housing reported that their children had difficulties adjusting to parent absence (e.g., missing school activities, feeling sad, not having peers who understand what their life is like) as compared to caregivers who needed to rent their homes. In a subsequent survey, the study team explored the factors that determine a military family's housing situation in more detail. Among the list of potential reasons provided for the question, "Why did you choose to rent?" researchers found that the top three reasons parents/caregivers cited for renting included: military housing was not available (31 percent); renting was most affordable (28 percent), and preference to not invest in the purchase of a home (26 percent).

Privatized housing expands the opportunity for families to live on the installation and is a welcome change for military families. We are pleased with the annual report that addresses the best practices for executing privatized housing contracts. As privatized housing evolves the Services are responsible for executing contracts and overseeing the contractors on their installations. With more joint basing, more than one Service often occupies an installation. The Services must work together to create consistent policies not only within their Service but across the Services as well. Pet policies, deposit requirements, and utility polices are some examples of differences across installations and across Services. How will Commanders address these variances as we move to joint basing? Our families face many transitions when they move, and navigating the various policies and requirements of each contractor is frustrating and confusing. It's time for the Services to increase their oversight and work on creating seamless transitions by creating consistent policies across the Services.

We are pleased the NDAA for Fiscal Year 2010 calls for a report on housing standards and housing surveys used to determine the Basic Allowance for Housing (BAH) and hope Congress will work to address BAH inequities.

Privatized housing is working! We ask Congress to consider the importance of family well-being as a reason for expanding the amount of privatized housing for our military families.

Commissaries and Exchanges

The commissary is a vital part of the compensation package for servicemembers and retirees, and is valued by them, their families, and survivors. Our surveys indicate that military families consider the commissary one of their most important benefits. In addition to providing average savings of more than 30 percent over local supermarkets, commissaries provide a sense of community. Commissary shoppers gain an opportunity to connect with other military families, and are provided with information on installation programs and activities through bulletin boards and publications. Commissary shoppers also receive nutritional information through commissary promotions and campaigns, as well as the opportunity for educational scholarships.

Our Reserve component families have benefited greatly from the addition of case lot sales. We thank Congress again for the provision allowing the use of proceeds from surcharges collected at these sales to help defray their costs. Not only have these case lot sales been extremely well received and attended by family members not located near an installation, they have extended this important benefit to our entire military community.

Our Association continues to be concerned that there will not be enough commissaries to serve areas experiencing substantial growth, including those locations with servicemembers and families relocated by BRAC. The surcharge was never intended to pay for DOD and Service transformation. Additional funding is needed to ensure commissaries are built or expanded in areas that are gaining personnel as a result of these programs.

Our Association believes that additional funding is needed to ensure commissaries are built or expanded in areas that are gaining personnel due to BRAC and transformation.

The military exchange system, like the commissary, provides valuable cost savings to members of the military community, while reinvesting their profits in essential Morale, Welfare and Recreation (MWR) programs. Our Association strongly believes that every effort must be made to ensure that this important benefit and the MWR revenue is preserved, especially as facilities are down-sized or closed overseas. In addition, exchanges must continue to be responsive to the needs of deployed servicemembers in combat zones and have the right mix of goods at the right prices for the full range of beneficiaries.

As a member of the Defense Commissary Patron Council and a strong proponent of the military exchange system, our Association remains committed to protecting commissary and exchange benefits which are essential to the quality of life of our servicemembers, retirees, families and survivors.

Flexible Spending Accounts

We would like to thank Members of Congress for the Sense of Congress on the establishment of Flexible Spending Accounts for uniformed servicemembers. We hope this subcommittee will press each of the seven Service Secretaries to establish these important pre-tax savings accounts in a consistent manner. Flexible Spending Accounts would be especially helpful for families with out-of-pocket dependent care and health care expenses. We ask that the flexibility of a rollover or transfer of funds to the next year be considered.

Financial Readiness

Financial readiness is a critical component of family readiness. Our Association applauds DOD for tackling financial literacy head-on with their Financial Readiness Campaign. Financial literacy and education must continue to be on the forefront. We are strong supporters of the Military Lending Act (MLA) and hope Congress will press States to enforce MLA regulations within their State borders. With the depressed economy, many families may turn to payday lenders. DOD must continue to monitor the MLA and its effectiveness of derailing payday lenders.

Military families are not immune from the housing crisis. We applaud Congress for expanding the Homeowners' Assistance Program to wounded, ill, and injured servicemembers, survivors, and servicemembers with Permanent Change of Station orders meeting certain parameters. We have heard countless stories from families across the Nation who have orders to move and cannot sell their home. Due to the mobility of military life, military homeowners must be prepared to be a landlord. We encourage DOD to continue to provide financial education to military servicemembers and their families to help families make sound financial decisions. We also encourage DOD to continue to track the impact of the housing crisis on our military families.

We appreciate the increase to the Family Separation Allowance (FSA) that was made at the beginning of the war. In more than 8 years, however, there has not been another increase. We ask that the FSA be indexed to the Cost of Living Allowance (COLA) to better reflect rising costs for services.

Increase the Family Separation Allowance by indexing it to COLA.

II. FAMILY HEALTH

Family readiness calls for access to quality health care and mental health services. Families need to know the various elements of their military health system are coordinated and working as a synergistic system. Our Association is concerned the DOD military health care system may not have all the resources it needs to meet both the military medical readiness mission and provide access to health care for all beneficiaries. It must be funded sufficiently, so the direct care system of Military Treatment Facilities (MTFs) and the purchased care segment of civilian providers can work in tandem to meet the responsibilities given under the TRICARE contracts, meet readiness needs, and ensure access for all military beneficiaries.

Military Health System

Improving Access to Care

In the question and answer period during a hearing of this subcommittee on June 3, 2009, Senator Lindsey Graham (R–SC) asked panel members to "give a grade to TRICARE." Panel members rated TRICARE a "B" or a "C minus." Our Association's Director of Government Relations stated it was a two-part question and assigned a grade of "B" for quality of care and "C-" for access to care. We welcomed this discussion focused on access issues in the direct care system—our military hospitals and clinics—reinforcing what our Association has observed for years. We have consistently heard from families that their greatest health care challenge has been getting timely care from their local military hospital or clinic.

Our Association continues to examine military families' experiences with accessing the Military Health System (MHS). Families' main issues are: access to their Primary Care Managers (PCM); getting someone to answer the phone at central appointments; having appointments available when they finally got through to central appointments; after hours care; getting a referral for specialty care; being able to see the same provider or PCM; and having appointments available 60, 90, and 120 days out in our MTFs for follow-ups recommended by their providers. Families familiar with how the MHS referral system works seem better able to navigate the system. Those families who are unfamiliar report delays in receiving treatment or sometimes decide to give up on the referral process and never obtain a specialty appointment. Continuity of care is important to maintain quality of care. The MTFs are stressed from 8 years of provider deployments, directly affecting the quality of care and contributing to increased costs. Our Association thanks Congress for requiring, in the NDAA for Fiscal Year 2009, a report on access to care and we look forward to the findings. This report must distinguish between access issues in the MTFs, as opposed to access in the civilian TRICARE networks.

Our most seriously wounded, ill, and injured servicemembers, veterans, and their families are assigned case managers. In fact, there are many different case managers: Federal Recovery Coordinators (FRC), Recovery Care Coordinators, coordinators from each branch of Service, TBI care coordinators, VA liaisons, et cetera. The goal is for a seamless transition of care between and within the two governmental agencies, DOD and the VA. However, with so many coordinators to choose from, families often wonder which one is the "right" case manager. We often hear from families, some whose servicemember has long been medically retired with a 100 percent disability rating or others with less than 1 year from date-of-injury, who have not yet been assigned a FRC. We need to look at whether the multiple, layered case managers have streamlined the process, or have only aggravated it. Our Association still finds families trying to navigate alone a variety of complex health care systems, trying to find the right combination of care. Individual Service wounded, ill, and injured program directors and case managers are often reluctant to inform families that FRCs exist or that the family qualifies for one. Many qualify for and use Medicare, VA, DOD's TRICARE direct and purchased care, private health insurance, and State agencies. Why can't the process be streamlined?

Support for Special Needs Families

Case management for military beneficiaries with special needs is not consistent because the coordination of the military family's care is being done by a non-synergistic health care system. Beneficiaries try to obtain an appointment and then find themselves getting partial health care within the MTF, while other health care is referred out into the purchased care network. Thus, military families end up managing their own care. Incongruence in the case management process becomes more apparent when military family members transfer from one TRICARE region to another and is further exacerbated when a special needs family member is involved. Families need a seamless transition and a warm handoff between TRICARE regions and a universal case management process across the MHS. Each TRICARE Managed Care Contractor has created different case management processes. The current case management system is under review by DOD and the TRICARE Management Activity.

We applaud Congress and DOD's desire to create robust health care, educational, and family support services for special needs children. But, these robust services do not follow them when they retire. We encourage the Services to allow these military families the opportunity to have their final duty station be in an area of their choice. We suggest the Extended Care Health Option (ECHO) be extended for 1 year after retirement for those already enrolled in ECHO prior to retirement. If the ECHO program is extended, it must be for all who are eligible for the program. We should not create a different benefit simply based on diagnosis.

There has been discussion over the past years by Congress and military families regarding the ECHO program. The NDAA for Fiscal Year 2009 included a provision to increase the cap on certain benefits under the ECHO program and the NDAA for Fiscal Year 201O established the Office of Community Support for Military Families with Special Needs. The ECHO program was originally designed to allow military families with special needs to receive additional services to offset their lack of eligibility for State or federally provided services impacted by frequent moves. We suggest that before making any more adjustments to the ECHO program, Congress should direct DOD to certify if the ECHO program is working as it was originally designed and if it has been effective in addressing the needs of this population. We need to make the right fixes so we can be assured we apply the correct solutions. This new office will go a long way in identifying and addressing special needs. How-

ever, we must remember that our special needs families often require medical, educational and family support resources. This new office must address all these various needs in order to effectively implement change.

National Guard and Reserve Member Family Health Care

National Guard and Reserve families need increased education about their health care benefits. We also believe that paying a stipend to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan while the servicemember is deployed may work out better for many families in areas where the TRICARE network may not be robust.

Grey Area Reservists

Our Association would like to thank Congress for the new TRICARE benefit for Grey Area Reservists. We want to make sure this benefit is quickly implemented and they have access to a robust network.

TRICARE Reimbursement

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. As the 111th Congress takes up Medicare legislation, we request consideration of how this legislation will impact military families' health care, especially our most vulnerable service, access to mental health.

National provider shortages in the mental health field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographic challenges—for example large populations in rural or traditionally underserved areas. Many mental health providers are willing to see military beneficiaries on a voluntary status. However, these providers often tell us they will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. More must be done to persuade these providers to participate in TRICARE and become a resource for the entire system, even if that means DOD must raise reimbursement rates.

Pharmacy

We caution DOD about generalizing findings of certain beneficiary pharmacy behaviors and automatically applying them to our Nation's unique military population. We encourage Congress to require DOD to utilize peer-reviewed research involving beneficiaries and prescription drug benefit options, along with performing additional research involving military beneficiaries, before making any recommendations on prescription drug benefit changes, such as co-payment and tier structure changes for military servicemembers, retirees, their families, and survivors.

We appreciate the inclusion of Federal pricing for the TRICARE retail pharmacies in the NDAA for Fiscal Year 2008. However, we still need to examine its effect on the cost of medications for both beneficiaries and DOD. Also, we will need to see how this potentially impacts Medicare, civilian private insurance, and the National Health Care Reform affecting drug pricing negotiations.

We believe it is imperative that all medications available through TRICARE Retail Pharmacy (TRRx) should also be available through TRICARE Mail Order Pharmacy (TMOP). Medications treating chronic conditions, such as asthma, diabetes, and hypertension should be made available at the lowest level of co-payment regardless of brand or generic status. We agree with the recommendations of the Task Force on the Future of Military Health Care that over-the-counter (OTC) drugs be a covered pharmacy benefit and there be a zero co-pay for TMOP Tier 1 medications.

The new T3 TRICARE contract will provide TRICARE Managed Care Contractors and Express-Scripts, Inc. the ability to link pharmacy data with disease management. This will allow for better case management, increase compliance, and decrease cost, especially for our chronically ill beneficiaries. However, this valuable tool is currently unavailable because the T3 contract is still under protest and has not yet been awarded.

National Health Care Proposal

Our Association is cautious about current rhetoric by the administration and Congress regarding National Health Care Reform. We request consideration of how this legislation will also impact TRICARE.

The perfect storm is brewing. TMA will hopefully be instituting the new T3 contract in 2011. Currently, there is the possibility that two out of three TRICARE Managed Care Contractors could change. This means that the contracts of 66 percent of our TRICARE providers would need to be renegotiated. Add the demands

and uncertainties to providers in regards to health care reform and Medicare reimbursement rate changes. This leads to our concern regarding the impact on providers' willingness to remain in the TRICARE network and the recruitment of new providers. The unintended consequences maybe a decrease in access to care due the lack of available health care providers.

DOD Must Look for Savings

We ask Congress to establish better oversight for DOD's accountability in becoming more cost-efficient. We recommend:

- Requiring the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality health care in a cost-effective manner;
- Creating an oversight committee, similar in nature to the Medicare Payment Advisor Commission, which provides oversight to the Medicare program and makes annual recommendations to Congress. The Task Force on the Future of Military Health Care often stated it was unable to address certain issues not within their charter or the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.
- Establishing a Unified "Joint" Medical Command structure, which was recommended by the Defense Health Board in 2006 and 2009.

Our Association believes optimizing the capabilities of the facilities of the direct care system through timely replacement of facilities, increased funding allocations, and innovative staffing would allow more beneficiaries to be cared for in the MTFs, which DOD asserts is the most cost effective. The Task Force made recommendations to make the DOD MHS more cost-efficient which we support. They conclude the MHS must be appropriately sized, resourced, and stabilized; and make changes in its business and health care practices.

We suggest additional funding and flexibility in hiring practices to address MTF provider deployments.

Our Association recommends a 1 year transitional active duty ECHO benefit for all eligible family members of servicemembers who retire.

We believe that Reserve component families should be given the choice of a stipend to continue their employer provided care during deployment.

Behavioral Health Care

Our Nation must help returning servicemembers and their families cope with the aftermath of war. DOD, VA, and State agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs. Partnering will also capture the National Guard and Reserve member population, who often straddle these agencies' health care systems.

Full Spectrum of Care

As the war continues, families' need for a full spectrum of behavioral health services—from preventative care and stress reduction techniques, to counseling and medical mental health services—continues to grow. The military offers a variety of psychological health services, both preventative and treatment, across many agencies and programs. However, as servicemembers and families experience numerous lengthy and dangerous deployments, we believe the need for confidential, preventative psychological health services will continue to rise. It will remain high, even after military operations scale down. Our study on the impact of the war on caregivers and children found the mental health of the caregiver directly affects the overall well-being of the children. Therefore, we need to treat the family as a unit rather than as individuals because the caregiver's health determines the quality of life for the children.

Access to Behavioral Health Care

Our Association is concerned about the overall shortage of mental health providers in TRICARE's direct and purchased care network. DOD's Task Force on Mental Health stated timely access to the proper psychological health provider remains one of the greatest barriers to quality mental health services for servicemembers and their families. The Army Family Action Plan (AFAP) identified mental health issues as their number three issue for 2010. While families are pleased more mental health providers are available in theater to assist their servicemembers, they are disappointed with the resulting limited access to providers at home. Families are reporting increased difficulty in obtaining appointments with social workers, psychologists, and psychiatrists at their MTFs and clinics. The military fuels the shortage by deploying some of its child and adolescent psychology providers to combat

zones. Providers remaining at home report they are overwhelmed by treating active duty members and are unable to fit family members into their schedules. This can lead to provider compassion fatigue, creating burnout and exacerbating the provider shortage problem.

We have seen an increase in the number of mental health providers joining the purchased care side of the TRICARE network. However, the access standard is 7 days. We hear from military families after accessing the mental health provider lists on the contractors' web sites that the provider is full and no longer taking TRICARE patients. The list must be up-to-date in order to handle real time demands by families. We need to continue to recruit more mental health providers to join the TRICARE network and we need to make sure we specifically add those in specialty behavioral health care areas, such as child and adolescence psychology and psychiatrists.

Families must be included in mental health counseling and treatment programs for servicemembers. Family members are a key component to a servicemember's psychological well-being. Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. We recommend an extended outreach program to servicemembers, veterans, and their families of available mental health resources, such as DOD, VA, and State agencies. We appreciate the VA piloting programs that incorporate active duty servicemembers and their families into their newly established OIF/OEF health care clinics. The family is accessed as a "unit" and educated about the VA's benefits and services. These initiatives need to be expanded throughout the VA and fully funded.

Frequent and lengthy deployments create a sharp need in mental health services by family members and servicemembers as they get ready to deploy and after their return. There is also an increase in demand in the wake of natural disasters, such as hurricanes and fires. We need to maintain a flexible pool of mental health providers who can increase or decrease rapidly in numbers depending on demand on the MHS side. Currently, Military Family Life Consultants and Military OneSource counseling are providing this type of service for military families on the family support side. The recently introduced web-based TRICARE Assistance Program (TRIAP) offers another vehicle for nonmedical counseling, especially for those who live far from counselors. We need to make the Services, along with military family members, more aware of resources along the continuum. We need the flexibility of support in both the MHS and family support arenas, as well as coordination of support between these two entities. We must educate civilian network providers about our culture. Communities along with nongovernment organizations are beginning to fulfill this role, but more needs to be done.

Availability of Treatment

Do DOD, VA, and State agencies have adequate mental health providers, programs, outreach, and funding? Better yet, where will the veteran's spouse and children go for help? Many will be left alone to care for their loved one's invisible wounds resulting from frequent and long combat deployments. Who will care for them when they are no longer part of the DOD health care system?

The Army's Mental Health Advisory Team (MHAT) IV report links reducing family issues to reducing stress on deployed servicemembers. The team found the top noncombat stressors were deployment length and family separation. They noted soldiers serving a repeat deployment reported higher acute stress than those on their first deployment and the level of combat was the major contribution for their psychological health status upon return. Our study on the impact of deployment on caregivers and children found it was the cumulative time deployed that caused increased stress. These reports demonstrate the amount of stress being placed on our troops and their families.

Our Association is especially concerned with the scarcity of services available to the families as they leave the military following the end of their activation or enlistment. Due to the servicemember's separation, the families find themselves ineligible for TRICARE, Military OneSource, and are very rarely eligible for health care through the VA. Many will choose to locate in rural areas lacking available mental health providers. We need to address the distance issues families face in finding mental health resources and obtaining appropriate care. Isolated servicemembers, veterans, and their families do not have the benefit of the safety net of services and programs provided by MTFs, VA facilities, Community-Based Outpatient Centers and Vet Centers. We recommend:

- using alternative treatment methods, such as telemental health;
- modifying licensing requirements in order to remove geographic practice barriers that prevent psychological health providers from participating in telemental health services outside of a VA facility;

- educating civilian network psychological health providers about our military culture as the VA incorporates Project Hero; and
- encouraging DOD and VA to work together to provide a seamless "warm hand-off" for families, as well as servicemembers transitioning from active duty to veteran status and funding additional transitional support programs if necessary.

National Guard and Reserve Members

The National Military Family Association is especially concerned about fewer mental health care services available for the families of returning National Guard and Reserve members. Some are eligible for TRICARE Reserve Select but, as we know, National Guard and Reserve members are often located in rural areas where there may be fewer mental health providers available. Policymakers need to address the distance issues that families face in linking with military mental health resources and obtaining appropriate care. Isolated National Guard and Reserve families do not have the benefit of the safety net of services provided by MTFs and installation family support programs. Families want to be able to access care with a provider who understands or is sympathetic to the issues they face. We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture. We urge DOD to expand information outreach about the new TRIAP program, which provides access to non-medical counseling via phone and web through the TRICARE managed care support contractors. We hear the National Guard Bureau's Psychological Health Services (PHs) is not working as designed to address members' mental health issues. This program needs to be evaluated to determine its effectiveness.

Children

Our Association is concerned about the impact deployment and/or the injury of the servicemember is having on our most vulnerable population, children of our military servicemember and veterans. Our study on the impact of the war on caregivers and children found deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not "rock the boat." They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve members face unique challenges since there are no military installations for them to utilize. They find themselves "suddenly military" without resources to support them. School systems are generally unaware of this change in focus within these family units and are ill prepared to lookout for potential problems caused by these deployments or when an injury occurs. Also vulnerable are children who have disabilities that are further complicated by deployment and subsequent injury of the servicemembers. Their families find stress can be overwhelming, but are afraid to reach out for assistance for fear of retribution to the servicemember's career. They often choose not to seek care for themselves or their families. We appreciate the inclusion of a study on the mental health needs of our children in the NDAA for Fiscal Year 201O.

The impact of the wounded, ill, and injured on children is often overlooked and underestimated. Military children experience a metaphorical death of the parent they once knew and must make many adjustments as their parent recovers. Many families relocate to be near the treating MTF or the VA Polytrauma Center in order to make the rehabilitation process more successful. As the spouse focuses on the rehabilitation and recovery, older children take on new roles. They may become the caregivers for other siblings, as well as for the wounded parent. Many spouses send their children to stay with neighbors or extended family members, as they tend to their wounded, ill, and injured spouse. Children get shuffled from place to place until they can be reunited with their parents. Once reunited, they must adapt to the parent's new injury and living with the "new normal." We appreciate the inclusion of a study to assess the impact on children of the severely wounded in the NDAA for Fiscal Year 2010.

We encourage partnerships between government agencies, DOD, VA, and State agencies and recommend they reach out to those private and nongovernmental organizations who are experts on children and adolescents. They could identify and incorporate best practices in the prevention and treatment of mental health issues affecting our military children. We must remember to focus on preventative care upstream, while still in the active duty phase, in order to have a solid family unit as

they head into the veteran phase of their lives. School systems must become more involved in establishing and providing supportive services for our Nation's children.

Caregiver Burnout

In the eighth year of war, care for the caregivers must become a priority. There are several levels of caregivers. Our Association hears from the senior officer and enlisted spouses who are so often called upon to be the strength for others. We hear from the health care providers, educators, rear detachment staff, chaplains, and counselors who are working long hours to assist servicemembers and their families. They tell us they are overburdened, burnt out, and need time to recharge so they can continue to serve these families. These caregivers must be afforded respite care, given emotional support through their command structure, and be provided effective family programs.

Education

The DOD, VA, and State agencies must educate their health care and mental health professionals of the effects of mild Traumatic Brain Injury (mTBI) in order to help accurately diagnose and treat the servicemember's condition. They must be able to deal with polytrauma-Post-Traumatic Stress Disorder (PTSD) in combination with multiple physical injuries. We need more education for civilian health care providers on how to identify signs and symptoms of mild TBI and PTSD.

The families of servicemembers and veterans must be educated about the effects of TBI, PTSD, and suicide in order to help accurately diagnose and treat the servicemember/veteran's condition. These families are on the "sharp end of the spear" and are more likely to pick up on changes attributed to either condition and relay this information to their health care providers. Programs are being developed by each Service. However, they are narrow in focus targeting line leaders and health care providers, but not broad enough to capture our military family members and the communities they live in. As Services roll out suicide prevention programs, we need to include our families, communities, and support personnel.

Reintegration Programs

Reintegration programs become a key ingredient in the family's success. Our Association believes we need to focus on treating the whole family with programs offering readjustment information; education on identifying mental health, substance abuse, suicide, and traumatic brain injury; and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties. We appreciate the inclusion in the NDAA for Fiscal Year 2010 for education programs targeting pain management and substance abuse for our families.

Successful return and reunion programs will require attention over the long term, as well as a strong partnership at all levels between the various mental health arms of DOD, VA, and State agencies. DOD and VA need to provide family and individual counseling to address these unique issues. Opportunities for the entire family and for the couple to reconnect and bond must also be provided. Our Association has recognized this need and successfully piloted family retreats in the national parks promoting family reintegration following deployment.

We recommend an extended outreach program to servicemembers, veterans, and their families of available psychological health resources, such as DOD, VA, and State agencies.

We encourage Congress to request DOD to include families in its Psychological Health Support survey; perform a pre- and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for servicemembers).

We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.

Caregivers must be afforded respite care; given emotional support through their command structure; and, be provided effective family programs.

Wounded Servicemembers Have Wounded Families

Our Association asserts that behind every wounded servicemember and veteran is a wounded family. It is our belief the government, especially the DOD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded, ill, and injured servicemember must also consider the needs of the spouse, children, parents of single servicemembers and their siblings, and the caregivers. DOD and VA need to think proactively as a team

and one system, rather than separately; and addressing problems and implementing initiatives upstream while the servicemember is still on active duty status.

Reintegration programs become a key ingredient in the family's success. For the past 2 years, we have piloted our Operation Purple™HealingAdventures camp to help wounded servicemembers and their families learn to play again as a family. We hear from the families who participate in this camp, as well as others dealing with the recovery of their wounded servicemembers that, even with Congressional intervention and implementation of the Services' programs, many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the servicemember. They must learn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes we need to focus on treating the whole family with DOD and VA programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process. We must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

Brooke Army Medical Center (BAMC) has recognized a need to support these families by expanding in terms of guesthouses colocated within the hospital grounds and a family reintegration program for their Warrior Transition Unit. The on-base school system is also sensitive to issues surrounding these children. A warm, welcoming family support center located in guest housing serves as a sanctuary for family members. The DOD and VA could benefit from looking at successful programs like BAMCs, which has found a way to embrace the family unit during this difficult time.

The Vet Centers are an available resource for veterans' families providing adjustment, vocational, and family and marriage counseling. The VA health care facilities and the community-based outpatient clinics (CBOCs) have a ready supply of mental health providers, yet regulations have restricted their ability to provide mental health care to veterans' families unless they meet strict standards. Unfortunately, this provision hits the veteran's caregiver the hardest, especially if they are the parents. We recommend DOD partner with the VA to allow military families access to mental health services. We also believe Congress should require the VA, through its Vet Centers and health care facilities to develop a holistic approach to care by including families when providing mental health counseling and programs to the wounded, ill, and injured servicemember or veteran.

The Defense Health Board has recommended DOD include military families in its mental health studies. We agree. We encourage Congress to direct DOD to include families in its Psychological Health Support survey; perform a pre- and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for servicemembers). We appreciate the NDAA for Fiscal Year 2010 report on the impact of the war on families and the DOD's Millennium Cohort Study including families. Both will help us gain a better understanding of the long-term effects of war on our military families.

Transitioning for the Wounded and Their Families

Transitions can be especially problematic for wounded, ill, and injured servicemembers, veterans, and their families. The DOD and the VA health care systems, along with State agency involvement, should alleviate, not heighten these concerns. They should provide for coordination of care, starting when the family is notified that the servicemember has been wounded and ending with the DOD, VA, and State agencies working together, creating a seamless transition, as the wounded servicemember transfers between the two agencies' health care systems and, eventually, from active duty status to veteran status.

Transition of health care coverage for our wounded, ill, and injured and their family members is a concern of our Association. These servicemembers and families desperately need a health care bridge as they deal with the after effects of the injury and possible reduction in their family income. We have created two proposals. servicemembers who are medically retired and their families should be treated as active duty for TRICARE fee and eligibility purposes for 3 years following medical retirement. This proposal will allow the family not to pay premiums and be eligible for greater access to care at certain MTFs and for certain benefits offered to active duty families for 3 years. Following that period, they would pay TRICARE premiums at the rate for retirees. servicemembers medically discharged from service

and their family members should be allowed to continue for 1 year as active duty for TRICARE benefits and then move into the Continued Health Care Benefit Program (CHCBP) if needed.

Caregivers

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded servicemembers and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DOD and VA health care providers because they tend to the needs of the servicemembers and the veterans on a regular basis. Their daily involvement saves DOD, VA, and State agency health care dollars in the long run. Their long-term psychological care needs must be addressed. Caregivers of the severely wounded, ill, and injured servicemembers who are now veterans have a long road ahead of them. In order to perform their job well, they will require access to mental health services.

The VA has made a strong effort in supporting veterans' caregivers. The DOD should follow suit and expand their definition. We appreciate the inclusion in NDAA for Fiscal Year 2010 of compensation for servicemembers with assistance in everyday living. However, our Association believes this provision does not go far enough. In order to perform their job well, caregivers must be taught the skills to be successful.

Compensation of caregivers should be a priority for DOD and the Secretary of Homeland Security. Caregivers must be recognized for their sacrifices and the important role they play in maintaining the quality of life of our wounded servicemembers and veterans. Financial compensation must be established for caregivers of injured servicemembers and veterans that begin while the hospitalized servicemember is still on active duty and transitions seamlessly to a VA benefit. Current law creates a potential gap in compensation during transition from active duty to veteran status. Our Association proposes that compensation should reflect the types of medical and non-medical care services provided by the caregiver. The caregiver should be paid directly for their services. Non-medical care should be factored into a monthly stipend tied to severity of injury—cognitive and physical injury and illness-and care provided. In order to perform their job well, caregivers must be taught the skills to be successful. This will require the caregiver to be trained through a standardized, certified program. Compensation for medical care should be an hourly wage linked to training and certification of the caregiver paid for by the VA and transferrable to employment in the civilian sector if the care is no longer needed by the servicemember or veteran.

Consideration should also be given to creating innovative ways to meet the health care and insurance needs of the caregiver, with an option to include their family. Current proposed legislation does not include a "family" option. Additional services caregivers need are: respite care, such as 24 hour in-home care, mental health services, and travel and lodging expenses when accompanying servicemembers and veterans for medical care.

There must be a provision for transition benefits for the caregiver if the caregiver's services are no longer needed, chooses to no longer participate, or is asked by the veteran to no longer provide services. The caregiver should still be able to maintain health care coverage for 1 year. Compensation would discontinue following the end of services/care provided by the caregiver. Our Association looks forward to discussing details of implementing such a plan with members of this subcommittee.

The VA currently has eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. DOD should evaluate these pilot programs to determine whether to adopt them for caregivers of servicemembers still on active duty. Caregivers' responsibilities start while the servicemember is still on active duty.

Relocation Allowance and Housing

Active duty servicemembers and their spouses qualify through the DOD for military orders to move their household goods when they leave the military service. Medically retired servicemembers are given a final PCS move. Medically retired married servicemembers are allowed to move their family; however, medically retired single servicemembers only qualify for moving their own personal goods.

Our Association suggests that legislation be passed to allow medically retired single servicemembers the opportunity to have their caregiver's household goods moved as a part of the medical retired single servicemember's PCS move. This should be allowed for the qualified caregiver of the wounded servicemember and the caregiver's family (if warranted), such as a sibling who is married with children or mom

and dad. This would allow for the entire caregiver's family to move, not just the caregiver. The reason for the move is to allow the medically retired single servicemember the opportunity to relocate with their caregiver to an area offering the best medical care, rather than the current option that only allows for the medically retired single servicemember to move their belongings to where the caregiver currently resides. The current option may not be ideal because the area in which the caregiver lives may not be able to provide all the health care services required for treating and caring for the medically retired servicemember. Instead of trying to create the services in the area, a better solution may be to allow the medically retired servicemember, their caregiver, and the caregiver's family to relocate to an area where services already exist.

The decision on where to relocate for optimum care should be made with the Federal Recovery Coordinator (case manager), the servicemember's medical physician, the servicemember, and the caregiver. All aspects of care for the medically retired servicemember and their caregiver shall be considered. These include a holistic examination of the medically retired servicemember, the caregiver, and the caregiver's family for, but not limited to, their needs and opportunities for health care, employment, transportation, and education. The priority for the relocation should be where the best quality of services is readily available for the medically retired servicemember and higher caregiver.

The consideration for a temporary partial shipment of caregiver's household goods may also be allowed, if deemed necessary by the case management team.

Medical Power of Attorney

We have heard from caregivers of the difficult decisions they have to make over their loved one's bedside following an injury. We support the Traumatic Brain Injury Task Force recommendation for DOD to require each deploying servicemember to execute a Medical Power of Attorney and a Living Will.

Provide medically-retired wounded, ill, and injured servicemembers and their families a bridge of extended active duty TRICARE e1igibility for 3 years, comparable to the benefit for surviving spouses.

Servicemembers medically discharged from Service and their family members should be allowed to continue for 1 year as active duty for TRICARE and then start the Continued Health Care Benefit Program (CHCBP) if needed.

Caregivers of the wounded, ill, and injured must be provided with opportunities for training, compensation and other support programs because of the important role they play in the successful rehabilitation and care of the servicemember.

The National Military Family Association is requesting the ability for medically retired single servicemembers to be allowed the opportunity to have their caregiver's household goods moved as a part of the medically retired single servicemember's PCS move.

DOD should require each deploying servicemember to execute a Medical Power of Attorney and a Living Will.

Senior Oversiqht Committee

Our Association is appreciative of the provision in the NDAA for Fiscal Year 2010 establishing a DOD Task Force on the Care, Management, and Transition of Recovery, Wounded, Ill, and Injured Members of the Armed Forces to access policies and programs. We understand the Office of Wounded Warrior Care and Transition Policy (WWCTP), a permanent structure for the Senior Oversight Committee, is in the process of being established and manned. This Task Force will be independent and in a position to monitor DOD and VA's partnership initiatives for our wounded, ill, and injured servicemembers and their families, while this organization is being created.

The National Military Family Association encourages all committees with jurisdiction over military personnel and veterans matters to talk on these important issues. We can no longer continue to create policies in a vacuum and be content on focusing on each agency separately because this population moves too frequently between the two agencies, especially our wounded, ill, and injured servicemembers and their families.

We would like to thank you again for the opportunity to provide information on the health care needs for the servicemembers, veterans, and their families. Military families support the Nation's military missions. The least their country can do is make sure servicemembers, veterans, and their families have consistent access to high quality mental health care in the DOD, VA, and within network civilian health care systems. Wounded servicemembers and veterans have wounded families. The caregiver must be supported by providing access to quality health care and mental health services, and assistance in navigating the health care systems. The system

should provide coordination of care with DOD, VA, and State agencies working together to create a seamless transition. We ask Congress to assist in meeting that responsibility.

III. FAMILY TRANSITIONS

Survivors

In the past year, the Services have increased their outreach to surviving families. In particular, the Army's Survivor Outreach Services (SOS) program makes an effort to remind these families that they are not forgotten. DOD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need, through all of VA's venues. New legislative language governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement or grief counseling. The goal is the right care at the right time for optimum treatment effect. DOD and the VA need to better coordinate their mental health services for survivors and their children.

We thank Congress for extending the TRICARE active duty family dental insurance benefit to surviving children. The current TRICARE Management Activity policy directive allows for the surviving children of Reserve component servicemembers who had not previously been enrolled to be eligible for the expanded benefit. We ask that eligibility be expanded to those active duty family members who had not been enrolled in the active duty TRICARE dental insurance program prior to the servicemember's death.

Our Association recommends that eligibility be expanded to active duty survivors who had not been enrolled in the TRICARE Dental Program prior to the servicemember's death. We also recommend that grief counseling be more readily available to survivors.

Our Association still believes the benefit change that will provide the most significant long-term advantage to the financial security of all surviving families would be to end the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP). Ending this offset would correct an inequity that has existed for many years. Each payment serves a different purpose. The DIC is a special indemnity (compensation or insurance) payment paid by the VA to the survivor when the servicemember's service causes his or her death. The SBP annuity, paid by DOD, reflects the longevity of the service of the military member. It is ordinarily calculated at 55 percent of retired pay. Military retirees who elect SBP pay a portion of their retired pay to ensure that their family has a guaranteed income should the retiree die. If that retiree dies due to a service-connected disability, their survivor becomes eligible for DIC.

Surviving active duty spouses can make several choices, dependent upon their circumstances and the ages of their children. Because SBP is offset by the DIC payment, the spouse may choose to waive this benefit and select the "child only" option. In this scenario, the spouse would receive the DIC payment and the children would receive the full SBP amount until each child turns 18 (23 if in college), as well as the individual child DIC until each child turns 18 (23 if in college). Once the children have left the house, this choice currently leaves the spouse with an annual income of $13,848, a significant drop in income from what the family had been earning while the servicemember was alive and on active duty. The percentage of loss is even greater for survivors whose servicemembers served longer. Those who give their lives for their country deserve more fair compensation for their surviving spouses.

We believe several other adjustments could be made to the SBP. Allowing payment of the SBP benefits into a Special Needs Trust in cases of disabled beneficiaries will preserve their eligibility for income based support programs. The government should be able to switch SBP payments to children if a surviving spouse is convicted of complicity in the member's death.

We believe there needs to be DIC equity with other Federal survivor benefits. Currently, DIC is set at $1,154 monthly (43 percent of the Disabled Retirees Compensation). Survivors of Federal workers have their annuity set at 55 percent of their Disabled Retirees Compensation. Military survivors should receive 55 percent of VA Disability Compensation. We are pleased that the requirement for a report to assess the adequacy of DIC payments was included in the NDAA for Fiscal Year 2009. We are awaiting the overdue report. We support raising DIC payments to 55 percent of VA Disability Compensation. When changes are made, ensure that DIC eligibles under the old system receive an equivalent increase.

We ask the DIC offset to SBP be eliminated to recognize the length of commitment and service of the career servicemember and spouse. We also request that SBP benefits may be paid to a Special Needs Trust in cases of disabled family members.

We ask that DIC be increased to 55 percent of VA Disability Compensation.

Education of Military Children

The National Military Family Association would like to thank Congress for including a "Sense of Congress" in regards to the Interstate Compact on Educational Opportunity for Military Children in last year's National Defense Authorization Act. The Compact has now been adopted in 27 States and covers over 80 percent of our military children. The Interstate Commission, the governing body of the Compact, is working to educate military families, educators, and States on the appropriate usage of the Compact. The adoption of the Compact is a tremendous victory for military families who place a high value on education.

However, military families define the quality of that education differently than most States or districts that look only at issues within their boundaries. For military families, it is not enough for children to be doing well in their current schools, they must also be prepared for the next location. The same is true for children in under performing school systems. Families are concerned that they will lag behind students in the next location. With many States cutting educational programs due to the economic downturn, this concern is growing. A prime example is Hawaii, which opted to furlough teachers on Fridays, cutting 17 days from the school calendar. With elementary schools already on a shortened schedule for Wednesday, these students are only getting 3½ days of instruction a week. In addition, the recent cuts have made it increasingly hard for schools to meet IEP requirements for special needs students. Furthermore, Hawaii is requiring parents to pay more for busing, and the cost of school meals have gone up 76 percent. Our Association believes that Hawaii's cuts are just the "tip of the iceberg" as we are beginning to see other States make tough choices as well. Although Hawaii's educational system has long been a concern for military families, many of whom opt for expensive private education, Hawaii is not the only place where parents have concerns. The National Military Family Association believes that our military children deserve to have a good quality education wherever they may live. However, our Association recognizes that how we provide that quality education may differ in each location.

We urge Congress to encourage solutions for the current educational situation in Hawaii and recognize that servicemembers' lack of confidence that their children may receive a quality education in an assignment location can affect the readiness of the force in that location.

While our Association remains appreciative for the additional funding Congress provides to civilian school districts educating military children, Impact Aid continues to be underfunded. We urge Congress to provide appropriate and timely funding of Impact Aid through the Department of Education. In addition, we urge Congress to increase DOD Impact Aid funding for schools educating large numbers of military children to $60 million for fiscal year 2011. We also ask Congress to include an additional $5 million in funding for special needs children. The DOD supplement to Impact Aid is critically important to ensure school districts provide quality education for our military children.

As increased numbers of military families move into new communities due to Global Rebasing and BRAC, their housing needs are being met further and further away from the installation. Thus, military children may be attending school in districts whose familiarity with the military lifestyle may be limited. Educating large numbers of military children will put an added burden on schools already hard-pressed to meet the needs of their current populations. We urge Congress to authorize an increase in this level of funding until BRAC and Global Rebasing moves are completed.

Once again, we thank Congress for passing the Higher Education Opportunity Act of 2008, which contained many new provisions affecting military families. Chief among them was a provision to expand in-State tuition eligibility for military servicemembers and their families, and provide continuity of in-State rates if the servicemember receives Permanent Change of Station (PCS) orders out of State. However, family members have to be currently enrolled in order to be eligible for continuity of in-State tuition. Our Association is concerned that this would preclude a senior in high school from receiving in-State tuition rates if his or her family PCS's prior to matriculation. We urge Congress to amend this provision.

We ask Congress to increase the DOD supplement to Impact Aid to $60 million to help districts better meet the additional demands caused by large numbers of military children, deployment-related issues, and the effects of military programs and policies. We also ask Congress provide $5 million for school districts with Special Needs children.

Support for Military Voters

The National Military Family Association would like to thank Congress for passing the Military and Overseas Voter Empowerment (MOVE) Act which was included in the National Defense Authorization Act for Fiscal Year 2010. As a member of the Alliance for Military and Overseas Voting Rights (AMOVR), our Association worked hard to pass this important legislation which resolves many of the absentee voting issues for our military servicemembers and their families. The passage of the MOVE ACT was a tremendous victory for our military community whose very service helps protect the right to vote.

Spouse Education and Employment

Our Association wishes to thank Congress for recent enhancement to spouse education opportunities. In-State tuition, Post-September 11 G.I. bill transferability to spouses and children, and other initiatives have provided spouses with more educational opportunities than previous years.

Since 2004, our Association has been fortunate to sponsor our Joanne Holbrook Patton Military Spouse Scholarship Program, with the generosity of donors who wish to help military families. Our 2010 application period closed on January 31, 2010. We saw a 33 percent increase in applications from previous years with more than 8,000 military spouses applying to our program. Military spouses remain committed to their education and need assistance from Congress to fulfill their educational pursuits.

We have heard from many military spouses who are pleased with the expansion of the Military Spouse Career Advancement Accounts, now called MyCAA. Unfortunately the abrupt halt of the program on February 16, 2010 has created a financial burden and undue stress for military spouses. Spouses who have established accounts and those who planned to set-up accounts in the future have been barred for accessing funds. The MyCAA system only permitted users to request financial assistance 30 days prior to a class start date. Many, who had planned on the funding, will not receive it, if they didn't have a start date entered into the system by February 16. We ask Congress to push DOD to restart this critical program and find a way to assist spouses who have been abruptly cut-off from receiving funding. We also ask Congress to fully fund the MyCAA program, which is providing essential educational and career support to military spouses. The MyCAA program is not available to all military spouses. We ask Congress to work with the appropriate Service Secretary to expand this funding to the spouses of Coast Guard, the Commissioned Corps of NOAA and U.S. Public Health Service.

Our Association thanks you for establishing a pilot program to secure internships for military spouses with Federal agencies. Military spouse are anxious for the program to launch and look forward to enhanced career opportunities through the pilot program. We hope Congress will monitor the implementation of the program to ensure spouses are able to access the program and eligible spouses are able to find Federal employment after successful completion of the internship program.

To further spouse employment opportunities, we recommend an expansion to the Workforce Opportunity Tax Credit for employers who hire spouses of active duty and Reserve component servicemembers, and to provide tax credits to military spouses to offset the expense in obtaining career licenses and certifications when servicemembers are relocated to a new duty station within a different State.

The Services are experiencing a shortage of medical, mental health and child care providers. Many of our spouses are trained in these professions or would like to seek training in these professions. We think the Services have an opportunity to create portable career opportunities for spouses seeking in-demand professions. In addition to the MyCAA funding, what can the Services do to encourage spouse employment and solve provider shortages? We would like to see the Services reach out to military spouses and offer affordable, flexible training programs in high demand professions to help alleviate provider shortages.

Our Association urges Congress to recognize the value of military spouses by fully funding the MyCAA program, and by creating training programs and employment opportunities for military spouses in high demand professions to help fill our provider shortages.

Military Families—Our Nation's Families

We thank you for your support of our servicemembers and their families and we urge you to remember their service as you work to resolve the many issues facing our country. Military families are our Nation's families. They serve with pride, honor, and quiet dedication. Since the beginning of the war, government agencies, concerned citizens and private organizations have stepped in to help. This increased support has made a difference for many servicemembers and families, yet, some of

these efforts overlap while others are ineffective. In our testimony, we believe we have identified improvements and additions that can be made to already successful programs while introducing policy or legislative changes that address the ever-changing needs of our military families. Working together, we can improve the quality of life for all these families.

Senator WEBB. Thank you very much.

Mr. Cline.

STATEMENT OF MASTER SERGEANT MICHAEL CLINE, USA (RET.), EXECUTIVE DIRECTOR, ENLISTED ASSOCIATION OF THE NATIONAL GUARD OF THE UNITED STATES

Mr. CLINE. Mr. Chairman, we thank you, on behalf of the Enlisted Association of the National Guard of the United States and the Military Coalition, for holding these hearings.

Mr. Chairman, over 142,000 National Guard and Reserve servicemembers are serving on Active Duty. Since September 11, 2001, more than 752,000 of our citizens, soldiers, airmen, sailors, marines, Guard and Reserve servicemembers, have been called up, including well over 200,000 who have served multiple tours.

With your permission, Mr. Chairman, I'd like to cut out the fluff and just get to the point of the needs of our Guard and Reserve people and their families.

The next step in modernizing the Reserve retirement system is to provide equal retirement age reduction credit for all activated service rendered since September 11, 2001. The current law that credits only active service since January 28, 2008, disenfranchises and devalues the service of hundreds of thousands of Guard and Reserve members who have served combat tours, many with multiple combat tours, between 2001 and 2008.

The statute also must be amended to eliminate the inequity inherent in the current fiscal year retirement calculation, which only credits 90 days of active service for early retirement purposes if it occurs within the same fiscal year. The current rule significantly penalizes members who deploy in July or August, versus those deploying earlier in the fiscal year. It is potently unfair, as the current law requires giving 3 months retirement-age credit for 90-day tours served from January through March, but only half credit for 120-day tours served from August through November, because the latter covers 60 days in each of the 2 fiscal years.

Mr. Chairman, we fully understand the budgetary problems facing our country, but we're also aware that more than $700 billion was given to banks, financial institutions, automakers; $3 billion for Cash for Clunkers was spent, in 3 weeks, that did nothing more than reduce the inventory of autodealers; the American people, many of which are the very veterans who have been passed by, are looking at a trillion-dollar healthcare bill. If CBO figures are accurate, it will cost $2.1 billion over 10 years, or just about $21 million a year, to provide retroactivity for early retirement for those who have protected our freedom. It's the right thing to do to honor the unselfish heroes and their families who have given up so much to protect us and our way of life.

For the near term, we place particular priority on authorizing early retirement credit for all qualifying post-September 11 Active Duty service performed by Guard and Reserve members, and eliminating the fiscal-year-specific accumulator that bars equal credit

for members deploying for equal periods during different months of the year. Ultimately, we believe we must move forward to provide a reduced-age entitlement for retired pay and health coverage for all Reserve component members that is an age-service formula or outright eligibility, if otherwise qualified, at age 55.

Further, we urge repeal of the annual cap of 130 days of inactive duty points that may be credited towards a Reserve retirement.

Yellow Ribbon. We urge the subcommittee to hold oversight hearings and to direct additional improvements in coordination and collaboration and consistency of Yellow Ribbon services. DOD must ensure that State-level best practices, such as those in Maryland, Minnesota, and New Hampshire, are applied for all operational Reserve Force members and their families, and that Federal Reserve veterans have equal access to services and support available to National Guard veterans. Community groups, employers, and Service organizations' efforts need to be encouraged and better coordinated to supplement unit, component, Service, and VA outreach and service.

We are grateful to you, in Congress, for inclusion of a critical "earn as you serve" principle, in the post-September 11 GI Bill, which allows operational reservists to accumulate additional benefits for each aggregate call-up of 90 days or more on Active Duty. However, Active Duty members of the National Guard serving under Title 32 orders were not included in the new program, despite their critical role in homeland defense, counterdrug, border control, and other missions. We urge this subcommittee to work with the Veterans Affairs Committee to include Title 32 AGRs in the post-September 11 statute.

The Military Coalition's longstanding recommendation of coordinating and integrating various educational benefit programs has been made more challenging with the post-September 11 GI Bill. For example, benefits for initially joining the Guard and Reserve, as authorized under Chapter 1606 of title 10, continue to decline in proportion to the Active Duty Montgomery GI Bill, Chapter 30, title 38, in the new post-September 11 GI Bill. Reserve MGIB benefit levels have slipped to 24 percent of the Active Duty MGIB benefit, compared to 47 to 50 percent during the first 15 years of the program. Restoration of the original ratio would raise basic Reserve rates from the current $333 a month to $643 to $684 a month for full-time duty. TMC maintains that restoring the ratio is not only a matter of equity, but essential to long-time success of the Guard and Reserve recruiting program.

Continuing healthcare insurance options for the Guard and Reserve. The Coalition is very grateful for the passage of TRICARE for gray-area retirees; however, we're very disappointed that it's going to take DOD 18 months to implement the new program. As we have sent letters to you, we ask that you intervene with DOD to speed this program up. It's a benefit——

Senator GRAHAM. Absolutely.

Mr. CLINE.—that is needed.

Senator GRAHAM. Absolutely.

Mr. CLINE. When we look at the TRICARE Reserve Select Program, a disturbing fact is that only 6 to 7 percent of our eligible beneficiaries are taking advantage of the TRICARE Reserve Select

Program. DOD and the Services and the Reserve components must do more to advertise the TRS program.

The Coalition also believes that Congress is missing an opportunity to reduce long-term healthcare costs and increase beneficiary satisfaction by authorizing eligible members the option of electing a DOD subsidy of their civilian insurance during periods of activation. Current law already authorizes payment of up to 24 months of FEHBP premiums for activated members who are civilian employees of the Defense Department. Over the long term, the Guard and Reserve activations can be expected at a reduced pace. This option would offer considerable savings opportunities, relative to DOD permanent, year-round TRICARE.

We recommend to the subcommittee—require a GAO review of DOD's methodology for determining TRS costs for premium adjustment purposes to assess whether it includes any costs of maintaining readiness or "costs of doing business" for DOD that don't contribute to beneficiary benefit values, and thus excluded from cost premium calculations.

Mr. Chairman, I look forward to any questions that you or Senator Graham may have.

Senator WEBB. Thank you very much.

Ms. Holleman.

STATEMENT OF DEIRDRE PARKE HOLLEMAN, EXECUTIVE DIRECTOR, THE RETIRED ENLISTED ASSOCIATION

Ms. HOLLEMAN. Good morning. Mr. Chairman——

Senator WEBB. Good afternoon, actually. [Laughter.]

Ms. HOLLEMAN. Good afternoon.

Senator GRAHAM. My stomach says it's afternoon.

Ms. HOLLEMAN. Life goes quickly, right?

It is an honor to speak to you today about the Military Coalition's legislative goals concerning military retirees and military survivors. I know you will not be surprised that TMC is urging you to, once and for all, end the unfair offset of military retired pay by VA disability pay.

We are grateful for the great strides that have been made in ending this practice, which we all now acknowledge is terribly unfair. But, there are two groups of valiant retirees who are not getting the relief that you ordered for the others. One group is those longevity retirees with VA disabilities of 10 to 40 percent. The other group is those servicemembers who were forced to medically retire with less than 20 years, due to an injury or medical condition that is not deemed combat-related under the Combat Related Special Compensation program. Even in these tough economic times, simple fairness should call for the end of the offset for all. But, even more dramatically, the President, for the second year, has proposed, in his budget, to end the offset for medical retirees. To have the administration propose a change that, in the past, was the goal of only you, in Congress, is a historic opportunity. We strongly urge you to join the President in this laudable goal and end the offset for medical retirees now.

It is also clearly time to finally end the Survivor Benefit Plan (SBP)/Dependency and Indemnity Compensation (DIC) offset. SBP is an employee benefit, while DIC is an indemnity program for sur-

vivors of those who died because of their service in the military. The present practice of taking a dollar from a survivor's SBP payment for every dollar paid by the VA's DIC program is unfair and illogical. Legislation to end this offset is pending in both Houses of Congress. Now that Senator Bill Nelson's S. 535 has 55 cosponsors, and Representative Ortiz's H.R. 811 has 319 cosponsors, it is clear that a majority of the Members of Congress agree that this offset should end. It should end now, while our servicemembers are fighting in two wars and at risk throughout the world.

While these two issues are of great and continuing concern to all of the members of the Coalition, there are several additional matters that we believe are critically important. We urge you to support Senator Blanche Lincoln's soon-to-be-introduced legislation that will be a companion bill to Representative Walter Jones's H.R. 613. Their Military Retirees Survivor Comfort Acts would authorize the retention of the full month's retired pay of the last month of a retiree's life by his or her surviving spouse. Presently, DFAS removed the month's retired pay from the retiree account, calculates how much is owed by how many days the retiree lived in the month that he or she died in, and then returns the prorated share to the survivor. This method can cause confusion and even bounce checks during a tremendously tense and sorrowful time. Senator Lincoln's bill would stop this, and treat military retiree survivors the same way as disabled veteran survivors are treated concerning the disability payments.

The Uniformed Services Former Spouse Protection Act desperately needs improvement. While some organizations want dramatic fundamental changes, and other groups adamantly do not, it truly is time that we had a hearing on this rather explosive issue. There are already several improvements that DOD has supported, for years, that could be made during this session. These changes include basing the amount awarded in a divorce on the grade and years of service at the time of the divorce, rather than at the time of retirement, and prohibiting the inclusion of imputed income in a divorce property award, which often forces Active Duty members into retirement. A full list of our suggestions can be found in our written testimony.

Finally, we urge that DFAS be allowed to make SBP payments into a Special Needs Trust. Presently, they may only pay SBP to a person. This means that a permanently disabled survivor cannot make use of this State-created legal device that allows a disabled person to protect their eligibility for SSI, Medicaid, and State means-tested programs. With the help of supporters like you, Chairman Webb, we hope that this change will be made. It would only affect a few people, but for those survivors, this small change would be an enormous help.

Thank you for your time, and may I have the honor to introduce Colonel Strobridge.

Senator WEBB. Thank you very much for your testimony.

Colonel Strobridge.

STATEMENT OF STEVEN P. STROBRIDGE, USAF (RET.), DIRECTOR OF GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

Colonel STROBRIDGE. Mr. Chairman, Senator Graham, my testimony is going to focus on healthcare and Wounded Warrior issues.

The primary issue for all beneficiaries is access. The primary threat to access continues to be the perpetual threat of major cuts in Medicare and TRICARE payments to doctors. We fully realize that's beyond the authority of this subcommittee, but it is the number-one healthcare issue among our beneficiaries.

On national healthcare reform, the principal issues for our members in the coalition are ensuring protection of military-unique health benefits, including TRICARE For Life, and protection of uniformed services beneficiaries from taxation on the value of those benefits.

On TRICARE fees, we're grateful that the administration has not proposed any increases for fiscal year 2011, however, without congressional action, the TRICARE standard outpatient deductible will be increased administratively by more than $110 per day as of October 1. Last October, the subcommittee acted, during conference action on the National Defense Authorization Act, to stop that change. We urge you to put a provision in law, capping the outpatient deductible at the current $535 per day, which the coalition believes is plenty high enough and should not be increased for the foreseeable future.

We also ask you to put a "Sense of Congress" provision in the National Defense Authorization Act, as the Senate approved last year, highlighting the importance of military health benefits in offsetting the adverse conditions of service and recognizing that military people pay large upfront premiums through decades of service and sacrifice, over and above their cash fees.

On Wounded Warriors, we're concerned that the change of the administration has left many senior positions vacant for more than a year, and that close joint oversight previously provided by top leaders has been delegated and diffused back along agency-centric lines. The coalition is particularly concerned that the diminution of the Senior Oversight Committee, or SOC, has weakened day-to-day oversight of, and priority on, joint agency operations and management. We urge revitalization of the SOC, or a similar joint agency staffed with senior officials with full-time primary oversight responsibility for seamless transition initiatives.

Similarly, the transition from Active Duty to retiree care or to VA coverage still catches many wounded warriors and their families unaware. They need the same protections that we provide when someone dies on Active Duty: 3 years of continued Active Duty-level coverage to ensure a smooth transition to the next phase of their life.

We appreciate the subcommittee's efforts last year to provide caregiver benefits on a par with what's provided by the VA. The Veterans Affairs Committees are now finalizing significant upgrades for caregivers, and we hope you'll act to reestablish comparability of DOD programs once that happens.

Regarding psychological health, PTSD, and TBI, we know the subcommittee and DOD and the Services are pursuing a wide

range of initiatives to enhance access to care and counseling, and to remove the stigma from seeking care. Unfortunately, some facets of the military environment continue to undermine those efforts. In that regard, many who suffer after-effects of combat continue being barred from reenlistment, or separated for other reasons, because service disciplinary and administrative systems are much less flexible and resilient than we're asking military people to be. We hope the subcommittee will continue its efforts to protect returnees from these lower profile, but still devastating, secondary effects of war.

Mr. Chairman, that concludes my remarks.

[The prepared statement of The Military Coalition follows:]

PREPARED STATEMENT BY THE MILITARY COALITION

Mr. Chairman and distinguished members of the subcommittee. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning issues affecting the uniformed services community. This testimony provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the 7 uniformed services, plus their families and survivors.

Air Force Association
Air Force Sergeants Association
Air Force Women Officers Associated
American Logistics Association
AMVETS (American Veterans)
Army Aviation Association of America
Association of Military Surgeons of the United States
Association of the United States Army
Association of the United States Navy
Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
Commissioned Officers Association of the U.S. Public Health Service, Inc.
Enlisted Association of the National Guard of the United States
Fleet Reserve Association
Gold Star Wives of America, Inc.
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the United States of America
Marine Corps League
Marine Corps Reserve Association
Military Chaplains Association of the United States of America
Military Officers Association of America
Military Order of the Purple Heart
National Association for Uniformed Services
National Guard Association of the United States
National Military Family Association
National Order of Battlefield Commissions
Naval Enlisted Reserve Association
Noncommissioned Officers Association
Reserve Enlisted Association
Reserve Officers Association
Society of Medical Consultants to the Armed Forces
The Retired Enlisted Association
United States Army Warrant Officers Association
United States Coast Guard Chief Petty Officers Association
Veterans of Foreign Wars of the United States

The Military Coalition, Inc., does not receive any grants or contracts from the Federal Government.

EXECUTIVE SUMMARY

Wounded Warrior Care

Institutional Oversight

The Coalition believes there's no substitute for a permanent Department of Defense (DOD)-Department of Veterans Affairs (VA) Senior Oversight Committee or other Joint Seamless Transition Office, staffed with senior officials working together

full-time and charged with innovation and daily oversight of initiatives to institutionalize and sustain a culture of cross-department seamless transition.

Continuity of Health Care

The Coalition recommends:

- Authorizing active-duty level TRICARE benefits, independent of availability of VA care, for 3 years after medical retirement to help ease transition from DOD to VA;
- Authorizing blanket waiver authority for VA physicians treating active duty patients with multiple medical trauma conditions for all aspects of the member's treatment, including referral outside the VA/TRICARE system if needed; and
- Either exempting severely wounded, ill, or injured members who must be medically retired from paying Medicare Part B premiums until age 65 or authorizing a special DOD allowance to help offset the cost of such premiums until age 65.

Mental/Behavioral Health Issues

TMC recommends:

- Increased efforts to promote the destigmatization on all levels in service/unit administrative and strict accountability programs with outlined and enforced consequences to non-compliancy to ensure unit actions are consistent with leadership pronouncements;
- Continuing priority efforts to deliver information and assistance on-line, confidential options for counseling and uniformed access and availability to telemedicine services;
- Substantial increases in outreach efforts to provide such services and resources to Guard and Reserve members, rural populations and all families who don't live near military or VA facilities;
- Priority efforts to educate private sector providers on the unique needs of military and veteran patients and family members, and deliver needed information via on-line services, including contact points for discussion/consultation with military and VA providers;
- Consistent implementation of pre- and post-deployment evaluations and follow-up programs, particularly for Guard and Reserve members who may be leaving active duty;
- Establishing common DOD and VA protocols for diagnosis, treatment, and rehabilitation for Traumatic Brain Injury (TBI) conditions, as well as an electronic system to share and exchange a patient's medical history and other key medical information;
- Expanding Traumatic Servicemember Group Life Insurance (TSGLI) criteria to include moderate and severe TBI, without onerous "functions of daily living" standards that aren't required for other (and often much more functional) TSGLI-eligibles;
- Increasing availability and outreach on substance abuse counseling options;
- Pursuing aggressive medication reconciliation and management programs to protect against inadvertent over medication and adverse reactions and or accidental or intentional overdose;
- Requiring TBI and psychological health assessments for members who have been deployed to a combat zone as part of the disciplinary process prior to a decision concerning nonmedical separation; and
- Implementing recommendations from the 2008 RAND report ("Invisible Wounds of War Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery").

DOD–VA Disability Evaluation Systems (DES)

TMC recommends:

- Barring "fit, but unsuitable" separations when a member's medical condition prevents continued service;
- Authorizing automatic enrollment in the VA health care system for any medically separated or medically retired servicemember (Chapter 61);
- Ending distinctions between disabilities incurred in combat vice non-combat;
- Monitoring the effectiveness of recent DOD compensation for catastrophically injured or ill servicemembers requiring assistance with activities of daily living authorized in the 2010 NDAA;

• Ensuring benefits afforded members wounded, ill, or disabled in the line of duty are applied equally for all uniformed services;
• Ensuring that the VA is the single authority for rating service-connected disabilities for military disability retirements and separations;
• Preserving the statutory 30 percent disability threshold for medical retirement and lifetime TRICARE coverage for members injured while on active duty;
• Continued monitoring of Service/DOD Medical-Physical Evaluation Boards, DOD DES Pilot Project, and the Physical Disability Board of Review, to assess needed DES changes;
• Eliminating member premiums for TSGLI;
• Barring "pre-existing condition" determinations for any member who deploys to a combat zone;
• Ensuring that any adjustment to the disability retirement system does not result in a member receiving less disability retired pay than he or she would receive under the current system; and
• Ensuring that members electing accelerated disability retirement/separation are fully counseled on any possible negative changes in compensation, health care and other benefits, with consideration to allowing a limited time to reverse a regrettable decision.

Caregiver/Family Support Services

The Coalition recommends:

• Upgraded compensation and assistance for caregivers of severely disabled active duty members, consistent with pending legislative action to improve compensation/assistance for caregivers of veterans; and
• Authorizing up to 1 year of continued residence in on-base housing facilities for medically retired, severely wounded servicemembers and their families.

Active Forces and Their Families

Military End Strength

The Coalition urges the subcommittee to:

• Continue end strength growth as needed to sustain the war and other operational commitments while materially increasing dwell time for servicemembers and families;
• Sustain adequate recruiting and retention resources to enable the uniformed services to achieve required optimum-quality personnel strength; and
• Seek a 2011 defense budget of at least 5 percent of Gross Domestic Product that funds both people and weapons needs.

Military Pay Comparability

The Coalition believes a basic pay raise of at least 1.9 percent—.5 percent above the Employment Cost Index (ECI) standard—is the bare minimum the Nation should do to sustain its military pay comparability commitment for 2011.

Family Readiness and Support

The Coalition recommends that the subcommittee:

• Press DOD to assess the effectiveness of programs and support mechanisms to assist military families with deployment readiness, responsiveness, and reintegration;
• Ensure that effective programs—including the Family Readiness Council—are fully funded and their costs are included in the annual budget process;
• Provide authorization and funding to accelerate increases in availability of child care to meet both Active and Reserve component requirements;
• Insist DOD implement flexible spending accounts to let active duty and Selected Reserve families pay out-of-pocket dependent and health care expenses with pre-tax dollars;
• Monitor and continue to expand family access to mental health counseling;
• Promote expansion of military spouse opportunities to further educational and career goals;
• Ensure additional and timely funding of Impact Aid plus continued DOD supplemental funding for highly-impacted military schools; and

- Mitigate the impact of Service transformation, overseas rebasing initiatives, housing privatization and base realignment on school facility needs and educational programs affecting military children.

Permanent Change of Station (PCS) Allowances

The Coalition urges the subcommittee to continue its efforts to upgrade permanent change-of-station allowances to better reflect expenses imposed on servicemembers, with priority on:

- Shipping a second vehicle on overseas accompanied assignments;
- Authorizing at least some reimbursement for house-hunting trip expenses; and
- Increasing PCS mileage rates to more accurately reflect members' actual transportation costs.

Education Enhancements

The Coalition urges the subcommittee to support amending the statute to authorize all otherwise-qualifying members of the "uniformed services" to transfer Post-September 11 GI Bill benefits to family members.

Morale, Welfare, and Recreation (MWR) and Quality of Life (QoL) Programs

TMC urges the subcommittee to:

- Protect funding for critical family support and QoL programs and services to meet the emerging needs of beneficiaries and the timelines of the Services' transformation plans;
- Oppose any initiative to withhold or reduce appropriated support for family support and QoL programs to include: recreation facilities, child care, exchanges and commissaries, housing, health care, education, family centers, and other traditional and innovative support services;
- Prevent any attempts to consolidate or civilianize military service exchange and commissary programs; and
- Sustain funding for support services and infrastructure at both closing and gaining installations throughout the entire transformation process, including exchange, commissary, and TRICARE programs.

National Guard and Reserve

Operational Reserve Sustainment and Reserve Retirement

For the near term, the Military Coalition places particular priority on authorizing early retirement credit for all qualifying post-September 11 active duty service performed by Guard/Reserve servicemembers and eliminating the fiscal-year-specific accumulator that bars equal credit for members deploying for equal periods during different months of the year.

Ultimately, TMC believes we must move forward to provide a reduced age entitlement for retired pay and health coverage for all Reserve component members—that is, an age/service formula or outright eligibility, if otherwise qualified, at age 55.

Further, TMC urges repeal of the annual cap of 130 days of inactive duty training points that may be credited towards a reserve retirement.

Guard and Reserve Yellow Ribbon Readjustment

TMC urges the subcommittee to hold oversight hearings and to direct additional improvements in coordination, collaboration, and consistency of Yellow Ribbon services. DOD must ensure that State-level best practices—such as those in Maryland, Minnesota, and New Hampshire—are applied for all Operational Reserve Force members and their families, and that Federal Reserve veterans have equal access to services and support available to National Guard veterans. Community groups, employers and service organization efforts need to be encouraged and better coordinated to supplement unit, component, Service and VA outreach and services.

Guard/Reserve GI Bill

TMC urges the subcommittee to work with the Veterans Affairs Committee to include Title 32 AGRs in the Post-September 11 statute.

Based on the DOD/Services' 10-year record of indifference to the basic Selected Reserve GI Bill under Chapter 1606, 10 U.S.C., TMC recommends either: restoring Reserve benefits to 47–50 percent of active duty benefits or transferring the chapter 1606 statute from title 10 to title 38 so that it can be coordinated with other educational benefits programs in a 21st century GI Bill architecture. TMC also supports assured academic reinstatement, including guaranteed re-enrollment, for returning operational reservists.

Special and Incentive Pays

The Coalition urges the subcommittee to ensure equitable treatment of Guard and Reserve vs. active duty members for the full range of special and incentive pays.

Retiree Issues

Concurrent Receipt

The Coalition's continuing goal is to fully eliminate the deduction of VA disability compensation from earned military retired pay for all disabled retirees. In pursuit of that goal, the Coalition's immediate priorities include:

- Phasing out the disability offset for all Chapter 61 (medical) retirees; and
- Correcting the Combat-Related Special Compensation (CRSC) formula to ensure the intended compensation is delivered.

Proposed Military Retirement Changes

TMC urges the subcommittee to:

- Reject any initiatives to "civilianize" the military system without adequate consideration of the unique and extraordinary demands and sacrifices inherent in a military vs. a civilian career; and
- Eliminate the Career Status Bonus for servicemembers as it significantly devalues their retirement over time. In the short term, the Services should be required to better educate eligible members on the severe long-term financial penalty inherent in accepting the REDUX option.

Disability Severance Pay

The Coalition urges the subcommittee to amend the eligibility rules for disability severance pay to include all combat—or operations—related injuries, using same definition as CRSC. For the longer term, the Coalition believes the offset should be ended for all members separated for service-caused disabilities.

Former Spouse Issues

The Coalition requests a hearing to address Uniformed Services Former Spouse Protection Act (USFSPA) inequities. In addition, we recommend legislation to include all of the following:

- Base the award amount to the former spouse on the grade and years of service of the member at time of divorce (and not retirement);
- Prohibit the award of imputed income, which effectively forces active duty members into retirement;
- Extend 20/20/20 benefits to 20/20/15 former spouses;
- Permit the designation of multiple Survivor Benefit Plan (SBP) beneficiaries with the presumption that SBP benefits must be proportionate to the allocation of retired pay;
- Eliminate the "10-year Rule" for the direct payment of retired pay allocations by the Defense Finance and Accounting Service (DFAS);
- Permit SBP premiums to be withheld from the former spouse's share of retired pay if directed by court order;
- Permit a former spouse to waive SBP coverage;
- Repeal the 1-year deemed election requirement for SBP; and
- Assist DOD and Services with greater outreach and expanded awareness to members and former spouses of their rights, responsibilities, and benefits upon divorce.

Survivor Issues

SBP–DIC Offset

The Coalition urges repeal of the SBP–DIC offset. TMC further recommends:

- Authorizing payment of SBP annuities for disabled survivors into a Special Needs Trust;
- Allowing SBP eligibility to switch to children if a surviving spouse is convicted of complicity in the member's death; and
- Reinstating SBP for survivors who previously transferred payments to their children at such time as the youngest child attains majority, or upon termination of a second or subsequent marriage.

Final Retired Paycheck

TMC urges the subcommittee to authorize survivors of retired members to retain the final month's retired pay for the month in which the retiree dies.

Health Care Issues

Defense Health Program Cost Requirements

The Coalition urges the subcommittee to take all possible steps to ensure continued full funding for Defense Health Program needs.

National Health Reform

TMC urges that any national health reform legislation must:

- Protect the unique TRICARE, TRICARE For Life (TFL), and VA health care benefits from unintended consequences such as reduced access to care;
- Bar any form of taxation of TRICARE, TFL, or VA health care benefits, including those provided in nongovernmental venues; and
- Preserve military and VA beneficiaries' choices.

TRICARE Fees

Establish a "Sense of Congress" which recognizes that military retiree health benefits are an essential offset to arduous service conditions which have been paid for upfront.

Military vs. Civilian Cost-Sharing Measurement

The Coalition believes that military beneficiaries from whom America has demanded decades of extraordinary service and sacrifice have earned coverage that is the best America has to offer.

Large Retiree Fee Increases Can Only Hurt Retention

Reducing military retirement benefits would be particularly ill-advised when an overstressed force already is at increasing retention risk despite the current downturn of the economy and current recruiting successes.

Pharmacy

The Coalition urges the subcommittee to ensure continued availability of a broad range of medications, including the most-prescribed medications, in the TRICARE pharmacy system, and to ensure that the first focus on cost containment should be on initiatives that encourage beneficiaries to take needed medications and reduce program costs without shifting costs to beneficiaries.

Alternative Options to Make TRICARE More Cost-Efficient

The Coalition has offered a long list of alternative cost-saving possibilities, including:

- Positive incentives to encourage beneficiaries to seek care in the most appropriate and cost effective venue;
- Encouraging improved collaboration between the direct and purchased care systems and implementing best business practices and effective quality clinical models;
- Focusing the military health system, health care providers, and beneficiaries on quality measured outcomes;
- Improving MHS financial controls and avoiding overseas fraud by establishing TRICARE networks in areas fraught with fraud;
- Establishing TRICARE networks in areas of high TRICARE Standard utilization to take full advantage of network discounts;
- Promoting retention of other health insurance by making TRICARE a true second-payer to other insurance (far cheaper to pay another insurance's co-pay than have the beneficiary migrate to TRICARE);
- Encouraging DOD to effectively utilize their data from their electronic health record to better monitor beneficiary utilization patterns to design programs which truly match beneficiaries needs;
- Sizing and staffing military treatment facilities to reduce reliance on network providers and develop effective staffing models which support enrolled capacities;
- Reducing long-term TRICARE Reserve Select (TRS) costs by allowing servicemembers the option of a government subsidy of civilian employer premiums during periods of mobilization;
- Doing far more to promote use of mail-order pharmacy system and formulary medications via mailings to users of maintenance medications, highlighting the convenience and individual expected cost savings; and
- Encouraging retirees to use lowest-cost-venue military pharmacies at no charge, rather than discouraging such use by limiting formularies, curtailing courier initiatives, etc.

TMC Healthcare Cost Principles

The Coalition strongly recommends that Congress establish statutory findings, a sense of Congress on the purpose and principles of military health care benefits earned by a career of uniformed service that states:

- Active duty members and families should be charged no fees except retail pharmacy co-payments, except to the extent they make the choice to participate in TRICARE Standard or use out-of-network providers under TRICARE Prime;
- The TRICARE Standard inpatient copay should not be increased further for the foreseeable future. At $535 per day, it already far exceeds inpatient copays for virtually any private sector health plan;
- There should be no enrollment fee for TRICARE Standard or TFL, since neither offers assured access to TRICARE-participating providers. An enrollment fee implies enrollees will receive additional services, as Prime enrollees are guaranteed access to participating providers in return for their fee. Congress already has required TFL beneficiaries to pay substantial Medicare Part B fees to gain TFL coverage;
- All retired servicemembers earned equal health care coverage by virtue of their service; and
- DOD should make all efforts to provide the most efficient use of allocated resources and cut waste prior to proposing additional or increased fees on eligible beneficiaries.

TRICARE Prime

The Military Coalition urges the subcommittee to require reports from DOD and from the managed care support contractors, on actions being taken to improve Prime patient satisfaction provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.

TRICARE Standard

TRICARE Standard Provider Participation

The Coalition urges the subcommittee to insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation. The Coalition also recommends requiring a specific report on participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.

TRICARE Reimbursement Rates

The Coalition places primary importance on securing a permanent fix to the flawed statutory formula for setting Medicare and TRICARE payments to doctors.

To the extent a Medicare rate freeze continues, we urge the subcommittee to encourage DOD to use its reimbursement rate adjustment authority as needed to sustain provider acceptance.

The Coalition urges the subcommittee to require a Comptroller General report on the relative propensity of physicians to participate in Medicare vs. TRICARE, and the likely effect on such relative participation of a further freeze in Medicare/TRICARE physician payments along with the effect of an absence of bonus payments.

Dental Care

Active Duty Dependent Dental Plan

The Coalition recommends increasing the DOD subsidy for the Active Duty Dependent Dental Plan to 72 percent and increasing the cap on orthodontia payments to $2,000.

Guard and Reserve Healthcare

Continuum of Health Care Insurance Options for The Guard and Reserve

The Coalition recommends the subcommittee:

- Require a GAO review of DOD's methodology for determining TRS costs for premium adjustment purposes to assess whether it includes any costs of maintaining readiness or "costs of doing business" for the Defense Department that don't contribute to beneficiary benefit value and thus should be excluded from cost/premium calculations;
- Authorize development of a cost-effective option to have DOD subsidize premiums for continuation of a Reserve employer's private family health in-

surance during periods of deployment as an alternative to ongoing TRS coverage;

• Allow eligibility in Continued Health Care Benefits Program (CHCBP) for Selected reservists who are voluntarily separating and subject to disenrollment from TRS;

• Authorize members of the IRR who qualify for a Reserve retirement at age 60 to participate in TRICARE Retired Reserve (TRR) as an incentive for continued service (and higher liability for recall to active duty);

• Monitor implementation of the new TRR authority to ensure timely action and that premiums do not exceed 100 percent of the TRS premium; and

• Allow FEHB plan beneficiaries who are selected reservists the option of participating in TRS.

Guard and Reserve Mental Health

TMC believes that Guard and Reserve members and their families should have access to evidence-based treatment for PTSD, TBI, depression, and other combat-related stress conditions. Further, Post Deployment Health examinations should be offered at the member's home station, with the member retained on active duty orders until completion of the exam.

Guard and Reserve Health Information

The Coalition believes there should be an effort to improve the electronic capture of non-military health information into the servicemember's medical record.

TRICARE For Life

Coalition priorities for TFL-eligibles include:

• Securing a permanent fix to the flawed formula for setting Medicare/TRICARE payments to providers;

• Resisting any effort to establish an enrollment fee for TFL, given that many beneficiaries already experience difficulties finding providers who will accept Medicare patients; and

• Including TFL beneficiaries in DOD programs to incentivize compliance with preventive care and healthy lifestyles.

Restoration of Survivors' TRICARE Coverage

The Coalition recommends restoration of TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

Base Realignment and Closure (BRAC) and Rebasing

The Coalition recommends requiring an annual DOD report on the adequacy of health resources, funding, services, quality and access to care for beneficiaries affected by BRAC/rebasing.

OVERVIEW

Mr. Chairman, The Military Coalition extends our thanks to you and the entire subcommittee for your steadfast support of our Active Duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors. Your efforts have had a dramatic, positive impact in the lives of the entire uniformed services community.

Last year was an extremely tumultuous, difficult year. As our servicemembers continued to fight terror on two separate fronts, our Nation slowly started to recover from an economic crisis, the worst seen since the great depression. Congress and the administration had difficult choices to make as they attempted to "jump start" the economy while faced with a record budget deficit.

We are grateful that both the Defense Department and Congress put top priority on personnel issues last year. As we enter the ninth year of extremely stressful wartime conditions, the Coalition believes that this prioritization should continue for fiscal year 2011.

Despite ever-increasing pressures on them at home and abroad, men and women in uniform are still answering the call—thanks in no small measure to the subcommittee's strong and consistent support—but only at the cost of ever-greater sacrifices.

Troubling indicators such as dramatic increases in suicide and divorce rates may reflect the effects of the long-term consequences we know are coming as we require the same people to return to combat again and again and yet again.

In these times of growing political and economic pressures, the Coalition relies on the continued good judgment of the Armed Services Committees to ensure the Na-

tion allocates the required resources to sustain a strong national defense, and in particular, to properly meet the pressing needs of the less than 1 percent of the American population—servicemembers and their families—who protect the freedoms of the remaining 99 percent.

In this testimony, The Coalition offers our collective recommendations on what needs to be done to meet these essential needs.

WOUNDED WARRIOR CARE

Much has been done in the last 3 years to address the grievous and negligent conditions that were brought to light since the tragic incident at Walter Reed Army Medical Center, where wounded and disabled troops and their families had fallen through the cracks as they transitioned from the military to VA health care and benefits systems.

Subsequently, the subcommittee has worked hard to address these difficulties, and significant progress has been made on that score.

But the extent and complexity of the challenges remain daunting, requiring continuing coordination of effort between the military services; the Department of Defense (DOD); the Department of Veterans Affairs (VA); several Centers of Excellence; a multitude of civilian contractors and nongovernmental agencies; and the two Armed Services, two Veterans Affairs, and two Appropriations Committees.

The Coalition looks forward to working with the subcommittee this year in its ongoing efforts to identify and ease significant remaining problems.

DOD–VA Seamless Transition

Institutional Oversight

While many legislative and fiscal changes have improved the care and support of our wounded and disabled members, the Coalition is concerned that the recent dissolution of the Senior Oversight Committee (SOC) poses significant risks for effective day-to-day leadership and coordination of DOD and VA seamless transition efforts.

Last year, the Coalition expressed concern that the change of administration would pose a significant challenge to the two departments' continuity of joint effort, as senior leaders whose personal involvement had put interdepartmental efforts back on track left their positions and were replaced by new appointees who had no experience with past problems and no personal stake in ongoing initiatives.

Unfortunately, those concerns are being realized, as many appointive positions in both departments have gone unfilled for a year, responsibilities have been reorganized, and oversight duties previously assumed by senior officials have been divested to lower-level administrators who are less regularly engaged with their cross-department counterparts.

The result has been more uncertainty and degradation of cooperation, communication, and collaboration between the two departments over the last year.

The Coalition is concerned that, having exerted major efforts to address the most egregious problems, there is a significant potential to fall victim to a "business as usual" operating mode, even though the difficult journey to true seamless transition between the departments has just begun.

While many well-meaning and hard working military and civilians are doing their best to keep pushing progress forward, transitions in leadership and mission changes clearly are challenging and require formal and more standardized structures, policies, and programs that won't be as subject to disruption by one participant's unilateral organizational changes.

It sends a message about departmental priorities when these responsibilities are pushed to lower-level officials.

The Coalition believes there's no substitute for a permanent DOD–VA Senior Oversight Committee or other Joint Seamless Transition Office, staffed with senior officials working together full-time and charged with innovation and daily oversight of initiatives to institutionalize and sustain a culture of cross-department seamless transition.

Continuity of Health Care

Transitioning between DOD and VA health care systems remains challenging, confusing, and overwhelming to those trying to navigate and use these systems. Systemic, cultural, and bureaucratic barriers often prevent the servicemember or veteran from receiving the necessary continuity of care they need to heal and have productive and a high level of quality of life they so desperately need and desire.

While servicemembers and their families tell us that DOD has done much to address trauma care, acute rehabilitation, and basic short-term rehabilitation, they

are less satisfied with their transition from the military health care systems to longer-term care and support in military and veterans medical systems.

We hear regularly from members who experienced significant disruptions of care upon separation or medical retirement from service.

One is in the area of cognitive therapy, which is available to retired members under TRICARE only if it is not available through the VA. Unfortunately, members are caught in the middle because of differences between DOD and VA authorities on what constitutes cognitive therapy and the degree to which effective, evidenced-based therapy is available.

The NDAA for Fiscal Year 2010 requires a report on such issues, but action is needed to protect the wounded and disabled. The subcommittee has acted previously to authorize 3 years of active-duty-level TRICARE coverage for the family members of those who die on active duty. The Coalition believes we owe equal transition care continuity to those whose service-caused illnesses or injuries force their retirement from service.

Another significant issue faced by many members forced from active duty by severe service-caused disabilities is that the severity of their disability qualifies them for Medicare. In such cases, TRICARE is second-payer to Medicare.

Under laws that were designed for elderly retirees but apply equally to all Medicare-eligible military beneficiaries, these younger disabled warriors must pay Medicare Part B premiums ($110 per month in 2010) to retain any coverage under TRICARE.

The Coalition believes it's wrong that members whose service caused them to become severely wounded, ill or injured should have to pay more for their care than they would if not injured by service, and believes they should either be exempt from paying the Part B premium until age 65 or DOD should help them offset the cost of such payments.

Finally, doctors at VA polytrauma centers indicate that one of their biggest problems is the requirement to get multiple authorizations from DOD to provide a variety of specialty care for active duty members with multiple medical problems.

When an active duty member is referred to VA facility for care, DOD should grant an automatic waiver of preauthorization/referral requirements to allow the VA providers to deliver needed care without bureaucratic delays.

The Coalition recommends:

- Authorizing active-duty-level TRICARE benefits, independent of availability of VA care, for 3 years after medical retirement to help ease transition from DOD to VA;
- Authorizing blanket waiver authority for VA physicians treating active duty patients with multiple medical trauma conditions for all aspects of the member's treatment, including referral outside the VA/TRICARE system if needed; and
- Either exempting severely wounded, ill, or injured members who must be medically retired from paying Medicare Part B premiums until age 65 or authorizing a special DOD allowance to help offset the cost of such premiums until age 65.

Mental/Behavioral Health Issues

The military community is experiencing a crisis of demand for mental/behavior health care, both for servicemembers and their spouses and children.

The subcommittee included several initiatives in the NDAA for Fiscal Year 2010 aimed at increasing the number of military providers in this field and improving access for members and families.

While the Coalition is very grateful for these initiatives, we respectfully request that the subcommittee continue, and more importantly expand, its efforts in addressing the growing epidemic of difficulties regarding post-traumatic stress disorder (PTSD), traumatic brain injuries (TBI), depression, and other mental/behavioral health issues disproportionally plaguing our military and veteran communities.

Today our servicemembers, their spouses and children are facing immense stresses and uncertainties associated with repeated deployments and protracted separations. Our country is at war on multiple fronts and we must take all the necessary actions to ensure the mental well being of all those involved, at home and those on the frontlines.

One of the most prevalent obstacles in successfully identifying and treating mental/behavioral health conditions is the stigma which the military's warrior culture continues to associate with such conditions and the threat or fear that admission of experiencing them may affect one's peer standing, security clearance, promotions, or ability to remain in service.

Despite the continued efforts by senior leaders to reduce the stigmas associated with mental health issues, the unit-level reality is far different. The reality is that many officers, NCOs, and peers continue to view these conditions as signs of weakness or inability to coup.

Furthermore, many servicemembers are deterred from seeking care by cases of friends who have been disciplined or separated as a result of using the available support systems the military has implemented.

As a direct result, the suicide and divorce rates, as well as childhood depression diagnosis' continue to climb within the military and veteran communities. DOD openly acknowledges that stigmas remain within the ranks, despite their efforts of significantly ramping up efforts and outreach programs composed of anti-stigma campaigns, upper-level training programs, and easier access to mental health providers.

The Coalition stresses our grave concerns to the subcommittee regarding the current state of DOD's inability to effectively handle the increasing demands/need for mental health services and outreach to all demographics of today's military forces. While our forces and their families display extraordinary strengths, resiliency and undaunted tenacity in the face of all stresses associated with service; it is vital that we never forget that these same stressors of service to this country are in all likelihood, leading to untreated mental and physical health conditions.

The Coalition believes that due to the numerous unrealistic standards and high expectations of resiliency and coping abilities we have somehow come to expect from our servicemembers and their families, that the current military administrative and disciplinary systems being used are not effectively meeting the mental health needs, whether proactive or reactive, of the same people to whom we expect so much. DOD and VA have an obligation to provide the best care available to any servicemember who sustains an injury as a result of their service.

Unfortunately, many of today's servicemembers have mental wounds that are undiagnosed and thus untreated. This lack of care or treatment for PTSD, TBI, or any one of the numerous stressors associated with service, is leading to an increased number of early separations or even more alarming, being barred from reenlisting due to a charge of misconduct, such as a driving under the influence (DUI) or other such incident, by a servicemember who has never previously displayed any such behaviors. These uncharacteristic behaviors are only one of the symptoms associated with untreated mental/behavioral health conditions. Ironically, some civil authorities often are more tolerant and offer more assistance in dealing with such cases involving combat veterans than military authorities.

As a result of such circumstances, thousands, if not countless, of affected servicemembers, veterans and their family members have gone unidentified, untreated, or deterred from being given the opportunity to seek the care they deserve. Moreover, many have difficulty accessing and utilizing programs that are in place.

In addition to expanding the availability of providers, the Coalition believes that two key elements will be in expanding the opportunities for confidential access to counseling or treatments and achieving more consistency between leadership campaigns for destigmatization/individual resiliency and the practical demonstration of greater resiliency and rehabilitation initiatives at the unit/administrative level.

TMC recommends:

- Increased efforts to promote the de-stigmatization on all levels in service/unit administrative and strict accountability programs with outlined and enforced consequences to non-compliancy to ensure unit actions are consistent with leadership pronouncements;
- Continuing priority efforts to deliver information and assistance on-line, confidential options for counseling and uniformed access and availability to telemedicine services;
- Substantial increases in outreach efforts to provide such services and resources to Guard and Reserve members, rural populations and all families who don't live near military or VA facilities;
- Priority efforts to educate private sector providers on the unique needs of military and veteran patients and family members, and deliver needed information via on-line services, including contact points for discussion/consultation with military and VA providers;
- Consistent implementation of pre-and post-deployment evaluations and follow-up programs, particularly for Guard and Reserve members who may be leaving active duty;
- Establishing common DOD and VA protocols for diagnosis, treatment, and rehabilitation for TBI conditions, as well as an electronic system to share and exchange a patient's medical history and other key medical information;

- Expanding Traumatic Servicemember Group Life Insurance (TSGLI) criteria to include moderate and severe TBI, without onerous "functions of daily living" standards that aren't required for other (and often much more functional) TSGLI-eligibles;
- Increasing availability and outreach on substance abuse counseling options;
- Pursuing aggressive medication reconciliation and management programs to protect against inadvertent over medication and adverse reactions and/or accidental or intentional overdose;
- Requiring TBI and psychological health assessments for members who have been deployed to a combat zone as part of the disciplinary process prior to a decision concerning non-medical separation; and
- Implementing recommendations from the 2008 RAND report ("Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery").

DOD–VA Disability Evaluation Systems (DES)

Several recommendations made by various commissions, task forces and committees were addressed in the National Defense Authorization Acts for Fiscal Year 2008, 2009, and 2010; however, more needs to be done.

One of the most emotional issues that emerged from the Walter Reed scandal was the finding that Services were "low-balling" disabled servicemembers' disability ratings, with the result that many significantly disabled members were being separated and turned over to the VA rather than being medically retired (which requires a 30 percent or higher disability rating).

Encouraging rhetoric was heard from leadership in both the DOD and VA that this would be addressed by having DOD accept the (usually higher) disability ratings awarded by the VA.

Congress has taken positive steps to correct previous "low-ball" ratings and streamline the DES. Congress created the Physical Disability Board of Review (PDBR) to give previously separated servicemembers an opportunity to appeal their "low-balled" disability rating.

They also authorized a jointly executed DOD–VA DES pilot in the 2008 NDAA, and feedback from members and families who participated in the pilot program is that it has simplified the process and provided a more standardized disability rating outcome.

TMC was further encouraged that wounded, ill, and injured members would benefit from the 19 Dec 07 Under Secretary of Defense (Personnel and Readiness) Directive Type Memorandum (DTM) which added "deployability" as a consideration in the DES decision process—permitting medical separation/retirement based on a medical condition that renders a member nondeployable.

Unfortunately, several cases have surfaced indicating the Services have failed to incorporate the DTM in their DES process.

In this regard, the services continue to issue findings that a member is "fit, but unsuitable" for service. Under this system, a member found "fit" by the PEB, is deemed by the service to be "unsuitable" for continued service—and administratively separated—because the member's medical condition prevents them from being able to deploy or maintain their current occupational skill.

The Coalition believes strongly that medical conditions which preclude servicemembers from continuing to serve should be deemed "unfitting"—not "unsuitable."

In addition, we remain concerned about language used by some indicating a wish to remove DOD from the DES process (i.e., DOD determines fitness and VA determines disability). This simplified process could result in neglect of DOD's employer responsibilities, such as TRICARE eligibility for disabled members and their families.

The Coalition believes strongly that members determined by parent service to be 30 percent or more disabled should continue to be eligible for a military disability retirement with all attendant benefits, including lifetime TRICARE eligibility for the member and his/her family. We do not support efforts to disconnect health care eligibility from disability retired pay eligibility. The Coalition also agrees with the opinion expressed by Secretary Gates that a member forced from service for wartime injuries should not be separated, but should be awarded a high enough rating to be retired for disability.

TMC recommends:

- Barring "fit, but unsuitable" separations when a member's medical condition prevents continued service;
- Authorizing automatic enrollment in the VA health care system for any medically separated or medically retired servicemember (Chapter 61);

- Ending distinctions between disabilities incurred in combat vice non-combat;
- Monitoring the effectiveness of recent DOD compensation for catastrophically injured or ill servicemembers requiring assistance with activities of daily living authorized in the 2010 NDAA;
- Ensuring benefits afforded members wounded, ill, or disabled in the line of duty are applied equally for all uniformed services;
- Ensuring that the VA is the single authority for rating service-connected disabilities for military disability retirements and separations;
- Preserving the statutory 30 percent disability threshold for medical retirement and lifetime TRICARE coverage for members injured while on active duty;
- Continued monitoring of Service/DOD Medical-Physical Evaluation Boards, DOD DES Pilot Project, and the Physical Disability Board of Review, to assess needed DES changes;
- Eliminating member premiums for Traumatic Servicemember Group Life Insurance (TSGLI);
- Barring "pre-existing condition" determinations for any member who deploys to a combat zone;
- Ensuring that any adjustment to the disability retirement system does not result in a member receiving less disability retired pay than he or she would receive under the current system; and
- Ensuring that members electing accelerated disability retirement/separation are fully counseled on any possible negative changes in compensation, health care and other benefits, with consideration to allowing a limited time to reverse a regrettable decision.

Caregiver/Family Support Services

The sad reality is that, for the most severely injured servicemembers, family members or other loved ones are often required to become full-time caregivers. Many have lost their jobs, homes, and savings in order to meet caregiver needs of a servicemember who has become incapacitated due to service-caused wounds, injuries or illness.

The Coalition believes the government has an obligation to provide reasonable compensation and training for such caregivers, who ever dreamed that their own well-being, careers, and futures would be devastated by military-caused injuries to their servicemembers.

Last year, the subcommittee authorized a special payment to an active duty servicemember to allow compensation of a family member or professional caregiver. The authorized payment was in the same amount authorized by the VA for veterans' aid-and-attendance needs, reflecting the subcommittee's thinking that caregiver compensation should be seamless when the member transitions from active duty to VA care, as long as the caregiver requirements remain the same.

The Coalition supported this initiative, but recognizes that both chambers have since approved legislation to authorize more significant VA assistance and compensation for caregivers.

Once the House and Senate versions of the VA caregiver legislation have been reconciled in conference, the Coalition hopes the subcommittee will propose similar upgrades for caregivers of members while on active duty, consistent with the "seamless transition" philosophy adopted last year.

In a similar vein, many wounded or otherwise-disabled members experience significant difficulty transitioning to medical retirement status. To assist in this process, consideration should be given to authorizing medically retired members and their families to remain in on-base housing for up to 1 year after retirement, in the same way that families are allowed to do so when a member dies on active duty.

The Coalition recommends:

- Upgraded compensation and assistance for caregivers of severely disabled active duty members, consistent with pending legislative action to improve compensation/assistance for caregivers of veterans; and
- Authorizing up to 1 year of continued residence in on-base housing facilities for medically retired, severely wounded servicemembers and their families.

ACTIVE FORCES AND THEIR FAMILIES

In our overview, the Coalition expressed our collective concern over the stressors our servicemembers and their families are experiencing due to the long, repeated deployments and unrelenting operations tempo. In order to sustain a sufficient,

highly trained and highly capable Active Force, the continuing overriding requirement is to find additional ways to ease the terrible burden of stress on servicemembers and their families.

Military End Strength

Increased end strength is the only effective way to reduce stress on forces and families as long as deployment requirements not only continue, but actually increase.

The creators of the All-Volunteer Force never envisioned that the force would be deployed into combat 1 year out of 3—let alone every other year, as has been the case with many ground units.

Regrettably, the scenario faced by today's forces is not unlike the World War II "Catch-22" situation described by Joseph Heller, in which aircrews braving horrendous enemy flak had their wartime mission requirements increased again and again, until they perceived that the terrible sacrifices being demanded of them would never end.

Unfortunately, many in government and among the public seem to have become desensitized to the truly terrible sacrifices that the current mismatch between missions and force levels has already imposed on those in uniform. They acknowledge the problem, but most assume that servicemembers and families will simply continue to accept these—or even greater—levels of sacrifice indefinitely.

Many point to the achievement of service recruiting and retention goals as indicators that all is well.

Such perceptions grossly underestimate the current stresses on the force and the risk that poses for readiness and national security. The Coalition believes any complacency about retention is sadly misplaced, and that the status of the current force should be viewed in the context of a rubber band that has been stretched to its limit. The fact that it has not yet broken is of little comfort.

Well-respected studies have shown that 20 to 30 percent of combat returnees have experienced PTSD, TBI, or depression, and that the likelihood of a servicemember returning as a changed person rises with each subsequent deployment. Other studies have shown that rising cumulative family separations are having significant negative effects on servicemembers' children.

These are not mere academic exercises. They are well-known facts of life to those who are alone in actually experiencing them.

A far truer, and truly tragic, indicator of these extremely troubling circumstances has been the significant rise in servicemembers' suicide and divorce rates.

So the Coalition is very grateful for the subcommittee's support for end strength increases for all Services in the National Defense Authorization Act for Fiscal Year 2010, and for fending off the efforts of those who proposed cutting force levels to fund hardware needs.

But we must not understate the reality that the increases approved to date will not significantly improve dwell time for military families anytime in the near future, given increasing operational requirements in Afghanistan.

New requirements for massive humanitarian aid in Haiti and elsewhere only exacerbate the already grievous situation.

The Coalition is relieved that the administration is requesting an increase to the overall defense budget by $100 billion over the next 5 years—we just hope it's enough.

The Coalition urges the subcommittee to:

- Continue end strength growth as needed to sustain the war and other operational commitments while materially increasing dwell time for servicemembers and families;
- Sustain adequate recruiting and retention resources to enable the uniformed services to achieve required optimum-quality personnel strength; and
- Seek a 2011 defense budget of at least 5 percent of Gross Domestic Product that funds both people and weapons needs.

Military Pay Raise

The Coalition thanks the subcommittee for its sustained commitment to restoring full military pay comparability—a fundamental underpinning of the All-Volunteer Force.

To that end, we are grateful for the committee's leadership in approving a 3.4 percent military pay raise for 2010—vs. the 2.9 percent proposed in the defense budget submission.

Throughout the 1980s and 1990s, military pay raises consistently were capped below private sector pay growth, causing a "pay comparability gap" that reached

13.5 percent in 1998–1999, and contributed significantly to serious retention problems.

Every year since then, the subcommittee has acted to pare the gap by approving military raises that have been at least .5 percent above private sector pay growth.

Now that significant progress has been made and the "erosion of pay and benefits" retention-related problems have abated, some have renewed calls to cut back on military raises, create a new comparability standard, or substitute more bonuses for pay raises in the interests of "efficiency."

The Defense Department has proposed a new comparability standard under which each pay and longevity cell would represent the 70th percentile of compensation for similarly-educated civilians. A recent Congressional Budget Office report asserted that, considering adjustments in housing allowances, military people actually are paid 10 percent more than their civilian counterparts in terms of Regular Military Compensation (RMC), composed of basic pay, food and housing allowances, and the tax advantage that accrues because the allowances are tax-free.

The Coalition believes such assertions are fundamentally flawed.

First, the RMC concept was developed in the 1960s, when all servicemembers received the same allowances, regardless of location, and the allowances were arbitrary figures that weren't actually based on anything. In the interim, Congress has transformed the allowances into reimbursements for actual food costs and median locality-based housing costs.

If one were to use the RMC comparability methodology in this scenario, basic pay—the largest element of military pay and the one that drives retired pay—would become "flex" compensation element. With tax rates and allowances figures set independently, a year in which average housing allowances rose (e.g., based on growth in high-cost areas) and taxes increased could actually yield a requirement to cut basic pay (and future retirement value) to restore "comparability."

Second, the Coalition is not convinced that the civilian comparison cohort or percentile comparison point proposed by DOD are the proper ones, given that the military:

- Recruits from the top half of the civilian aptitude population;
- Finds that only about 25 percent of America's youth qualify for entry;
- Requires career-long education and training advancement;
- Enforces a competitive "up-or-out" promotion system; and
- Imposes severe limits on personal freedoms (e.g., not being able to quit when you want; risking a felony conviction for refusing an order).

A fundamental requirement for any pay comparability standard is that it should be transparent and understandable. The Coalition has asked for, but has never been provided by DOD, any data on what civilian comparison cohort was selected and why, and what rationale was used to establish a specific percentile comparison point.

Third, the Coalition believes it is essential to recognize that compensation is not simply the amount one is paid. It is pay divided by what's required of the recipient to earn that pay. If we increase pay 25 percent but require 100 percent more sacrifice to earn it, that's not a pay raise.

In that context, today's conditions of service are far more arduous than anything envisioned 40 years ago by the creators of the All-Volunteer Force, who believed a protracted war would require reinstitution of the draft.

Finally, private sector pay growth between 2008 and 2009 would set the military pay raise for 2011 at 1.4 percent—the smallest military pay raise in almost 50 years, even while servicemembers are being asked to endure the most arduous service conditions in more than 60 years. Further, the Coalition observes that there is a lag of more than a year between the time the civilian pay growth is measured and the time it is applied to the military.

The Coalition agrees with the approach the subcommittee has taken consistently -that the best comparability measure is a comparison of the military basic pay raise percentage with the percentage growth in the ECI.

The government uses the ECI for every other measure of private pay growth, and it's very transparent to government leaders and servicemembers alike. As of 2010, cumulative military basic pay increases lag cumulative private sector pay growth by 2.4 percent since 1982—the last time it was generally agreed that a state of comparability existed.

Given the historic low raise produced by the ECI for 2011, the historic sacrifices being asked of servicemembers in this time of protracted war, and the dubious rationale for alternative pay raise proposals, any assertion that military people are overpaid is grossly off the mark.

The Coalition believes a basic pay raise of at least 1.9 percent—.5 percent above the ECI standard—is the bare minimum the Nation should do to sustain its military pay comparability commitment for 2011.

Family Readiness and Support

A fully funded, robust family readiness program continues to be crucial to overall readiness of our military, especially with the demands of frequent and extended deployments.

Resource issues continue to plague basic installation support programs. At a time when families are dealing with increased deployments, they often are being asked to do without in other important areas. We are grateful that the subcommittee included a provision in last year's defense bill that will help improve family readiness and support though greater outreach. The Department's establishment of a comprehensive benefits web site for servicemembers and their families will help provide virtual assistance regardless of their physical proximity to installation-supported networks.

Additionally, we could not agree more with last year's "Sense of Congress" regarding the establishment of flexible spending accounts (FSAs) for members of the uniformed services. We urge the subcommittee to continue to press the Defense Department until servicemembers are provided the same eligibility to participate in FSAs that all other Federal employees enjoy.

Quality education is a top priority to military families. Servicemembers are assigned all across the United States and the world. Providing appropriate and timely funding of Impact Aid through the Department of Education is critical to ensuring quality education military children deserve, regardless of where they live.

The Coalition believes that several initiatives could have unintended negative consequences on school facility needs and educational programs affecting military children. Service transformation, overseas rebasing initiatives, housing privatization, base realignment and closure actions all have the potential to affect the military family and their access to quality education programs.

The Coalition recommends that the subcommittee:

- Press DOD to assess the effectiveness of programs and support mechanisms to assist military families with deployment readiness, responsiveness, and reintegration;
- Ensure that effective programs—including the Family Readiness Council—are fully funded and their costs are included in the annual budget process;
- Provide authorization and funding to accelerate increases in availability of child care to meet both Active and Reserve component requirements;
- Insist DOD implement flexible spending accounts to let active duty and Selected Reserve families pay out-of-pocket dependent and health care expenses with pre-tax dollars;
- Monitor and continue to expand family access to mental health counseling;
- Promote expansion of military spouse opportunities to further educational and career goals;
- Ensure additional and timely funding of Impact Aid plus continued DOD supplemental funding for highly-impacted military schools; and
- Mitigate the impact of Service transformation, overseas rebasing initiatives, housing privatization and base realignment on school facility needs and educational programs affecting military children.

Permanent Change of Station (PCS) Allowances

It's an unfortunate fact that members and their families are forced to incur significant out-of-pocket expenses when complying with government-directed moves.

For example, the current Monetary Allowance in Lieu of Transportation (MALT) rate used for PCS moves still fall significantly short of meeting members' actual travel costs. The current rate of 24 cents per mile is less than half of the 50 cents per mile authorized for temporary duty travel. Also, military members must make any advance house-hunting trips at personal expense, without any government reimbursements such as Federal civilians receive.

DOD states that the MALT rate was not intended to reimburse servicemembers for travel by automobile, but simply a payment in lieu of providing transportation in-kind.

The Coalition believes strongly that the MALT concept is an outdated one, having been designed for a conscripted, single, non-mobile force.

Travel reimbursements should be adjusted to reflect the reality that today's all-volunteer servicemembers do, in fact, own cars and that it is unreasonable not to

reimburse them for the cost of driving to their next duty stations in conjunction with PCS orders.

Simply put, PCS travel is no less government-ordered than is TDY travel, and there is simply no justification for paying less than half the TDY travel rate when personal vehicle use is virtually essential.

Additionally, the government should acknowledge that reassigning married servicemembers within the United States (including overseas locations) usually requires relocation of two personal vehicles. In that regard, the overwhelming majority of service families consist of two working spouses, making two privately owned vehicles a necessity. Yet the military pays for shipment of only one vehicle on overseas moves, including moves to Hawaii and Alaska, which forces relocating families into large out-of-pocket expenses, either by shipping a second vehicle at their own expense or selling one car before leaving the States and buying another upon arrival.

At a minimum, the Coalition believes military families being relocated to Alaska, Hawaii, and U.S. territories should be authorized to ship a second personal vehicle, as the subcommittee has rightly supported in the past.

The Coalition urges the subcommittee to continue its efforts to upgrade permanent change-of-station allowances to better reflect expenses imposed on servicemembers, with priority on:

- Shipping a second vehicle on overseas accompanied assignments;
- Authorizing at least some reimbursement for house-hunting trip expenses; and
- Increasing PCS mileage rates to more accurately reflect members' actual transportation costs.

Education Enhancements

The Post-September 11 GI Bill was a truly historic achievement that will provide major long-term benefits for military people and for America; however, the Coalition remains sensitive that transferability of the benefit to family members was restricted to members of the "Armed Forces."

The Coalition believes all members of the uniformed services, including commissioned officers of the U.S. Public Health Service and NOAA Corps, should be able to transfer their benefit to family members. All previous GI Bill provisions have applied equally to all uniformed services, and the Post-September 11 GI Bill should not be an exception.

The Coalition urges the subcommittee to support amending the statute to authorize all otherwise-qualifying members of the "uniformed services" to transfer Post-September 11 GI Bill benefits to family members.

Morale, Welfare, and Recreation (MWR) and Quality of Life (QoL) Programs

MWR activities and QoL programs have become ever more critical in helping servicemembers and their families cope with the extended deployments and constant changes going on in the force.

The availability of appropriated funds to support MWR activities is an area of continuing concern for the Coalition. We are especially apprehensive that additional reductions in funding or support services may occur due to slow economic recovery and record budget deficits.

BRAC actions pose an additional concern as DOD is struggling to meet the 2011 deadline at many BRAC locations. Two reports issued by the Government Accountability Office indicate significant challenges remain in areas of funding, facilities, and overall management.

The Coalition is very concerned whether needed infrastructure and support programs will be in place in time to meet families' needs.

TMC urges the subcommittee to:

- Protect funding for critical family support and QoL programs and services to meet the emerging needs of beneficiaries and the timelines of the Services' transformation plans;
- Oppose any initiative to withhold or reduce appropriated support for family support and QoL programs to include: recreation facilities, child care, exchanges and commissaries, housing, health care, education, family centers, and other traditional and innovative support services;
- Prevent any attempts to consolidate or civilianize military service exchange and commissary programs; and
- Sustain funding for support services and infrastructure at both closing and gaining installations throughout the entire transformation process, including exchange, commissary and TRICARE programs.

NATIONAL GUARD AND RESERVE

Over 142,000 Guard and Reserve service men and women members are serving on active duty.

Since September 11, 2001, more than 752,000 Guard and Reserve service men and women have been called up, including well over 200,000 who have served multiple tours. There is no precedent in American history for this sustained reliance on citizen-soldiers and their families. To their credit, Guard and Reserve combat veterans continue to reenlist, but the current pace of routine, recurring deployments cannot be sustained indefinitely.

Guard and Reserve members and families face unique challenges in their readjustment following active duty service. Unlike active duty personnel, many Guard and Reserve members return to employers who question their contributions in the civilian workplace, especially as multiple deployments have become the norm. Many Guard-Reserve troops return with varying degrees of combat-related injuries and stress disorders, and encounter additional difficulties after they return that can cost them their jobs, careers and families.

Despite the continuing efforts of the Services and Congress, most Guard and Reserve families do not have access to the same level of counseling and support that active duty members have. In short, the Reserve components face increasing challenges virtually across the board, including major equipment shortages, end-strength requirements, wounded-warrior health care, and pre- and post-deployment assistance and counseling.

Operational Reserve Retention and Retirement Reform

Congress took the first step in modernizing the Reserve compensation system with enactment of early retirement eligibility for certain reservists activated for at least 90 continuous days served since January 28, 2008. This change validates the principle that compensation should keep pace with service expectations and work as an inducement to retention and sustainment of the Operational Reserve Force.

Guard/Reserve mission increases and a smaller Active-Duty Force mean Guard/Reserve members must devote a much more substantial portion of their working lives to military service than ever envisioned when the current retirement system was developed in 1948.

Repeated, extended activations make it more difficult to sustain a full civilian career and impede reservists' ability to build a full civilian retirement, 401(k), etc. Regardless of statutory protections, periodic long-term absences from the civilian workplace can only limit Guard/Reserve members' upward mobility, employability and financial security. Further, strengthening the Reserve retirement system will serve as an incentive to retaining critical mid-career officers and NCOs for continued service and thereby enhance readiness.

As a minimum, the next step in modernizing the Reserve retirement system is to provide equal retirement-age-reduction credit for all activated service rendered since September 11, 2001. The current law that credits only active service since January 28, 2008 disenfranchises and devalues the service of hundreds of thousands of Guard/Reserve members who served combat tours (multiple tours, in thousands of cases) between 2001 and 2008.

The statute also must be amended to eliminate the inequity inherent in the current fiscal year retirement calculation, which only credits 90 days of active service for early retirement purposes if it occurs within the same fiscal year. The current rule significantly penalizes members who deploy in July or August vs. those deploying earlier in the fiscal year.

It is patently unfair, as the current law requires, to give 3 months retirement age credit for a 90-day tour served from January through March, but only half credit for a 120-day tour served from August through November (because the latter covers 60 days in each of 2 fiscal years).

For the near term, the Military Coalition places particular priority on authorizing early retirement credit for all qualifying post-September 11 active duty service performed by Guard/Reserve servicemembers and eliminating the fiscal-year-specific accumulator that bars equal credit for members deploying for equal periods during different months of the year.

Ultimately, TMC believes we must move forward to provide a reduced age entitlement for retired pay and health coverage for all Reserve component members—that is, an age/service formula or outright eligibility, if otherwise qualified, at age 55.

Further, TMC urges repeal of the annual cap of 130 days of inactive duty training points that may be credited towards a Reserve retirement.

Guard and Reserve Yellow Ribbon Readjustment

Congress has provided increased resources to support the transition of warrior-citizens back into the community. But program execution remains spotty from State to State and falls short for returning Federal Reserve warriors in widely dispersed regional commands. Military and civilian leaders at all levels must improve the coordination and delivery of services for the entire Operational Reserve Force. Many communities are eager to support and many do that well. But, yellow ribbon efforts in a number of locations amount to little more than PowerPoint slides and little or no actual implementation.

TMC is grateful for the subcommittee's attention to this issue and for including reporting requirements on progress in the National Defense Authorization Act for Fiscal Year 2010.

Making Yellow Ribbon work effectively is a major Coalition priority, and our hope is that the NDAA-required reports will point the way for further subcommittee action in this important area.

TMC urges the subcommittee to hold oversight hearings and to direct additional improvements in coordination, collaboration, and consistency of Yellow Ribbon services. DOD must ensure that State-level best practices—such as those in Maryland, Minnesota and New Hampshire—are applied for all Operational Reserve Force members and their families, and that Federal Reserve veterans have equal access to services and support available to National Guard veterans. Community groups, employers, and service organization efforts need to be encouraged and better coordinated to supplement unit, component, Service and VA outreach and services.

Guard/Reserve GI Bill

TMC is grateful to Congress for inclusion of a critical "earn as you serve" principle in the new Post-September 11 GI Bill, which allows operational reservists to accrue educational benefits for each aggregate call-up of 90 days or more active duty. Inexplicably, however, active duty members of the National Guard serving under Title 32 orders were not included in the new program despite their critical role in homeland defense, counter-drug, border control, and other missions.

TMC urges the subcommittee to work with the Veterans Affairs Committee to include Title 32 AGRs in the Post-September 11 statute.

TMC's longstanding recommendation of coordinating and integrating various educational benefit programs has been made more challenging with the Post-September 11 GI Bill.

For example, benefits for initially joining the Guard or Reserve as authorized in Chapter 1606, 10 U.S.C. continue to decline in proportion to the active duty Montgomery GI Bill (Chap. 30, 38 U.S.C.) and the new Post-September 11 GI Bill. Reserve MGIB benefit levels have slid to 24 percent of the active duty MGIB benefit, compared to 47–50 percent during the first 15 years of the program. Restoration of the original ratio would raise basic Reserve rates from the current $333 per month to $643–$684 per month for full-time study.

TMC maintains that restoring the ratio is not only a matter of equity, but essential to long-term success of Guard and Reserve recruiting programs.

Based on the DOD/Services' 10-year record of indifference to the basic Selected Reserve GI Bill under Chapter 1606, 10 U.S.C., TMC recommends either: restoring Reserve benefits to 47–50 percent of active duty benefits or transferring the Chapter 1606 statute from title 10 to title 38 so that it can be coordinated with other educational benefits programs in a 21st century GI Bill architecture. TMC also supports assured academic reinstatement, including guaranteed re-enrollment, for returning operational reservists.

Special and Incentive Pays

Increased reliance on Guard and Reserve Forces to perform active duty missions has highlighted differentials and inconsistencies between treatment of active duty vs. Guard and Reserve members on a range of special and incentive pays. Congress has acted to address some of these disparities, but more work is needed.

The Coalition urges the subcommittee to ensure equitable treatment of Guard and Reserve vs. Active Duty members for the full range of special and incentive pays.

RETIREE ISSUES

The Military Coalition remains grateful to the subcommittee for its support of maintaining a strong military retirement system to help offset the extraordinary demands and sacrifices inherent in a career of uniformed service.

Concurrent Receipt

In the NDAA for Fiscal Year 2003 and Fiscal Year 2004, Congress acknowledged the inequity of the disability offset to earned retired pay and established a process to end or phase out the offset for many disabled retirees. The Coalition is extremely grateful with the subcommittee's efforts to continue progress in easing the adverse effects of the offset.

Last year we were very optimistic that another very deserving group of disabled retirees would become eligible for concurrent receipt when the White House included a concurrent receipt proposal in the Budget Resolution—the first time in history any administration had ever proposed such a fix.

The administration's proposal, again submitted in this year's budget, would expand concurrent receipt eligibility over a 5 year period to all those forced to retire early from Service due to a disability, injury, or illness that was service-connected (chapter 61 retirees).

Thanks to the strong support of Armed Services Committee leaders, the proposal was included in the House version of the NDAA for Fiscal Year 2010. The Coalition was dismayed that, despite your leadership efforts and White House support, the provision failed to survive conference—an extremely disappointing outcome for a most deserving group of disabled retirees.

Our fervent hope is that the subcommittee will redouble its efforts to authorize this initiative for fiscal year 2011.

Additionally, the Coalition is concerned that an inadvertent problem exists in the statutory Combat-Related Special Compensation (CRSC) computation formula causes many seriously disabled and clearly eligible members to receive little or nothing in the way of CRSC. The Defense Department has acknowledged the problem in discussions with the subcommittee staff, and the Coalition urges the subcommittee to correct this technical problem.

The Coalition believes strongly in the principle that career military members earn their retired pay by service alone, and that those unfortunate enough to suffer a service-caused disability in the process should have any VA disability compensation from the VA added to, not subtracted from their service-earned military retired pay and this remains a key goal in 2010—regardless of years of service or severity of their disability rating.

The Coalition's continuing goal is to fully eliminate the deduction of VA disability compensation from earned military retired pay for all disabled retirees. In pursuit of that goal, the Coalition's immediate priorities include:

- Phasing out the disability offset for all Chapter 61 (medical) retirees; and
- Correcting the CRSC formula to ensure the intended compensation is delivered.

Proposed Military Retirement Changes

The Coalition remains concerned that as budgets get tighter and calls to establish a new entitlement or debt-reduction commission grow louder, the military retirement system may come under greater scrutiny to seek savings or "efficiencies."

Our concern is based on past experience that seeking to wring savings from military retirement programs poses a significant threat to long-term retention and readiness by decreasing the attractiveness of serving for 2 or 3 decades in uniform, with all of the extraordinary demands and sacrifice inherent in such extended career service.

For example, the Coalition is very concerned that proposals to "civilianize" military retirement benefits, such as the changes recommended by the 10th Quadrennial Review of Military Compensation (QRMC) fail utterly to recognize the fundamental purpose of the military retirement system in offsetting service conditions that are radically more severe than those experienced by the civilian workforce.

The QRMC proposed converting the military retirement system to a civilian-style plan under which full retired pay wouldn't be paid until age 57–60; vesting retirement benefits after 10 years of service; and using flexible "gate pays" and separation pay at certain points of service to encourage continued service in certain age groups or skills and encourage others to leave, depending on service needs for certain kinds of people at the time.

Reduced to its essence, this admittedly cost-neutral plan would take money from people who stay for a career in order to pay additional benefits to those who leave the military short of a career.

If this system were in place today, a 10-year infantryman facing his or her fourth combat tour would be offered a choice between: (a) allowing immediate departure with a vested retirement; vs. (b) continuing under current service conditions for another 10–20 years and having to wait until age 58 for immediate retired pay.

The Coalition believes strongly that, if such a system existed for today's force under today's service conditions, the military services would already be mired in a deep and traumatic retention crisis.

Further, the QRMC proposal is so complicated that people evaluating career decisions at the 4- to 10-year point would have no way to project their future military retirement benefits. Gate pays available at the beginning of a career could be cut back radically if the force happened to be undergoing a strength reduction later in a member's career.

In contrast, the current military retirement system makes it very clear from the pay table what level of retired pay would be payable, depending how long one served and how well one progressed in grade.

The sustained drawing power of the 20-year retirement system provides an essential long-term moderating influence that keeps force managers from over-reacting to short-term circumstances. Had force planners had such a system in effect during the drawdown-oriented 1990s, the Services would have been far less prepared for the post-September 11 wartime environment.

Many such proposals have been offered in the past, and have been discarded for good reasons. The only initiative to substantially curtail/delay military retired pay that was enacted—the 1986 REDUX plan—and only a remnant remain as the mandatory REDUX was scrapped 13 years later after it began inhibiting retention.

The only remnant that remains—and has been in place unchanged since 1999—is a voluntary program known as the Career Status Bonus—a $30,000 "bonus" bait and switch—where the servicemember can receive $30,000 at their 15 year point as long as they accept REDUX.

That "bonus" was a bad deal at the time and it gets worse with every passing year as pay (and retired pay) increases.

After taxes, the so-called bonus is more like $22,000 or $23,000. To get that, the typical NCO who retires with 20 years of service must agree to sacrifice more than $300,000 in future retired pay (those who live longer than average sacrifice far more). That's how much less REDUX is worth compared to the normal system.

TMC urges the subcommittee to:

- Reject any initiatives to "civilianize" the military system without adequate consideration of the unique and extraordinary demands and sacrifices inherent in a military vs. a civilian career; and
- Eliminate the Career Status Bonus for servicemembers as it significantly devalues their retirement over time. In the short term, the Services should be required to better educate eligible members on the severe long-term financial penalty inherent in accepting the REDUX option.

Disability Severance Pay

The Coalition is grateful for the subcommittee's inclusion of a provision in the NDAA for Fiscal Year 2008 that ended the VA compensation offset of a servicemember's disability severance for people injured in the combat zone.

However, we are concerned that the language of this provision imposes much stricter eligibility than that used for Combat-Related Special Compensation.

The Coalition urges the subcommittee to amend the eligibility rules for disability severance pay to include all combat—or operations—related injuries, using same definition as CRSC. For the longer term, the Coalition believes the offset should be ended for all members separated for service-caused disabilities.

Former Spouse Issues

For nearly a decade the recommendations of the Defense Department's September 2001 report to Congress on the Uniformed Services Former Spouse Protection Act (USFSPA) have gone nowhere. For several years, DOD submitted many of the report's recommendations annually to Congress only to have one or two supported by the subcommittee while many others were dropped.

The USFSPA is a very emotional topic with two distinct sides to the issue—just as any divorce has two distinct parties affected. The Coalition believes strongly that there are several inequities in the act that need to be addressed and corrected that could benefit both affected parties—the servicemember and the former spouse.

But in order to make progress, we believe Congress cannot piecemeal DOD's recommendations. We support a collective grouping of legislation that would provide benefit to both affected parties. Absent this approach, the legislation will be perceived as supporting one party over the other and go nowhere.

To fairly address the problems with the act, all affected parties need to be heard—and the Coalition would greatly appreciate the opportunity to address the inequities in a hearing before the subcommittee.

The Coalition requests a hearing to address USFSPA inequities. In addition, we recommend legislation to include all of the following:

- Base the award amount to the former spouse on the grade and years of service of the member at time of divorce (and not retirement);
- Prohibit the award of imputed income, which effectively forces active duty members into retirement;
- Extend 20/20/20 benefits to 20/20/15 former spouses;
- Permit the designation of multiple Survivor Benefit Plan (SBP) beneficiaries with the presumption that SBP benefits must be proportionate to the allocation of retired pay;
- Eliminate the "10-year Rule" for the direct payment of retired pay allocations by the Defense Finance and Accounting Service (DFAS);
- Permit SBP premiums to be withheld from the former spouse's share of retired pay if directed by court order;
- Permit a former spouse to waive SBP coverage;
- Repeal the 1-year deemed election requirement for SBP; and
- Assist the DOD and Services with greater outreach and expanded awareness to members and former spouses of their rights, responsibilities, and benefits upon divorce.

SURVIVOR ISSUES

The Coalition is grateful to the subcommittee for its significant efforts in recent years to improve the Survivor Benefit Plan (SBP), especially its major achievement in eliminating the significant benefit reduction previously experienced by SBP survivors upon attaining age 62.

SBP–DIC Offset

The Coalition believes strongly that current law is unfair in reducing military SBP annuities by the amount of any survivor benefits payable from the DIC program.

If the surviving spouse of a retiree who dies of a service-connected cause is entitled to DIC from the Department of Veterans Affairs and if the retiree was also enrolled in SBP, the surviving spouse's SBP annuity is reduced by the amount of DIC. A pro-rata share of the SBP premiums is refunded to the widow upon the member's death in a lump sum, but with no interest. This offset also affects all survivors of members who are killed on active duty.

The Coalition believes SBP and DIC payments are paid for different reasons. SBP is insurance 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 VA indemnity compensation should be added to the SBP annuity the retiree paid for, not substituted for it.

It should be noted as a matter of equity that surviving spouses of Federal civilian retirees who are disabled veterans and die of military-service-connected causes can receive DIC without losing any of their Federal civilian SBP benefits.

The reality is that, in every SBP–DIC case, active duty or retired, the true premium extracted by the Service from both the member and the survivor was the ultimate one—the very life of the member. This reality was underscored by the August 2009 Federal Court of Appeals ruling in *Sharp* v. *U.S.* which found "After all the servicemember paid for both benefits: SBP with premiums; DIC with his life."

The Veterans Disability Benefits Commission (VDBC) was tasked to review the SBP–DIC issue, among other DOD/VA benefit topics. The VDBC's final report to Congress agreed with the Coalition in finding that the offset is inappropriate and should be eliminated.

In 2005, Speaker Pelosi and all House leaders made repeal of the SBP–DIC offset a centerpiece of their GI Bill of Rights for the 21st Century. Leadership has made great progress in delivering on other elements of that plan, but the only progress to date on the SBP–DIC offset has been the enactment a small monthly Special Survivor Indemnity Allowance (SSIA).

The Coalition recognizes that the subcommittee's initiative in the fiscal year 2008 defense bill to establish a special survivor indemnity allowance (SSIA) was intended as a first, admittedly very modest, step in a longer-term effort to phase out the Dependency and Indemnity Compensation (DIC) offset to SBP.

We appreciate the subcommittee's subsequent work to extend the SSIA to survivors of members who died while on active duty in the NDAA for Fiscal Year 2009, as well as its good-faith effort to provide a substantial increase in SSIA payments as part of the Family Smoking Prevention and Tobacco Control Act.

The Coalition was extremely disappointed that the final version of that legislation greatly diluted the House-passed provision and authorized only very modest increases several years in the future.

While fully acknowledging the subcommittee's and full committee's good-faith efforts to win more substantive progress, the Coalition shares the extreme disappointment and sense of abandonment of the SBP–DIC widows who are being forced to sacrifice up to $1,110 each month and being asked to be satisfied with a $60 monthly rebate.

For years, legislative leaders touted elimination of this "widow's tax" as a top priority. The Coalition understands the mandatory-spending constraints the subcommittee has faced in seeking redress, but also points out that those constraints have been waived for many, many far more expensive initiatives. The Coalition believes widows whose sponsors' deaths were caused by military service should not be last in line for redress.

The Coalition urges repeal of the SBP–DIC offset. TMC further recommends:

- Authorizing payment of SBP annuities for disabled survivors into a Special Needs Trust; (Certain permanently disabled survivors can lose eligibility for Supplemental Security Income (SSI) and Medicaid and access to means-tested State programs because of receipt of SBP. This initiative is essential to put disabled SBP annuitants on an equal footing with other SSI/Medicaid-eligibles who have use of special needs trusts to protect disabled survivors.)
- Allowing SBP eligibility to switch to children if a surviving spouse is convicted of complicity in the member's death; and
- Reinstating SBP for survivors who previously transferred payments to their children at such time as the youngest child attains majority, or upon termination of a second or subsequent marriage.

Final Retired Pay Check

Under current law, DFAS recoups from military widows' bank accounts all retired pay for the month in which a retiree dies. Subsequently, DFAS pays the survivor a pro-rated amount for the number of days of that month in which the retiree was alive. This often creates hardships for survivors who have already spent that pay on rent, food, etc., and who routinely are required to wait several months for DFAS to start paying SBP benefits.

The Coalition believes this is an extremely insensitive policy imposed by the government at the most traumatic time for a deceased member's next of kin. Unlike his or her active duty counterpart, a retiree's survivor receives no death gratuity. Many older retirees do not have adequate insurance to provide even a moderate financial cushion for surviving spouses.

The VA is required by law to make full payment of the final month's VA disability compensation to the survivor of a disabled veteran. The disparity between DOD and VA policy on this matter is simply indefensible. Congress should do for retirees' widows the same thing it did 10 years ago to protect veterans' widows.

TMC urges the subcommittee to authorize survivors of retired members to retain the final month's retired pay for the month in which the retiree dies.

HEALTH CARE ISSUES

The Coalition appreciates the subcommittee's strong and continuing interest in keeping health care commitments to military beneficiaries. We are particularly grateful for your support for the last few years in refusing to allow the Department of Defense to implement disproportional beneficiary health care fee increases.

The Coalition is encouraged that the current administration so far has declined to pursue such increases, but has worked to reestablish a mutually constructive dialogue with beneficiary representatives.

The unique package of military retirement benefits—of which a key component is a top-of-the-line health care benefit—is the primary offset afforded uniformed servicemembers for enduring a career of unique and extraordinary sacrifices that few Americans are willing to accept for 1 year, let alone 20 or 30. It is an unusual, and essential, compensation package that a grateful Nation provides for a relatively small fraction of the U.S. population who agree to subordinate their personal and family lives to protecting our national interests for so many years. This sacrifice, in a very real sense, constitutes a pre paid premium for their future healthcare.

Defense Health Program Cost Requirements

The Coalition is grateful for the subcommittee's support for maintaining—and expanding where needed—the healthcare benefit for all military beneficiaries and especially for the Guard, Reserve, and military children, consistent with the demands imposed upon them.

It's true that many private sector employers are choosing to shift an ever-greater share of health care costs to their employees and retirees, and that's causing many

still-working military retirees to fall back on their service-earned TRICARE coverage. Fallout from the recent economic recession is likely to reinforce this trend.

In the bottom-line-oriented corporate world, many firms see their employees as another form of capital, from which maximum utility is to be extracted at minimum cost, and those who quit are replaceable by similarly experienced new hires. But that can't be the culture in the military's closed, all-volunteer personnel system, whose long-term effectiveness is dependent on establishing a sense of mutual, long-term commitment between the servicemember and his/her country.

The Coalition believes it's essential to bear other considerations in mind when considering the extent to which military beneficiaries should share in military health care costs.

First and foremost, the military health system is not built for the beneficiary, but to sustain military readiness. Each Service maintains its unique facilities and systems to meet its unique needs, and its primary mission is to sustain readiness by keeping a healthy force and to be able to treat casualties from military actions. That model is built neither for cost efficiency nor beneficiary welfare. It's built for military readiness requirements.

When military forces deploy, the military medical force goes with them, and that forces families, retirees and survivors to use the more expensive civilian health care system in the absence of so many uniformed health care providers.

These military-unique requirements have significantly increased readiness costs. But those added costs were incurred for the convenience of the military, not for any beneficiary consideration, and beneficiaries should not be expected to bear any share of that cost -particularly in wartime.

The Coalition urges the subcommittee to take all possible steps to ensure continued full funding for Defense Health Program needs.

National Health Reform

The Coalition opposes any effort to integrate TRICARE and VA health care systems in any proposal that Congress may develop as part of national health care reform. These two programs are integral to military readiness and are designed expressly to meet the unique needs of servicemembers, military retirees, veterans, wounded servicemembers, guardsmen and reservists, their families, and survivors.

TMC urges that any national health reform legislation must:

- Protect the unique TRICARE, TRICARE For Life, and VA health care benefits from unintended consequences such as reduced access to care;
- Bar any form of taxation of TRICARE, TRICARE For Life, or VA health care benefits, including those provided in nongovernmental venues; and
- Preserve military and VA beneficiaries' choices.

Military vs. Civilian Cost-Sharing Measurement

Defense leaders have in the past, and may in the future, assert that substantial military fee increases are needed to bring military beneficiary health care costs more in line with civilian practices. But merely contrasting military vs. civilian cash cost-shares is a grossly misleading, "apple-to-orange" comparison.

For all practical purposes, those who wear the uniform of their country are enrolled in a 20- to 30-year prepayment plan that they must complete to earn lifetime health coverage. In this regard, military retirees and their families paid enormous "upfront" premiums for that coverage through their decades of service and sacrifice. Once that prepayment is already rendered, the government cannot simply pretend it was never paid, and focus only on post-service cash payments.

DOD and the Nation—as good-faith employers of the trusting members from whom they demand such extraordinary commitment and sacrifice—have a reciprocal health care obligation to retired servicemembers and their families and survivors that far exceeds any civilian employer's to its workers and retirees.

The Coalition believes that military beneficiaries from whom America has demanded decades of extraordinary service and sacrifice have earned coverage that is the best America has to offer.

Large Retiree Fee Increases Can Only Hurt Retention

The reciprocal obligation of the government to maintain an extraordinary benefit package to offset the extraordinary sacrifices of career military servicemembers is a practical as well as moral obligation. Mid-career military losses can't be replaced like civilians can.

Eroding benefits for career service can only undermine long-term retention/readiness. Today's servicemembers are very conscious of Congress' actions toward those who preceded them in service. One reason Congress enacted TRICARE For Life in

2000 is because the Joint Chiefs of Staff at that time said inadequate retiree health care was affecting attitudes among active duty servicemembers.

That's more than backed up by two independent Coalition surveys. A 2006 Military Officers Association of America survey drew 40,000 responses, including more than 6,500 from active duty servicemembers. Over 92 percent in all categories of respondents opposed the DOD-proposed fee hikes. There was virtually no difference between the responses of active duty servicemembers (96 percent opposed) and retirees under 65 (97 percent opposed). A Fleet Reserve Association survey showed similar results.

Reducing military retirement benefits would be particularly ill-advised when an overstressed force already is at increasing retention risk despite the current downturn of the economy and current recruiting successes.

Pharmacy

The Coalition supports a strong TRICARE pharmacy benefit which is affordable and continues to meet the pharmaceutical needs of millions of eligible beneficiaries through proper education and trust. The TMC will oppose any degradation of current pharmacy benefits, including any effort to charge fees or copayments for use of military treatment facilities.

The Coalition would oppose the need for pharmacy co-pay increases now that Congress has approved Federal pricing for the TRICARE retail pharmacy system. The Coalition notes that due to continued legal maneuvering, Federal pricing still has not been implemented by the executive branch, and this failure is costing DOD tens of millions of dollars with every passing month. This is an excellent example of why the Coalition objects to basing beneficiary fees on a percentage of DOD costs—because DOD all-too-frequently does not act, or is not allowed to act, in a prudent way to hold costs down.

The Coalition has volunteered to conduct a joint campaign with DOD to promote beneficiary use of lower-cost medications and distribution venues—a "win-win" opportunity that will reduce costs for beneficiaries and the government alike.

The Coalition also believes that positive incentives are the best way to encourage beneficiaries to continue medication regimens that are proven to hold down long-term health costs. In this regard, TMC believes eliminating copays for medications to control chronic conditions (e.g., diabetes, asthma, high blood pressure, and cholesterol) are more effective than negative ones such as copayment increases.

The Coalition urges the subcommittee to ensure continued availability of a broad range of medications, including the most-prescribed medications, in the TRICARE pharmacy system, and to ensure that the first focus on cost containment should be on initiatives that encourage beneficiaries to take needed medications and reduce program costs without shifting costs to beneficiaries.

Alternative Options to Make TRICARE More Cost-Efficient

TMC continues to believe strongly that DOD has not sufficiently investigated options to make TRICARE more cost-efficient without shifting costs to beneficiaries. The Coalition has offered a long list of alternative cost-saving possibilities, including:

- Positive incentives to encourage beneficiaries to seek care in the most appropriate and cost effective venue;
- Encouraging improved collaboration between the direct and purchased care systems and implementing best business practices and effective quality clinical models;
- Focusing the military health system, health care providers, and beneficiaries on quality measured outcomes;
- Improving MHS financial controls and avoiding overseas fraud by establishing TRICARE networks in areas fraught with fraud;
- Establishing TRICARE networks in areas of high TRICARE Standard utilization to take full advantage of network discounts;
- Promoting retention of other health insurance by making TRICARE a true second-payer to other insurance (far cheaper to pay another insurance's co-pay than have the beneficiary migrate to TRICARE);
- Encouraging DOD to effectively utilize their data from their electronic health record to better monitor beneficiary utilization patterns to design programs which truly match beneficiaries needs;
- Sizing and staffing military treatment facilities to reduce reliance on network providers and develop effective staffing models which support enrolled capacities;

- Reducing long-term TRICARE Reserve Select (TRS) costs by allowing servicemembers the option of a government subsidy of civilian employer premiums during periods of mobilization;
- Doing far more to promote use of mail-order pharmacy system and formulary medications via mailings to users of maintenance medications, highlighting the convenience and individual expected cost savings; and
- Encouraging retirees to use lowest-cost-venue military pharmacies at no charge, rather than discouraging such use by limiting formularies, curtailing courier initiatives, etc.

The Coalition is pleased that DOD has begun to implement some of our suggestions, and stands ready to partner with DOD to investigate and jointly pursue these and other options that offer potential for reducing costs.

TMC Healthcare Cost Principles

The Military Coalition believes strongly that the recent fee controversy is caused in part by the lack of any statutory record of the purpose of military health care benefits and the specific benefit levels earned by a career of service in uniform. Under current law, the Secretary of Defense has broad latitude to make administrative adjustments to fees for TRICARE Prime and the pharmacy systems. Absent congressional intervention, the Secretary can choose not to increase fees for years at a time or can choose to quadruple fees in 1 year.

Until a few years ago, this was not a particular matter of concern, as no Secretary had previously proposed dramatic fee increases. Given recent years' unsettling experience, the Coalition believes strongly that the subcommittee needs to establish more specific and permanent principles, guidelines, and prohibitions to protect against dramatic budget-driven fluctuations in this most vital element of servicemembers' career compensation incentive package.

The Coalition strongly recommends that Congress establish statutory findings, a sense of Congress on the purpose and principles of military health care benefits earned by a career of uniformed service that states:

- Active duty members and families should be charged no fees except retail pharmacy co-payments, except to the extent they make the choice to participate in TRICARE Standard or use out-of-network providers under TRICARE Prime;
- The TRICARE Standard inpatient copay should not be increased further for the foreseeable future. At $535 per day, it already far exceeds inpatient copays for virtually any private sector health plan;
- There should be no enrollment fee for TRICARE Standard or TRICARE For Life (TFL), since neither offers assured access to TRICARE-participating providers. An enrollment fee implies enrollees will receive additional services, as Prime enrollees are guaranteed access to participating providers in return for their fee. Congress already has required TFL beneficiaries to pay substantial Medicare Part B fees to gain TFL coverage;
- All retired servicemembers earned equal health care coverage by virtue of their service; and
- DOD should make all efforts to provide the most efficient use of allocated resources and cut waste prior to proposing additional or increased fees on eligible beneficiaries.

TRICARE Prime

The Coalition is very concerned about growing dissatisfaction among TRICARE Prime enrollees—which is actually higher among active duty families than among retired families. The dissatisfaction arises from increasing difficulties experienced by beneficiaries in getting appointments, referrals to specialists, and sustaining continuity of care from specific providers.

Increasingly, beneficiaries with a primary care manager in a military treatment facility find they are unable to get appointments because so many providers have deployed, PCSed, or are otherwise understaffed/unavailable.

The Coalition supports the implementation of a pilot study by TMA in each of the three TRICARE Regions to study the efficacy of revitalizing the resource sharing program used prior to the implementation of the TRICARE-The Next Generation (T–NEX) contracts under the current Managed Care Support contract program.

The Coalition supports adoption of the "Medical Home" patient-centered model to help ease such problems.

But the new TRICARE contracts and the attendant reduction of Prime service areas outside the vicinity of military installations will exacerbate anxieties by forcing disenrollment of many thousands of current Prime beneficiaries.

The Coalition strongly advocates the transparency of healthcare information via the patient electronic record between both the MTF provider and network providers. Additionally, institutional and provider healthcare quality information should be available to all beneficiaries so that they can make better informed decisions.

The Military Coalition urges the subcommittee to require reports from DOD and from the managed care support contractors, on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.

TRICARE STANDARD

TRICARE Standard Provider Participation

The Coalition appreciates the subcommittee's continuing interest in the specific problems unique to TRICARE Standard beneficiaries. TRICARE Standard beneficiaries need assistance in finding participating providers within a reasonable time and distance from their home. This is particularly important with the expansion of TRICARE Reserve Select and the upcoming change in the Prime Service Areas, which will place thousands more beneficiaries into TRICARE Standard.

The Coalition is concerned that DOD has not yet established any standard for adequacy of provider participation, as required by section 711(a)(2) of the NDAA for Fiscal Year 2008. Participation by half of the providers in a locality may suffice if there is not a large Standard beneficiary population. The Coalition hopes to see an objective participation standard (perhaps number of beneficiaries per provider) that would help shed more light on which locations have participation shortfalls of Primary Care Managers and Specialists that require positive action.

The Coalition urges the subcommittee to insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation. The Coalition also recommends requiring a specific report on participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.

TRICARE Reimbursement Rates

Physicians consistently report that TRICARE is virtually the lowest-paying insurance plan in America. Other national plans typically pay providers 25–33 percent more. In some cases the difference is even higher.

While TRICARE rates are tied to Medicare rates, TRICARE Managed Care Support Contractors make concerted efforts to persuade providers to participate in TRICARE Prime networks at a further discounted rate. Since this is the only information providers receive about TRICARE, they see TRICARE as lower-paying than Medicare.

This is exacerbated by annual threats of further reductions in TRICARE rates due to the statutory Medicare rate-setting formula. Physicians may not be able to afford turning away Medicare patients, but many are willing to turn away a small number of patients who have low-paying, high-administrative-hassle TRICARE coverage.

The TRICARE Management Activity has the authority to increase the reimbursement rates when there is a provider shortage or extremely low reimbursement rate for a specialty in a certain area and providers are not willing to accept the low rates. In some cases, a State Medicaid reimbursement for a similar service is higher than that of TRICARE. But the Department has been reluctant to establish a standard for adequacy of participation to trigger higher payments.

The Coalition places primary importance on securing a permanent fix to the flawed statutory formula for setting Medicare and TRICARE payments to doctors.

To the extent a Medicare rate freeze continues, we urge the subcommittee to encourage DOD to use its reimbursement rate adjustment authority as needed to sustain provider acceptance.

The Coalition urges the subcommittee to require a Comptroller General report on the relative propensity of physicians to participate in Medicare vs. TRICARE, and the likely effect on such relative participation of a further freeze in Medicare/TRICARE physician payments along with the effect of an absence of bonus payments.

Dental Care

The Coalition appreciates the subcommittee's action in continuing active duty-level dental coverage for dependent survivors and allowing transitional dental care for Reserve members who separate after supporting contingency missions.

Active Duty Dependent Dental Plan

TMC is sensitive to beneficiary concerns that Active Duty Dental Plan coverage for orthodontia has been eroded by inflation over a number of years.

The current orthodontia payment cap is $1,500, which has not been changed since 2001. In the intervening years, the orthodontia cost has risen from an average of $4,000 to more than $5,000.

The Coalition understands that, under current law, increasing this benefit could require a reduction in some other portion of the benefit, which we do not support.

The Coalition notes that current law assumes a 60 percent DOD subsidy for the active duty dental plan, whereas other Federal health programs (e.g., FEHB Plan and TRS) are subsidized at 72 percent.

The Coalition recommends increasing the DOD subsidy for the Active Duty Dependent Dental Plan to 72 percent and increasing the cap on orthodontia payments to $2,000.

Guard and Reserve Healthcare

Continuum of Health Care Insurance Options for The Guard and Reserve

The Coalition is very grateful for passage of TRICARE Retired Reserve (TRR) coverage for "gray area" reservists in the NDAA for Fiscal Year 2010.

The Coalition notes that DOD complied with direction from Congress to reduce TRICARE Reserve Select (TRS) premiums to the actual cost of coverage. For 2009, monthly TRS premiums were reduced to $47.51 (vs. $81) for member-only coverage and to $180.17 (vs. $253) for family coverage.

TMC believes a review of the current statutory methodology for adjusting premiums based on program costs should be conducted to assess whether any of the costs currently included are, in fact, costs of maintaining readiness or "costs of doing business" for the Defense Department that don't contribute to delivering benefit value to beneficiaries (and therefore should be excluded, with the expected result that premiums would go down). In principle, TMC believes Congress should establish a moratorium on TRS premium increases and direct DOD to make a determined effort for the most efficient use of resources allocated and to cut waste prior to the consideration of any adjustment in such premiums.

Moreover, TMC believes that holding the line on TRS premiums will encourage more families to enroll. DOD, the Services, and the Reserve components must do much more to advertise the TRS program which stands at only 6–7 percent of eligible beneficiaries.

The Coalition also believes Congress is missing an opportunity to reduce long-term health care costs and increase beneficiary satisfaction by authorizing eligible members the option of electing a DOD subsidy of their civilian insurance premiums during periods of activation.

Current law already authorizes payment of up to 24 months of FEHBP premiums for activated members who are civilian employees of the Defense Department. The Coalition believes all members of the Selected Reserve should have a similar option to have continuity of their civilian family coverage.

Over the long term, when Guard and Reserve activations can be expected at a reduced pace, this option would offer considerable savings opportunity relative to funding permanent, year-round TRICARE coverage.

DOD could calculate a maximum monthly subsidy level that would represent a cost savings to the government, so that each member who elected that option would reduce TRICARE costs.

The Coalition recommends the subcommittee:

- Require a GAO review of DOD's methodology for determining TRS costs for premium adjustment purposes to assess whether it includes any costs of maintaining readiness or "costs of doing business" for the Defense Department that don't contribute to beneficiary benefit value and thus should be excluded from cost/premium calculations;
- Authorize development of a cost-effective option to have DOD subsidize premiums for continuation of a Reserve employer's private family health insurance during periods of deployment as an alternative to ongoing TRS coverage;
- Allow eligibility in Continued Health Care Benefits Program (CHCBP) for Selected reservists who are voluntarily separating and subject to disenrollment from TRS;
- Authorize members of the IRR who qualify for a Reserve retirement at age 60 to participate in TRR as an incentive for continued service (and higher liability for recall to active duty);

- Monitor implementation of the new TRR authority to ensure timely action and that premiums do not exceed 100 percent of the TRS premium; and
- Allow FEHB plan beneficiaries who are Selected reservists the option of participating in TRS.

Guard and Reserve Mental Health

The Coalition is concerned that Guard and Reserve members and their families are at particular risk for undetected effects of the unseen injuries of war. The risk is compounded by Reserve component members' anxiety to return to their families as soon as possible, which typically entails expedited departure from active duty and return to a community where military health care and other support systems are limited.

Unfortunately, most such members view the current post deployment health self-assessment program at demobilization sites as an impediment to prompt return to their families. Under this scenario, strong disincentives for self-reporting exacerbate an already wide variation in the diagnosis and treatment of post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, and other combat-related stress conditions.

The Coalition believes redeploying Reserve component members should be allowed to proceed to their home station and retained on active duty orders to complete post-deployment examination requirements at the home station. This change is important to improve proper diagnosis, reporting and treatment of physical and mental injuries; to help perfect potential service connected disability claims with the VA; and to help correct the non-reporting of injuries at the demobilization site.

The Coalition believes that Guard and Reserve members and their families should have access to evidence-based treatment for PTSD, TBI, depression, and other combat-related stress conditions. Further, post-deployment health examinations should be offered at the member's home station, with the member retained on active duty orders until completion of the exam.

Guard and Reserve Health Information

The Coalition is concerned that the current health records for many Guard and Reserve members do not contain treatment information that could be vital for diagnosis and treatment of a condition while on active duty. The capture of nonmilitary treatment is an integral part of the member's overall health status.

The Coalition believes there should be an effort to improve the electronic capture of nonmilitary health information into the servicemember's medical record.

TRICARE For Life (TFL)

When Congress enacted TFL in 2000, it explicitly recognized that this coverage was fully earned by career servicemembers' decades of sacrifice, and that the Medicare Part B premium would serve as the cash portion of the beneficiary premium payment. The Coalition believes that this remains true today and will oppose any new additional fees. Additionally, the Coalition believes that means-testing has no place in setting military health fees.

The Coalition is aware of the challenges imposed by Congress' mandatory spending rules, and appreciates the subcommittee's efforts to include TFL-eligibles in the preventive care pilot programs included in the NDAA for Fiscal Year 2009. We believe their inclusion would, in fact, save the government money and hope the subcommittee will be able to find a more certain way to include them than the current discretionary authority, which DOD has declined to implement.

The Coalition also hopes the subcommittee can find a way to resolve the discrepancy between Medicare and TRICARE treatment of medications such as the shingles vaccine, which Medicare covers under pharmacy benefits and TRICARE covers under doctor visits. This mismatch, which requires TFL patients to absorb the cost in a TRICARE deductible or purchase duplicative Part D coverage, deters beneficiaries from seeking this preventive medication.

Coalition priorities for TFL-eligibles include:

- Securing a permanent fix to the flawed formula for setting Medicare/TRICARE payments to providers;
- Resisting any effort to establish an enrollment fee for TFL, given that many beneficiaries already experience difficulties finding providers who will accept Medicare patients; and
- Including TFL beneficiaries in DOD programs to incentivize compliance with preventive care and healthy lifestyles.

Restoration of Survivors' TRICARE Coverage

When a TRICARE-eligible widow/widower remarries, he/she loses TRICARE benefits. When that individual's second marriage ends in death or divorce, the individual has eligibility restored for military ID card benefits, including SBP coverage, commissary/exchange privileges, etc.—with the sole exception that TRICARE eligibility is not restored.

This is out of line with other Federal health program practices, such as the restoration of CHAMPVA eligibility for survivors of veterans who died of service-connected causes. In those cases, VA survivor benefits and health care are restored upon termination of the remarriage. Remarried surviving spouses deserve equal treatment.

The Coalition recommends restoration of TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

Base Realignment and Closure (BRAC) and Rebasing

Military transformation and BRAC become more pressing issues as the Pentagon approaches the BRAC deadline set for September 15, 2011. The impact on the MHP is significant and concern about the impact on beneficiaries is of high priority to TMC. Specific areas of interest to the TMC include:

- Supporting a Health Facilities Program that uses evidenced-based design to update or replace Military Treatment Facilities (MTFs) to maintain world-class health care delivery capability in support of all eligible beneficiaries;
- Protecting full access, availability and services to beneficiaries and their families during the entire military transformation (BRAC and global rebasing) process, with added focus on Walter Reed Army Medical Center, Bethesda National Naval Medical Center, DeWitt Healthcare Network, and San Antonio Army Medical Center, while seeking full and timely funding for these world-class projects;
- Encouraging DOD to establish and sustain provider networks and capacity at both closing and gaining installations and units impacted by transformation;
- Promoting the coordination of efforts between Managed Care Support Contractors to ensure smooth beneficiary transition from one geographic area to another;
- Codifying the requirement to continue Prime benefits and assistance in localities affected by realignment and closure actions; and
- Monitoring the National Capitol Region Medical Joint Task Force activities to ensure the most effective use of resources to improve access and quality.

The Coalition recommends requiring an annual DOD report on the adequacy of health resources, funding, services, quality and access to care for beneficiaries affected by BRAC/rebasing.

Senator WEBB. Thank you very much.

I want to thank all of you for your testimony. The feedback is important to us. It's useful. It's not only useful, it's valuable. It will be taken into full consideration.

There are a dozen really important points that were raised, from my perspective, listening to your testimony.

TRICARE will not be affected, as long as I have anything to do with it. I know Senator Graham feels the same way. I've seen the benefits in my own family, I've seen it with my mother right now.

When you mention the SBP situation, my father paid into SBP for 28 years. When he died in 1997, they took it out of my mother's Social Security. Luckily, we had that situation fixed, but we will give the situation you mentioned a hard look. I'm on Senator Bill Nelson's bill.

With respect to commissary benefits, I grew up in the military. I used to work in a commissary, actually; I was a bagboy for 2½ years when I was in high school. [Laughter.]

But, I've always looked at commissary benefits in the same way that we articulate the healthcare benefits to people. It's—the idea

of being able to go to the commissary after you retire is something that people count on while they're in the military. That's something we don't think about, I think, as much as we need to up here.

Your comment, Ms. Moakler, about family difficulties and the need to get on top of that, there was a period in my life when my dad was either deployed or stationed where there was no family housing, for 3½ years. We had no structure in—at that period. We were—this idea of the family as a part of the operational military was not even in its infancy at the time.

I also recall when I was in the Marine Corps and I got back from Vietnam, in Quantico—they did a study of the Quantico school system, and I think the statistic at the time was that the kids in the Quantico school system—the high school—had three times the level of emotional difficulties as the national level at the time, because of the intensity of the Vietnam war. About 100,000 killed or wounded in the U.S. Marine Corps. People forget that. We had more total killed or wounded in Vietnam than we did in World War II, in the Marine Corps. The stress of these 13-month deployments on the marines, and wondering what your dad was doing, and, at that time, he could be dead. Enormous impact.

I really salute you for bringing the issue to us the way that you did today.

I had one question, quickly. I know we're way behind schedule here, and I know Senator Graham wants to also participate here. But, there's a lot of experience in this panel—military experience. I am really puzzled when I keep hearing the statistic that two-thirds of the—your phraseology was "optimally-aged potential enlistees" are not qualifying, and that defies historical trends. If you go back, for instance, to the Vietnam era, which I've done a lot of study on, obviously, over my life—one-third of the entire age group served—9 million out of 27 million actually served. We're now saying that only one-third of an age group could even qualify to serve. What are your thoughts on that? Are the standards not fitting the potential? Or are the physical and mental capabilities different? Where do we get this—and what could we do about it?

Mr. BARNES. Mr. Chairman, I'll speak to that first. Those statistics are from recruiting—Navy Recruiting Command——

Senator WEBB. Yes, I've actually heard them in other hearings, so——

Mr. BARNES. Exactly. I think there are a number of facets associated with that. Number one, it's the All-Volunteer Force, which has obviously been up and functioning since the early 1970s. The service requirements across the Services as to what the expectations are with regard to them; social issues, with practices and whatever, that are not conducive or not compatible with the requirements; perhaps drug use or other things that are happening.

So, it's a multifaceted issue. It's very troubling to our Association. We have a number of recognition programs, work very closely with Navy, Marine Corps, and Coast Guard recruiting communities, I share your concern about that. It's kind of a staggering statistic, but it's held consistent for several years, now.

Senator WEBB. Does anyone else have any thoughts on that?

Colonel STROBRIDGE. Yes, sir. I attended a briefing by Dr. Curt Gilroy recently, the DOD Director of Accession Policy. I think one

of the things he emphasized is—and, as a matter of fact, he—the number he gave was, only 25 percent qualify. One of the changes, I think, is obesity. We have a significantly larger number of people who are overweight today than we did in the past. Another thing is, kind of, the incongruity, perhaps, in some of the drug issues. If you report to Basic Training and say you experimented once with marijuana, they'll let you stay, but if you had a conviction for possession of a marijuana cigarette when you were 18, you can't come in. So, there is a variety of things like that, I think.

Ms. MOAKLER. I think we also need to look at the converse of that. You have an example of this, Chairman Webb, as do I. I'm the mother of two soldiers. It behooves us to keep our promises to our families so that our children see that the military lifestyle is a rewarding one. We're already teaching them self-sacrifice. So many of our children are eligible, because they see that physical fitness is an important part of everyday life, because they are discouraged from using drugs, and because they seek that life of selfless service. So, that's just another aspect to look on it, as well.

Mr. CLINE. Mr. Chairman, we have similar problems in the Guard and Reserve. Standards today in the Guard and Reserve are much higher—back in the day when I joined. The education requirements, the drug problems are just higher today than they are.

We're living in a day of fast food, as Colonel Strobridge mentioned. Overweight problems. We're constantly weeding out people who cannot meet the physical fitness requirements.

Senator WEBB. I know Senator Graham has to go, and he wanted to——

Senator GRAHAM. Well, one, we've been doing this together for several years now, and you all really do a good job of making the case for benefit increases and inequities. That's what your job is, and our job is to listen and try to meet as many needs as we can, understanding we can't be everything for everybody all the time because of budget problems.

The thing about TRICARE—I want to just let Senator Webb know that, working with Senator Clinton and others, we're able to make the Guard and Reserve Force eligible for TRICARE year round. The belief is that 25 percent did not have healthcare in the private sector; it gives them a healthcare home. It will allow them to have healthcare throughout their military service, which is an incentive to stay in.

I'm very disheartened by the numbers you gave me. We're going to do everything we can on this subcommittee to let people know, this benefit is there, you've earned it; it's a good deal, compared to the private sector; and try to get people to take more advantage of it. So, I promise you—18 months is too long, so we're going to start—about the other problem you mentioned, about 18 months to implement the GI stuff, benefits.

So, this really helps us understand how these programs actually work. Because when I go around talking about them, I'm very proud of it, but only 6 or 7 percent of the force is joining up, there's a disconnect. You all are really fair arbitrators of that.

One thing I would suggest, Mr. Chairman, is that this country has to come to grips with Medicare and Social Security and entitlement programs that have no end in sight and beginning to eat up

the budgets of everything else we do. The same is true for military healthcare. We haven't had a premium increase since 1995. I understand that what the past administration tried to do was just too much, too quick. I mean, it's just—couple hundred percent. Lowering the deductible from 500, or whatever it is, to 100 is just kind of a—just pretty rapid change that hits the wallet pretty hard.

But, I would suggest that we try to work with these groups. You all have done a—remember when we had that big meeting a couple years ago? How could you lower the cost of military healthcare? How could you improve access and quality? What things could we put on the table, that are preventive, that would allow the military member and their family to get better treatment, but actually lower cost?

I think it would be—probably behoove us to look at that again, before we ask for more money; to really go into this system and see, is it serving, an optimal level, the beneficiaries? Are we doing preventive medicine things that will lower costs and improve quality of life? But also understand one word: sustainability. None of these programs are going to be sustainable if we don't do something about that. That's what I would like to have this subcommittee look at, if we could, a way to get sustainable medical healthcare benefits for the retired force, the active and Guard force, and their families, so you can recruit and retain, but not have the dilemma of taking money away from a budget where you also are going to need to fight the war and buy equipment.

That's the challenge of our lifetime, quite frankly, and you and your organization that you represent can really be helpful here.

Mr. Chairman, thank you. You—obviously——

Senator WEBB. Well said.

Senator GRAHAM. Just listening to you—I mean, you have so many experiences. I don't know how you got through school. [Laughter.]

I mean, changing schools that many times. Can you imagine the stress on that? I didn't know that. I didn't know that more Marines were killed in Vietnam, and wounded, than World War II.

Senator WEBB. More total casualties——

Senator GRAHAM. I did not know that, so——

Senator WEBB.—killed in World War II, more total casualties.

Senator GRAHAM. You have lived the life that these people are talking about, from personal and from your parents' point of view, and let's take that knowledge and put it to good use.

Senator WEBB. It's a pleasure to be working with you, Senator Graham, and I take all your points on track.

I want to make one 30-second point here, just to wrap up this question I had about percentage of people who might be able to come in.

I think we undervalue what we can get out of people who haven't yet finished high school, who fall out of the system, who can come into the military. I've seen too many success stories from the Marine Corps with—we have about the same percentage of people now who aren't finishing high school as did when I was in the Marine Corps. We took them, some of my best friends, some of my close friends in my life, people like Carlton Sherwood, high school dropout, three Purple Hearts in Vietnam, became a Pulitzer Prize-win-

ning investigative reporter. Walter Anderson, Chief Executive Officer of Parade Magazine, Parade Enterprises, high school dropout, went in the Marine Corps, came back, and was valedictorian of his college class.

I mean, there's a pool of people out there who, with the—if you take their mental scores, the capability they have, who are looking for structure in their life, and can come in and really add value to our society. Maybe we ought to take that piece and look at it and talk to DOD about it, if we want to increase this pool.

It's been a great discussion; and Senator Graham, it's a pleasure working with you.

The hearing is adjourned. Thank you all.

[Questions for the record with answers supplied follow:]

QUESTION SUBMITTED BY SENATOR DANIEL K. AKAKA

CATASTROPHIC INJURIES ASSISTANCE

1. Senator AKAKA. Dr. Stanley, Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, the 2010 National Defense Authorization Act includes a provision concerning the special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday living. (Subtitle A, Sec. 603 of the Conf Report to accompany H.R. 2647) Please provide an update on the Department of Defense's (DOD) actions concerning this provision.

Dr. STANLEY. The program was briefed at the March 18, 2010 Senior Oversight Committee (SOC) meeting, co-chaired by the Deputy Secretary of Defense, and the SOC decided the level to set monthly payments. We anticipate a decision establishing eligibility for this program will be made this month. The Services support providing compensation to catastrophically wounded, ill, and injured servicemembers for the assistance provided by designated caregivers. We anticipate completing formal coordination and signing a DOD-level Directive Type Memorandum by the end of May to implement this program.

Mr. LAMONT. The DOD Wounded Warrior Care and Transition Program Office (WWCTP) began developing a Directive-Type Memorandum (DTM) in December 2009 to provide guidance to the Services for the implementation of the provisions of Section 603 of Public Law 111–84, the National Defense Authorization Act for Fiscal Year 2010. To accomplish this task, the WWCTP established a work group consisting of representatives from all Services, the TRICARE Management Agency, the Defense Finance and Accounting Service, and other key stakeholders in the implementation of the special compensation program. The DTM is nearing completion.

Mr. GARCIA. The Office of the Secretary of Defense (OSD) is in the final stages of developing draft policy for coordination with the Services prior to implementing in April.

Mr. GINSBERG. The Air Force is working with Army, Navy, and the OSD to implement this program in April 2010. OSD is finalizing a DTM for the Services to review and coordinate. Because we have been working on this together for several weeks, it is anticipated that the review will be finalized very quickly by the Services and signed by the Under Secretary of Defense (Personnel & Readiness) in the next few weeks. It is our desire to implement this special monthly compensation as quickly as possible to offer the financial assistance caregivers of our catastrophically wounded, ill, and injured servicemembers deserve when dedicating their time to assisting these servicemembers with daily living activities.

QUESTIONS SUBMITTED BY SENATOR KAY R. HAGAN

CENSUS BUREAU TABULATION OF DEPLOYED SERVICEMEMBERS

2. Senator HAGAN. Dr. Stanley, I am very concerned that servicemembers that are deployed during the conduct of the 2010 Census will be counted in a way that negatively impacts communities that host military installations. North Carolina currently has approximately 41,200 servicemembers deployed as a part of the overseas contingencies, and in the event that they are counted as prescribed by the U.S. Census Bureau, areas with large concentrations of military personnel will be significantly undercounted, and underfunded for the next 10 years. What is preventing the Defense Manpower Data Center from providing the U.S. Census Bureau with infor-

mation regarding the base of last assignment or permanent U.S. duty station as the primary response for deployed servicemembers currently engaged in overseas contingencies?

Dr. STANLEY. While there is no law specifying how to count servicemembers deployed overseas, for the 2010 census the Census Bureau has directed use of the same procedures used in the 1990 and 2000 Censuses. These procedures were developed based on a bill that passed the House of Representatives in 1990 (H.R. 4903) and recognition of strong bipartisan congressional support for including overseas military personnel in the census.

The decision for specific methodology used falls under the purview of the Census Bureau, and the Department follows its guidance for this accounting. The Census Bureau believes that the current methodology provides the benefit of consistency over time.

The directed methodology counts overseas military personnel, both stationed and deployed (including the National Guard), as part of the U.S. overseas population. The Department uses the following hierarchy (based on data availability): State home of record, State of legal residence, and State of last duty station (i.e., base of last assignment). While servicemembers deployed overseas at the time of the census will be included in the federally affiliated overseas count for apportionment purposes, their families residing in the U.S. will be counted through the standard census questionnaire.

The Department understands the potentially beneficial effects counting by "last duty station" first could have on States with a large military population and has discussed this and other methodologies with the Census Bureau. Clear legislation would resolve questions and codify the methodology to count deployed servicemembers. The Department stands ready to discuss all possible methodologies with the Census Bureau and Congress.

POST-SEPTEMBER 11 GI BILL

3. Senator HAGAN. Dr. Stanley, due to the Post-September 11 GI Bill, servicemember benefits were increased to rates that are 100 percent of in-State public university tuition rates. Eligible veterans are also provided with a housing allowance in order to offset living expenses. These benefits have been extended to officers that had their bachelor degrees funded through attendance at the service academies or through ROTC programs. However, servicemembers that served in the Reserves prior to commissioning and received benefits under Chapter 1606 while funding their own educational expenses, are not similarly included under the Post-September 11 GI Bill. Additionally, several programs that were included under the GI Bill, such as vocational programs, are not included under the Post-September 11 GI Bill. Now that the Post-September 11 GI Bill has been fully implemented, do you feel that technical correction legislation would be appropriate in order to reconcile some of the program inequities that have been identified?

Dr. STANLEY. DOD does not believe technical changes are necessary to the Post-September 11 GI Bill at this time. The Department supports the widest possible usage of benefits for our former Active and Reserve servicemembers, who served on active duty since September 11, 2001.

4. Senator HAGAN. Mr. Lamont, Mr. Garcia, and Mr Ginsberg, at a time when the Nation is relying more and more on its Reserve Forces, there now appears to be the largest historical gap in the relative value of education benefits provided under Chapter 1606 when compared to those under Chapters 30 or 33 of the GI Bill. Do you anticipate that the disparity in educational benefits will have a negative impact on Reserve recruiting?

Mr. LAMONT. The Army Reserve and Army National Guard components exceeded its accession goal last year. There are no indicators at this time that enactment of the Post-September 11 GI Bill has had a negative influence among potential candidates for either Active or Reserve components.

Mr. GARCIA. Both Navy and Marine Corps reservists are poised to take advantage of Post-September 11 GI Bill benefits (Chapter 33) as well as other VA education programs to include Chapter 30, Chapter 1607 (REAP), and Chapter 1606 (MGIB–SR). It is because our reservists are answering the call to service that their education benefits continue to expand and grow. RC members continue to have the opportunity to choose which VA education benefits they would like to use based on their eligibility. These benefits will continue to have a strong positive impact on recruiting and on retention in the RC well into the future.

Mr. GINSBERG. The disparity in Chapters 1606, 30 and 33 educational benefits has proven not to have a negative impact on recruiting. The Air Force Reserve (AFR) continues to exceed recruiting goals despite the disparity. Although Reserve and active duty component recruiters compete in the same marketplace, our products are distinctly different—specifically, part-time versus full time employment. Accordingly, there will be a continual "full-time/part time" benefit disparity among MGIB programs. (The disparity between Chapters 1606 and 30 has increased and is currently at 26 percent). In addition, Chapter 30 was created as a reward for service whereas Chapter 33 is primarily a retention tool—increasing monetary benefits and allowing members to commit to additional service in exchange for transferring educational benefits to dependents.

UNEMPLOYMENT RATE AMONG RETURNING MILITARY PERSONNEL

5. Senator HAGAN. Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, the current economic climate has been difficult for all of America's families; statistics show it has been especially difficult for returning military personnel serving in the National Guard and Reserves. For combat veterans returning home, it is especially challenging as they make the transition back to being a citizen soldier, while at the same time, having to deal with symptoms commonly associated with Post Traumatic Stress Disorder (PTSD). With an all-volunteer military that relies upon the National Guard and Reserves as essential components of the total force structure, what steps are being taken in order to provide more comprehensive transitional assistance for servicemembers returning home, and what are the significant gaps that remain?

Mr. LAMONT. We are doing whatever is necessary to help Reserve soldiers transition back to everyday life. Reserve soldiers are briefed at the demobilization station on the Transitional Assistance Management Program (180 days of TRICARE coverage post mobilization), Veteran's Healthcare Benefits, Yellow Ribbon, Military OneSource (counseling services at no cost to our soldiers), Joint Family Assistance Program (augments existing family programs to provide a continuum of support and services), Strong Bonds Program (relationship training to Singles, Couples and Families) and Recovery Care Coordinators (facilitators assigned to work with recovering Army Reserve soldiers to include those with psychological health conditions and/or Traumatic Brain Injury (TBI)).

The Army Reserve has partnered with the Department of Labor and is implementing an Employer Awareness Campaign which will provide employers with access to education and informational tools regarding psychological health and TBI, as well as a variety of other topics located at America's Heroes at Work website.

A significant gap is the transition assistance programs are of limited duration and are temporary programs (tied to contingency operations); continued support to ensure the programs are properly resourced is essential. Another gap is when an Army Reserve soldier is released from active duty; the soldier is no longer eligible for support. For example, the Army Emergency Relief only offers financial assistance to soldiers and their Family members when the soldier is in an active duty status. Providing transitioning Army Reserve soldiers access to all Services afforded Active component soldiers will bridge some current gaps.

The National Guard soldiers and airman go through a number of steps in their transition phase, from an active duty status back to a Reserve status. The first step begins with a demobilization process with the active component. During this step they process through various stations to address issues such as financial, personnel, logistics, medical and dental services, and benefits.

In the medical station both physical and behavioral areas, such as PTSD, are assessed. In the benefits station a Veterans Administration representative reviews the services provided through the Veterans Health Administration and can enroll the Guard member for care at a Veterans Affairs hospital in their local area when they return home.

The next step occurs when the National Guard soldier is at home. Through the Yellow Ribbon Program there are a series of events at 30-, 60-, and 90-day intervals. Each of these events revisits the various processes they went through at the demobilization station. These meetings remind Guard soldiers and their families of the services and benefits as well as an introduction to the various local community resources that are available. These resources include our own internal Warrior Support team consisting of an Employer Support of the Guard/Reserve, Psychological Health, and Family Program representatives, and a Transition Assistance Advisor.

Working in concert with the National Guard Yellow Ribbon Reintegration Program, Employer Support, and Warrior Support offices participate in Yellow Ribbon Reintegration events and activities to ensure that all returning servicemembers are

made aware of their employment rights under law as well as employment opportunities within the States and Territories to include the District of Columbia. Additionally, the National Guard is working with the DOD Transition Assistance Task Force to recommend change to the current Transition Assistance Program legislation to reflect the specific needs of the Guard and Reserve in relation to transition assistance.

Mr. GARCIA. Both the Navy and Marine Corps offer Transition Assistance Programs to separating and retiring servicemembers. Program outcomes are intended to provide participants with the skills they need to obtain appropriate post-service employment and make the transition back to being a citizen soldier. These services are provided at Navy and Marine Corps installations worldwide.

In accordance with title 10 U.S.C., section 1142 and 1143, Transitional Assistance Management Program (TAMP) services are provided to all servicemembers who are released from active duty/separated/retired who serve 180 continuous days or longer on active duty. Although existing transition programs were originally designed for the active component, the program supports reservists, as members of the total force, provided eligibility requirements are met (i.e., served 180 continuous days or longer on active duty, and are within 12-months from separation, or are within 24-months from retirement).

Reserve servicemembers are provided information on their rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA) which is intended to minimize the disadvantages to an individual that can occur when a person needs to be absent from his or her civilian employment in order to serve in the uniformed services.

In addition to providing assistance with career, employment, education and training benefits, Pre-separation Counseling, which is required by title 10 U.S.C., section 1142, includes information on how to maximize the use of benefits earned through their service such as determining health and life insurance requirements, financial planning, and Veteran's benefits and entitlements.

The Yellow Ribbon Reintegration Program (YRRP), which was created by P.L. 110–181 (NDAA for Fiscal Year 2008), provides access to programs, resources, and services to minimize stresses on National Guard and Reserve members and their families before, during, and after deployments of 90 days or more.

The Warrior Transition Program was established in Kuwait and provides a place and time for sailors to decompress and transition from the war zone to life back home. Through small group discussions facilitated by chaplains and medical personnel, Warrior Transition Workshops prepare sailors for resumption of family and social obligations, return to civilian employment, and reintegration with the community.

The Returning Warrior Workshop (RWW) is another important step in the demobilization and reintegration process for the Total Force and their families. The RWW is designed to remove stigma and direct family members to appropriate support programs. Originally developed by and for the Navy Reserve, the RWW has expanded to include Navy active and Marine Corps Reserve members and their families.

The Navy's Operational Stress Control (OSC) and Marine Corps' Combat and Operational Stress Control (COSC) programs are a set of policies, programs, training and tools to enable leaders, marines, sailors, family members, and caregivers to deal effectively with the stress of operational deployment and training.

The Marine Corps also developed a specific "Demobilization Tool Kit" and Career Guide CD which supplement our existing transition program. These Kits were designed to meet the unique needs and concerns of demobilizing Reserve marines and family members as they return to civilian life and workforce. Toolkits were not redistributed in fiscal year 2010 since the OSD Office of Wounded Warrior Care and Transition Policy is in the process of creating a toolkit that will serve both the transitioning Active Duty and Reserve community.

The Deputy Under Secretary of Defense, Office of Wounded Warrior Care and Transition Policy is leading an effort to expand transition support to the National Guard and Reserves through an amendment to the current law as well as revision of the DODD 1332.35 and DODD 1332.36. The Marine Corps is also convening an Operational Planning Team (OPT) to look at program improvements, such as starting the transition process 2 years earlier (recognizing that over 65 percent leave the Marine Corps after the first term) and offering tiered delivery of services, such as Education, Training, and Employment Job Placement.

Mr. GINSBERG. The AFR and Air National Guard (ANG) enlist the resources of a variety of programs to ease the transition of its members back to civilian status. The YRRP is the comprehensive DOD program used by all components to provide assistance to members and families. In addition, because health care and employ-

ment issues are particularly important to returning veterans, the AFR and ANG have programs and resources that place particular emphasis on these areas.

Yellow Ribbon

The AFR and ANG employ the Yellow Ribbon Program as a key component to effectively address the transition back to civilian life. Experts who participate regularly in Yellow Ribbon events—pre-deployment, during deployment, and post-deployment—include the DOD contracted Military Family Life Consultants (MFLCs), Military OneSource, and Personal Financial Readiness. Since the standup of the Yellow Ribbon Program by the AFR Command in August 2008, comprehensive support to airman, families, and employers throughout the deployment cycle minimizes the stress of deployment and family separation. During the period from August 2008 through 1 March 2010, the Yellow Ribbon Program held 156 total events across 39 Wings/Groups with 5,668 Reserve members and 5,288 family members participating.

National Guard soldiers and airman go through a number of steps in their transition from an active duty status back to a Reserve status. The first step begins with their participation in a demobilization process along with the active component. During this step they go through various stations with subject matter experts to address issues such as financial, personnel, logistics, medical, dental, services, and benefits. In the medical station both physical and behavioral areas, such as PTSD, are assessed. In the benefits station a Veterans Administration representative reviews the services provided through the Veterans Health Administration and can enroll the Guard member for care at a VA hospital in their local area when they return home.

The next step occurs when the National Guardsman is at home. The Yellow Ribbon program conducts a series of events at 30-, 60-, and 90-day intervals. Each of these events reassembles the various experts that were available at the demobilization station. These events remind Guardsmen and their Families of the services and benefits as well as introduce them to the available local community resources. These resources include an internal Warrior Support team consisting of an Employer Support of the Guard/Reserve Specialist, Psychological Health, Family Program representatives, and a Transition Assistance Advisor. The Warrior Support team members are available via phone, email and personal meetings for the Guard member or their family at any time and serve as a resource and referral advocate for them. In addition, the creation of the Joint Services Support portal covers all transitional assistance programs and initiatives to enable all Guardsmen and their families to access information about support and services available in their local areas.

Health Care

Both the AFR and ANG have placed particular emphasis on mental health. The AFR employs Psychological Health Advocates (PHAs), reservists who are mental health or clinical nurses and enlisted personnel, and are qualified to provide assessment and referrals for mental health services. The PHAs and MFLCs work in concert with one another to ensure comprehensive services are available to reservists and their families. The ANG has placed Directors of Psychological Health in each State and territory to perform as an assessment and referral resource and act as the subject matter expert to the State/territory with regards to psychological health matters. In its inaugural year (fiscal year 2009) they intervened in 255 critical cases that were deemed high risk suicide/homicide situations.

Air Force Reserve Command (AFRC) is also working cooperatively with Department of Veterans Affairs Veterans Health Administration to ensure implementation of the Combat Veteran Heath Care Benefits and Co-Pay Exemption Post-Discharge from Military Service. Reserve personnel returning from any theater of combat operations are briefed by VHA representatives and given the opportunity to apply for Veterans Health care. This allows reservists to receive medical care, to include treatment for post-traumatic stress disorder (PTSD) at VA health facilities with no co-pay. In addition, those who serve in combat theater for not less than 90-days are informed of their eligibility for one-time correction of dental conditions if they had not had dental care while deployed.

Employment Assistance

In addition to providing assistance with benefits and entitlements associated with active service, Air Force Reserve Airman and Family Readiness Centers provide employment assistance. Unemployment in the civilian sector is a growing concern for the AFR, but not a ubiquitous problem. Much of the unemployment seems to be associated with the economic situation where a reservist resides. Several locations, with one full-time Airman and Family Readiness staff member, offer employment-related classes similar to those offered during a Transition Assistance Program (TAP) seminar including resume writing, interviewing, job search skills, how to

dress for career fairs and job interviews. The employment focus of TAP is to make the reservist more marketable in an environment where there are few or no jobs. reservists are often tied to communities where their spouses have employment so relocation for job opportunites may create another problem. This is not unlike situations active duty spouses find themselves in the job market.

For the ANG, Employer Support, and Warrior Support offices participate in Yellow Ribbon Reintegration events and activities to ensure that all returning servicemembers are made aware of their employment rights under law as well as employment opportunities within the States and Territories (to include the District of Columbia). The National Guard is working with the DOD Transition Assistance Task Force to change the current Transition Assistance Program legislation to reflect the specific needs of the Guard and Reserve in relation to transition assistance. Finally, the National Guard Employer Support Program Support Specialist located in each Joint Force Headquarters State is responsible to connect returning Guardsman with Federal, State, local, and private agencies to obtain employment referrals. In many cases these referrals may involve additional training and education to compete for areas of future employment. Additionally, the National Guard Program Support Specialist advise returning Guardsman of specific unemployment trends and retraining benefits in their local area.

QUESTIONS SUBMITTED BY SENATOR ROLAND W. BURRIS

DEFENSE INTEGRATED MILITARY HUMAN RESOURCES SYSTEM

6. Senator BURRIS. Dr. Stanley, now that the Defense Integrated Military Human Resources System (DIMHRS) is being canceled by the Secretary of Defense, what is the plan to look at other options to manage personnel and pay under a single system for the DOD?

Dr. STANLEY. When the Department determined to terminate the DIMHRS program, the decision also included direction for a way forward. There are no plans to review options for a single DOD system to manage military personnel and pay; rather each of the Services will implement enterprise standards in their own systems.

The software configured to support the original DIMHRS effort has been provided to each Service for their individual development efforts called Service Integrated Personnel and Pay Systems (SIPPS). SIPPS-Army is currently the most mature effort and expects to begin deployment in fiscal year 2013. A governance structure is also in place to manage development of the individual Service systems that includes the DIMHRS Transition Council, mandated by Congress in the National Defense Authorization Act for Fiscal Year 2010. A Joint Enterprise Change Management Board was put in place to ensure changes to the Service systems do not adversely impact the Enterprise Standards compliance. This body is co-chaired by the OUSD (P&R) Director, Information Management and the Director, Defense Finance and Accounting Service, Financial Management Center of Excellence.

I am confident this governance structure ensures the individual Service development programs support and execute military personnel and pay policies accurately, equitably, and in a timely manner for our servicemembers.

MINORITIES

7. Senator BURRIS. Dr. Stanley, what are the percentages of minorities by category and women in the Senior Executive Service (SES) General and Flag Officer ranks of the Armed Services, and DOD headquarters?

Dr. STANLEY. For the General and Flag officer population, gender composition is 93.6 percent males and 6.4 percent females. The race/ethnic composition is 89.8 percent White, 6.0 percent Black, 1.6 percent Hispanic, 1.3 percent Asian/Pacific, .2 percent American Indian/Alaskan Native and 1.1 percent Other. These data are current as of March 2010

For the SES population, gender composition is 76.3 percent males and 23.7 percent females. The race composition is 90.53 percent White, 4.48 percent Black/African American, 1.6 percent Hispanic, 2.10 percent Asian, 0.14 percent Native Hawaiian/Pacific Islander, 0.87 percent Multiracial; 0.14 percent ID Pending; and 1.3 percent Unspecified. The Unspecified group primarily consists of individuals designated as Hispanic but who do not have a race specification. The percentage of SES population identified as Hispanic ethnicity is 1.73 percent. These data are current as of January 2010.

CIVILIAN EMPLOYEES

8. Senator BURRIS. Dr. Stanley, civilian employees that participate in the Thrift Savings Plan (TSP) are entitled to receive matching agency contributions to their TSP account, yet military members do not. When will this disparity be addressed for our military personnel?

Dr. STANLEY. To address the appropriateness of providing agency matching contributions to military members, it is important to consider and compare the role of the TSP in the civilian and military compensation systems.

For a civilian employee under the Federal Employee Retirement System (FERS), the funds provided by the government in the form of matching contributions are one of the key components of retirement. Under FERS, in addition to receiving matching contributions, the employee contributes to a defined benefit plan and receives an annuity upon retirement after reaching a specified age and years of service.

For a military member, the government provides a defined benefit retirement plan more generous than FERS and fully funded by the government. Unlike the civilian employee under FERS, the military member does not contribute to the defined benefit plan and receives monthly retired pay immediately upon retirement, but at an earlier age with many working years ahead.

The military member is also allowed to contribute to the TSP. However, the ability to participate in the TSP was not designed as a key component of the military member's retirement. For the military member, participation in the TSP is a valuable, additional benefit, one that facilitates long-term saving. Although participation in the TSP may be a common element across both military retirement and FERS, the roles of the TSP and the need for and purpose of providing agency matching contributions are different.

In the past, the Department has investigated the impact on recruiting and retention and the cost effectiveness of providing military members with agency matching contributions. Based on data of members currently contributing to TSP, the cost of providing agency matching contributions is estimated to be between $840 million and $2.8 billion annually, depending upon the level of participation.

RAND and the Center for Naval Analyses (CNA) have both investigated the issue of providing agency matching contributions. RAND reviewed an Army pilot program which offered agency matching contributions from 2006 through 2008 to new enlistees who selected longer enlistments and enlisted in hard-to-fill specialties. RAND found no appreciable increase as a result of providing agency matching contributions. CNA also studied the issue of providing agency matching contributions and determined providing agency matching contributions would have minimal impact on retention.

DON'T ASK, DON'T TELL

9. Senator BURRIS. Dr. Stanley, how will a moratorium on Don't Ask, Don't Tell (DADT) affect the pending cases of servicemembers facing discharge?

Dr. STANLEY. The Secretary of Defense has appointed a high-level Working Group to review how to implement repeal of 10 U.S.C. § 654. As the Secretary has said, he does not support a moratorium while this Working Group is undertaking its review. In general, a moratorium would prohibit the separation of servicemembers on the basis of homosexual conduct until the moratorium ends. This would presumably have the effect of allowing openly gay and lesbian servicemembers to continue serving on active duty for the duration of the moratorium and would, in that respect, have an effect very similar to repeal of section 654.

END STRENGTH

10. Senator BURRIS. Mr. Lamont, given the operational tempo placed on the forces, particularly as it relates to the Army Reserve components, do you feel there is a need for the end strength of the Army Reserve and Army National Guard to increase?

Mr. LAMONT. Yes. The Army is considering if additional funded end strength is needed for the Reserve components in order to optimize Army National Guard and Army Reserve Trainees, Transients, Holdees, and Student (TTHS) accounts. Each of the Army's components requires a TTHS account to allow them to optimize the management of their force. The Active component is authorized approximately 71,000 soldiers (~13 percent of Active component end-strength) within a TTHS account, allowing the Active component to segregate nondeployable personnel (e.g. non-trained or soldiers in resident training) from units. In contrast, the relative

small size of the Army National Guard (~2.5 percent) and Army Reserve (2 percent) TTHS accounts are insufficient to make full use of a TTHS mechanism and its positive effects on readiness.

11. Senator BURRIS. Mr. Lamont, the Army has asked for a temporary end strength increase, due in part to deployments and now with perhaps a bigger burden on the forces given the requirements brought forth from the Quadrennial Defense Review, don't you think the Reserve component needs additional forces as well?

Mr. LAMONT. The Army is doing an ongoing RAND Study to determine if increasing the end strength of the Reserve components (RC) is necessary. Should the study show additional end strength is required to optimize the RC, we will include additional cost in the next Army budget request.

RESERVE

12. Senator BURRIS. Mr. Lamont, the Army Reserve has the lowest percentage of full time support comparing it with the size of the Reserve component forces, followed by, I believe, the Army National Guard. Yet, their participation in Overseas Contingency Operations (OCO) is more significant than the other Reserve components. How can you explain that?

Mr. LAMONT. Adequate full-time support is essential for Reserve component (RC) unit readiness, training, administration, logistics, family assistance and maintenance. The Commission on the National Guard and Reserve found that effective performance of such functions correlates directly to a RC unit's readiness to deploy. The Army with the largest Reserve operational force has 12.89 percent of its RC end strength as full-time support; the Air Force has 25.29 percent of its Reserve components as full-time manning. The current full-time support levels of the Army's Reserve Components are based, in part, on a 1999 RAND Study that was revalidated in 2005. The manpower authorization levels established by RAND are currently funded at 72 percent of validated requirements, which was sufficient for a Strategic Reserve Force. Since 2001 the RC's have used personnel on Active Duty Operational Support-Reserve Components (ADOS–RC) orders and other full-time equivalent (FTE) manpower to meet the full-time support requirements generated by contingency operations. The Army is considering what full-time support for the Guard and Reserve is needed to ensure adequate manning for various support functions (organizing, manning, training and equipping) required for managing the Reserve components as an operational force.

RECRUITING

13. Senator BURRIS. Mr. Lamont, is there an initiative to consolidate the recruiting programs of the three Army components (Army, Army Reserve, and National Guard)?

Mr. LAMONT. While there have been informal discussions about having a single Army recruiting command that serves the needs of the total force—Regular Army, Army Reserve (USAR) and Army National Guard (ARNG)—there are no initiatives to further consolidate recruiting at this time.

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

RECRUITING HEALTH CARE PROFESSIONALS

14. Senator GRAHAM. Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, you indicated in your written statements that achieving Service recruiting goals for doctors, psychologists, nurses, dentists, and other health care professionals, in both the active and Reserve components, presents significant challenges. Please discuss the challenge of recruiting health professionals in this wartime environment in your Service, and how you plan to meet this challenge.

Mr. LAMONT. Hiring difficulties continue to stem from remote locations, compensation limitations inherent to government employment, and a national shortage of qualified providers. The Army is using numerous traditional mechanisms to recruit and retain both civilian and uniformed providers including Retention Bonuses; Student Loan Repayment Program; Special Pay for Certified Nurses; Medical Special Pays for Psychiatrists, and a Social Work Program in partnership with Fayetteville State University. A non-traditional recruiting approach has been the Military Accessions Vital to the National Interest (MAVNI) Pilot Program. MAVNI was launched

in 2009 to attract high quality individuals with exceptional skills in health care professions or special language and cultural backgrounds. MAVNI recruits are non-U.S. citizens who have been legally present in the United States for 2 or more years and are licensed health care professionals or possess specific language and cultural capabilities in a language critical to the DOD, but who do not have permanent residency.

Mr. GARCIA. Navy has a comprehensive medical recruiting focus, which enabled us to exceed our overall medical recruiting goals in fiscal years 2008 and 2009. We are on track to meet our overall goal in the Active component (AC) in 2010, but are experiencing challenges in meeting the Reserve component (RC) goal, which increased by 121 accessions this year, an increase of 43 percent.

Increased 2010 recruiting goals notwithstanding, our analysis indicates medical professionals do not often consider military service a primary career option. Reasons for this include:

- Civilian salaries are more lucrative than military pay and continue to outpace financial incentives we offer to our target market.
- Excessive debt is a major concern for medical professionals, who are able to find low-interest loans outside of the military.
- Percentage of females attending medical school has risen over the past 10 years yet females are less inclined to serve in the military than males.
- Concerns over multiple deployments.
- Potential Reserve medical providers fear a loss of their private practice.

It should also be noted that we remain in keen competition with the private sector, the Department of Veterans Affairs, as well as with the other military departments, for the same finite talent pool.

We are continuing best practices learned during the past 2 years and are implementing several new initiatives that we expect will bear fruit in our shortfall areas including:

- Adjusting bonuses and incentives for fully trained medical professionals.
- Participating in the Military Accessions Vital to the National Interest (MAVNI) pilot program to access qualified, legal non-citizen medical doctors.
- Initiating an accession process for legal permanent residents who are qualified physicians or medical students.
- Offering loan repayment opportunities for critical medical specialties.
- Expanding use of medical officers to inform undergraduate and professional medical students across the Nation of opportunities in Navy medicine.
- Adding more full time recruiters to recruiting medical professionals.
- Expanding the Health Service Collegiate Program to include Permanent Residents (green card) in critical student specialties.
- Offering bonuses for clinical psychologists, physician's assistants, and social workers.
- Continuing the Critical Wartime Skills Accession Bonus to target physicians (up to $400,000) and dentists (up to $300,000).

Mr. GINSBERG. Accessing fully qualified professionals is our greatest challenge. Air Force recruiting is challenged by the same factors our Nation faces in having sufficient health care professions such as: nursing, general surgery, family practice, psychology, and oral maxillofacial surgery. The Air Force faces keen competition for fully qualified specialists from the private sector and other Federal agencies, such as the Department of Veterans Affairs and the Public Health Service, where multiple deployments are not an issue. Also, there are significant pay disparities between the military and private sector employers, especially those surgical specialties crucial for wartime support. The changing demographics of health professions, with increased numbers of women entering the profession who may be less inclined to choose military service, also provide a challenging environment for our recruiters. Current data suggests less than 7 percent of eligible graduates consider entering military service.

Using feedback from exit interviews and informal counseling, the Air Force confronts the above challenges in a three-pronged approach: (1) education, (2) compensation, and (3) quality of life.

(1) Education: Due to historical problems in recruiting fully qualified and trained specialists, the Air Force deliberately places increased emphasis and funding into educational scholarship opportunities. We have found great success in "growing our own," either through the scholarship programs or through training in the Uniformed Services University of Health Sciences (USUHS). The highest retention occurs when we control the educational environment. The Health Professions Scholarship Program (HPSP)

is a resounding success with 1,466 students currently enrolled. As reflected in the DOD budget for fiscal year 2013, the Air Force has a programmed budget to support a gradual increase to 1,666 students. We have also optimized our enlisted commissioning programs, such as the InterService Physician assistant Program (37 graduates per year), the Nurse Enlisted Commissioning Program (50 graduates per year), or guidance and statutory limitations in Section 2124 of Title 10, capping the total students enrolled DOD-wide in HPSP at 6,000. USUHS programs have physical constraints with the facility and academic accreditation constraints of oversight committees. Enlisted commissioning programs are constrained by the number of training-years programmed and funding against all enlisted training. Even with limitations, education has proven the most successful avenue of accession for the health professions.

(2) Other ways we entice fully qualified specialists into the Air Force is through compensation, using accession bonuses and incentives. Under the auspices of Health Affairs, the Air Force has funded accession bonuses and incentive pays to entice selected fully qualified specialists. For fiscal year 2011, the Air Force has sufficiently budgeted $16.4 million of this towards accession bonuses for personnel in fully qualified critical specialties based on historical rates of accession. Historically, as outlined in the first paragraph and under section (1), above, our accession bonuses have been of limited success due in part to bonus structures, as section 301d and 301e of Title 37 are mutually exclusive of section 302k and 302l of Title 37. Because these accession bonuses cannot be taken with a multi-year special pay, we have had limited effectiveness from its use. In fiscal year 2009, 12 of 118 fully qualified physicians accessed were eligible for an accession bonus; only 2 actually accepted the bonus. Our greatest success is within the Dental Corps, where 14 of 17 billets were filled for fiscal year 2009. Our other programs have limited success with nurse specialties at 120 of 155 qualified nurse billets filled. The various specialties of the Biomedical Sciences Corps having only 129 of 321 requested specialty positions filled for fiscal year 2009. As we migrate our compensation portfolio under the new pay authority of section 335 of Title 37, we will be able to initiate specialty pays for the mental health care providers and other critical wartime or shortage specialties that previously were excluded from accession and incentive pays. We feel this will be of great benefit to the Air Force and military health care in general, allowing targeted accession bonuses, incentive pays, and retention bonuses to address the manning shortages in the health professions. Due to the complexity of medical specialty and incentive pays and entitlements, scheduled migration of these contractual agreements under ASD(HA) will take time to fully implement. In general, recruiting many of the fully qualified specialists without bonuses is extremely limited. Level of compensation is an important consideration, but does not entirely ease the burden of multiple deployments.

(3) Lastly, no recruit enters without discussing quality of life issues, whether this is family services, medical practice, educational or leadership opportunities, or frequency of moves and deployments. We address many of these issues amongst the Air Force agencies. Ongoing projects include the Family Health Initiative, which is a medical model that better leverages our personnel. We are building force sustainment models, analyzing promotion opportunities, and developing a more proactive approach to provide more opportunities for advancement. In specialties with increasing wartime deployments, we are better able to spread the deployment load more evenly among our members. Restructuring of our medical groups allow increased opportunities for all health professions to become leaders in the Air Force.

We remain committed to obtaining the best in health care for our Nation' s military and their familiy members through enhanced recruiting efforts maximizing the tools provided for education, compensation, and creative quality of life efforts of new health professionals.

15. Senator GRAHAM. Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, what about retention of health care professionals; how much visibility do you have and oversight do you exercise into how well your medical community leaders and personnel chiefs are doing in effectively retaining mid-career personnel?

Mr. LAMONT. The Army Medical Department continuously monitors the need for behavioral health care providers based on the reliant populations' ongoing and changing demand. MEDCOM has increased funding for scholarships and bonuses to support expansion of our provider inventory. The Army expanded the use of the ac-

tive Duty Health Professions Loan Repayment Program and offers a $20K accessions bonus for Medical and Dental Corps health professions scholarship applicants. MEDCOM increased the number of Health Professions Scholarship Allocations dedicated to Clinical Psychology and the number of seats available in the Clinical Psychology Internship Program (CPIP). In partnership with Fayetteville State University, MEDCOM developed a Masters of Social Work program which graduated 19 in the first class in 2009. The program has a current capacity of 30 candidates.

Mr. GARCIA. Recruiting and retention rates of health care professionals are tracked very closely. I receive updates monthly from the Chief of Naval Personnel and the Surgeon General of the Navy, with particular emphasis on retention of mid-career medical personnel. Additionally, I receive a quarterly update, which is also presented to the Chief of Naval Operations. My staff coordinates with the staffs of the Bureau of Naval Personnel and Bureau of Medicine and Surgery to address any shortfalls, leveraging current policies and legislative authorities, consistent with the President's budget to recruit and retain these highly skilled professionals along the entire career continuum

Mr. GINSBERG. Within the Air Force I have visibility on a quarterly basis into the special pays and retention bonuses offered to the Medical Corps, Dental Corps, Biomedical Science Corps, Nurse Corps, and Medical Service Corps. My office monitors the amounts offered, the number of personnel eligible to elect the special pays, and the acceptance rate among our health care professionals, especially those in the critical wartime specialties, as well as among the mental health professionals. I firmly believe the Air Force medical community is sensitive to the health care needs of the population we serve and does an exceptional job ensuring the requisite health care professionals are retained. My office continues to work closely with the Air Force Surgeon General in anticipating requirements and using all available authorities to retain trained and experienced health care providers.

16. Senator GRAHAM. Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, please provide a snapshot effective March 1, 2010, of the current status of each of your Service's health care professional recruiting and retention, clearly indicating where shortfalls exist and also indicating by specific officer grade (e.g., O3, O4 , O5).

Mr. LAMONT. As of 22 March 2010, the United States Army Recruiting Command (USAREC) Medical Recruiting Brigade (MRB) has achieved 51 percent (457 of 905) of the fiscal year 2010 Active Duty recruiting mission and 46 percent (425 of 926) of the fiscal year 2010 U.S. Army Reserve mission. Mission achievement is most problematic in recruiting fully qualified military physicians, where only 18 percent (11 of 60) of mission is currently achieved, even given the availability of the Critical Wartime Skills Accession Bonus, which ranges from $180,000 to $400,000 depending on the specialty. The Army Medical Department (AMEDD) is currently short at the grade of Major (O4) across the board. This is a function of several phenomena; the most notable being the loss of officers in the grade of Captain (O3) who had completed their obligation prior to implementation of current retention initiatives, thus decreasing the number of officers available to promote to the grade of O4. While this grade imbalance is true, each Corps also has specific specialty shortages at differing grades, signifying a potential capability gap. Resolution of specific shortages is being addressed through precision recruiting, training and retention initiatives. Recent recruiting success has increased the company grade inventory that will increase the inventory at the rank of Major if these junior officers are retained, select specialty training and are promoted. Current projections for the end of fiscal year 2010 suggest that all but the Medical and Dental Corps will exceed the aggregate Budgeted End Strength. In fiscal year 2011, the Army G–1 will direct the recruiting force to emphasize specific qualifications.

Mr. GARCIA. Navy recruiting for health care professionals in the active Component is on track to meet program fiscal year 2010 goals, while we continue to experience challenges in recruiting health care professionals into the Reserve Component.

Active Component (AC):

We have reached 57 percent of overall AC health professions officer accession goals as of March 1, 2010. Student programs are out-performing the direct accession programs, continuing last year's strong student recruiting:

- Dental Corps: 51.6 percent of goal (77 of 149)
- Medical Corps: 44.5 percent of goal (143 of 321)
- Medical Service Corps: 64.1 percent of goal (143 of 223)
- Nurse Corps: 75.5 percent of goal (136 of 180)

Reserve Component (RC):

We have reached 24 percent of overall RC health professions officer accession goals as of March 1, 2010. This remains our most significant challenge. We are encouraged by recent authorization to establish a bonus for RC Nurse Corps officers, the health professions community which has the highest accession goal but the lowest attainment to date. We anticipate that implementation of this new incentive will favorably impact production.

- Medical Corps: 23.6 percent of goal (140)
- Dental Corps: 24 percent of goal (50)
- Medical Service Corps: 40 percent of goal (45)
- Nurse Corps: 19.4 percent of goal (165)

As of January 1, 2010, retention rate among Navy health profession officers is 93.5 percent AC and 85.3 percent RC. Fiscal year 2010 brings significant changes to Navy Medical Department's manning, such as the military to civilian buyback. Individual Corps status is summarized below:

- Medical Corps. AC manning is 97.3 percent and RC manning is 70.5 percent.
  - Shortfalls exist in the following critical wartime specialties: General and Orthopedic Surgery, Family Practice and Psychiatry.
- Dental Corps. AC manning is 89.9 percent and RC manning is 102.0 percent.
  - Shortfalls exist among O3–04 officers and in certain subspecialties: Oral Surgeons, Prosthodontists, General Dentists and Endodontists.
- Medical Service Corps. AC manning is 92.0 percent and RC manning is 93.8 percent.
  - Shortfalls exist in Podiatry and the following critical wartime specialties: Clinical Psychology, Physician's assistant and Social Work.
  - Navy is increasing the number of mental health providers to meet operational demand over the next few years, and the focus remains on filling and retaining critical wartime specialties.
  - USD (P&R) authorized establishment of a Health Professions Officer Special Pay to support accession bonuses for Clinical Psychology, Social Work and Physician's assistant, and retention bonuses for Clinical Psychology and Physician's assistant. This special pay package will be critical to meeting accession and retention goals in these specialties.
- Nurse Corps. AC manning is 90.7 percent and RC manning is 83.7 percent. We continue to see improved retention due to new special pays for critical and undermanned specialties.

It must be noted that we remain in keen competition with the private sector, the Department of Veterans Affairs, as well as with the other military departments, for the same finite talent pool.

Mr. GINSBERG. The snapshot requested is best answered by discussing the Air Force Medical Service (AFMS) in general, with focus on specific specialties as targeted examples. Of the 189 specialties in the AFMS, manning by specialty varies.

AFMS: Current officer manning as of March 1, 2010 shows officer manning at 91.2 percent, which includes medical residents but does not include other student categories. The Health Professions Scholarship Program (HPSP) continues to remain our primary vehicle for the recruitment of entry-level medical and dental officers with 82 percent of their fiscal year 2010 scholarships awarded. The Nurse Corps (NC) and Biomedical Sciences Corps (BSC) also utilize HPSP as an entry into these critical specialties, and 76 percent of these Corps' fiscal year 2010 scholarships are awarded. It is expected the remaining scholarships will be filled at the next selection board. The Medical Service Corps (MSC) does not participate in this program.

Accession of fully qualified (FQ) and experienced health professions officers remains problematic. It is much easier to access new graduates than residency-trained or specialized health care professionals. To date, Air Force Recruiting Service has successfully accessed only 35 percent of fiscal year 2010 requirements for FQ health professions.

Retention of health care professionals once their initial educational obligation is completed is also very problematic, and varies by Corps and by specialties within the Corps. Dental Corps (DC) retention after completion of educational obligations is 42 percent, an increase of 10 percent since 2004. As a Corps, dental officers show a small shortfall at the O–5 ranks, which corresponds to a ripple effect from retention problems in past years. This is most pronounced in our critically manned Oral Maxillofacial Surgeons with has large defects in manning within the O–5 rank for those officers with 14 to 19 years of commissioned service.

The Medical Corps has not shown a significant improvement in physician retainability even with the sluggish economy. Retention after completion of initial education obligation has not risen. There are several critical areas of concern with the MC. Foremost are our general and trauma surgeons, where we have limited personnel in the skilled O–5 rank. As surgical training and educational obligation encompasses the O–3 and O–4 rank, we find they leave at their earliest opportunity at completion of their military obligation in the O–4 and O–5 rank. Another concern is psychiatry with decreased retention at the O–4 rank, which produces a ripple shortfall to the O–5 rank. Critically important are our family practice and internal medicine specialists where we tend to lose the O–4 and O–5 experienced specialists, producing a shortage of senior skilled physicians in higher ranks.

Retention of Nurse Corps specialists is improving with the selective use of incentive pays with multi-year contracts. For the Nurse Corps in general, we have historically noticed a loss of O–3 officers. This trend is reflected throughout our clinical nurse specialties, but is magnified in our Surgical Nurse specialty where we have a loss of O–3 ranks and again at the O–4 rank. The implementation of our multi-year incentive contract has just passed its first year and we note retention has risen 13 percent since 2008, and now stands at 80 percent at the 4-year point for the Nurse Corps as a whole.

Our Biomedical Sciences Corps is the most diverse Corps and represents 19 specific specialties. Retention appears to have improved for some of these professions, although as a whole, the BSC has significant losses in the O3 rank and O4 rank. Early indicators show use of the special and incentive pays under the Consolidation of Pays authority released in July 2009 are showing increased retention for the physician assistant field as attritions in this field have decreased. The clinical psychologist specialty has gross losses after their initial completion of their initial obligation in the O3 rank, with ripple effects throughout the specialty. The public health career field also has similar deficits at the O3 rank and struggles to maintain adequate retention to meet mission requirements. Many other biomedical science career fields are not authorized or funded for special and incentive pays, although recruitment and retention of these fields is a challenge.

Retention of the Medical Service Corps is generally not an issue, but recently we have noticed a loss trend in O–4 and O–5 rank as increasing numbers of personnel with long prior service become eligible for retirement with only 10 years of commissioned service. Recent changes to the selection process should provide more stability in this field.

In summary, improved recruitment and retention incentives are projected to stabilize the chronic manning shortfall of several critical health professions specialties. Educational incentives (HPSP, FAP, USUHS) are especially successful to fulfill out-year requirements, however recruiting FQ health professionals continues to be a challenge.

17. Senator GRAHAM. Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, what is your Service's plan for accomplishing the difficult task of recruiting and retaining highly qualified and motivated health care professionals?

Mr. LAMONT. The Army will continue to use monetary and nonmonetary incentives to recruit and retain sufficient quantity of military and civil service behavioral health providers.

Mr. GARCIA. Navy met overall health professions recruiting goals in fiscal years 2008 and 2009 and is on track to meet overall Active medical goals in 2010. With a 43 percent increase in Reserve Component (RC) medical goal in 2010, an increased accession requirement of 121 providers, we continue to experience challenges in all four RC health profession corps.

We are continuing best practices learned during the past 2 years and are implementing several new initiatives that we expect will bear fruit in our shortfall areas including:

- Adjusting bonuses and incentives for fully trained medical professionals.
- Participating in the Military Accessions Vital to the National Interest (MAVNI) pilot program to access qualified, legal non-citizen medical doctors.
- Initiating an accession process for legal permanent residents who are qualified physicians or medical students.
- Offering loan repayment opportunities for critical medical specialties.
- Expanding use of medical officers to inform undergraduate and professional medical students across the Nation of opportunities in Navy medicine.
- Adding more full time recruiters to recruiting medical professionals.

• Expanding the Health Service Collegiate Program to include Permanent Residents (green card) in critical student specialties.
• Offering bonuses for clinical psychologists, physician's assistants, and social workers.
• Continuing the Critical Wartime Skills Accession Bonus to target physicians (up to $400,000) and dentists (up to $300,000).

Navy's most effective tools for retaining health care are special and incentive pays. Each of the four Corps (Medical, Dental, Medical Service and Nurse) has unique special pays designed to enhance retention among their respective health professionals. Other tools include training opportunities, age waivers and selective use of retired retained officers.

• Medical Corps. The retention challenge for the Medical Corps is maintaining the needed inventory with the proper specialty mix to meet requirements. We are addressing this challenge through targeted use of direct accessions, age waivers, and selective use of retaining retired officers for undermanned critical medical specialties. Multi-year Special Pay (MSP), Additional Special Pay and Board Certified Pay are all critical retention tools the Navy uses to maintain its inventory. Of these, MSP offers the greatest leverage with a 2- to 4-year obligation that enables achievement of proper specialty mix.
• Dental Corps. The Dental Corps is falling short of meeting retention goals. Junior officers are especially difficult to retain. Just as with the Medical Corps, special pays are critical to Dental Corps retention efforts. The Dental Corps has a Critical Skills Retention Bonus for junior officers, which was recently renewed for another 3 years and a multi-year retention bonus targeted at junior officer dentists. Additionally, a Critical Wartime Skills Accession Bonus was approved fiscal year 2010.
• Medical Service Corps (MSC). Fiscal year 2009 gains in MSC exceeded losses for first time since 2002. The overall loss rates are starting to stabilize at 9 percent, but still fall short of meeting the 5-year retention goals. Another retention challenge is retaining the proper specialty mix. MSC retention bonuses were recently approved for clinical psychology and physician's assistants, along with the retention special pay that exists for pharmacists and optometrists. Navy is addressing the retention of mental health and wartime specialties through the Health Professions Loan Repayment program and other special/retention pays.
• Nurse Corps. Retention of Nurse Corps junior officers has been difficult due to issues around work/life balance and long deployments. Navy is working to improve retention through application of new special pays for critically manned and undermanned specialties. Additionally, the Nurse Corps is allowing junior officers to apply for funded training earlier in their career and using the Health Profession Loan repayment program to encourage retention of junior officers.

Mr. GINSBERG. The specific recruiting challenges faced by the Air Force and our plan to overcome those challenges were described in the response to Senator Graham's question on the challenge of recruiting health professionals in the wartime environment and how we plan to meet this challenge. Our future members have many of the same concerns as our current members. Retention presents many of the same challenges as recruiting. As we attempt to retain our skilled health care professionals, the private sector and other Federal agencies, such as Department of Veterans Affairs (VA) and Public Health Service, are our strongest competitors. Private sector pays, sign-on bonuses, annual compensation, and retirement packages are increasing due to the growing demand for these skilled professionals. Once the education of our health care professionals is completed, the value of these individuals is enhanced, leading to significant pay disparities between our members and their private sector counterparts. This is especially true for those surgical specialties crucial for wartime support. Limited compensation packages, limited educational and leadership opportunities, limited family and quality of life benefits are all areas we hear as reasons for our health professionals leaving the Air Force. Similar to the approach we have for recruiting, the Air Force is confronting retention challenges with an aggressive three-pronged approach to enhance: (1) education, (2) compensation, and (3) quality of life.

(1) Education: Education is an invaluable tool. We continue to find great success in "growing our own" through civilian or military-sponsored residency and subspecialty programs, with over 13 percent of the Air Force Medical Service (AFMS) commissioned officers in formal training programs. "Growing our own" encompasses the spectrum from accessing new recruits,

developing their skills and specialties, to maintaining and expanding on those capabilities for use in both state-of-the-art medical centers and in the deployed and austere environments of wartime and humanitarian missions. Our highest retention occurs when we control both the educational environment and the service obligations associated with advanced training programs. Our educational opportunities include aggressive use of subspecialty training and post-baccalaureate degree programs for our Nurse Corps, Biomedical Sciences Corps, and Medical Service Corps. Our surgical optimization project partners with VA hospitals and other non-Federal facilities. The continuing education of our health care professionals enhances the retention and value of these military members through continuing commitments and service obligations.

(2) Direct compensation through contractual agreements is another way we retain members, using all available pay authorities equitably amongst the other Services and under the auspices of Health Affairs. By fully funding multi-year contract retention programs with our incentive pay programs, the Air Force affirms its commitment to retaining long-term the best skilled health care professionals. With the exception of our wartime and critical surgical specialties, the total enhanced pay compensation programs are helping to retain mid-and senior-level physician specialists. The Air Force investment in health professions special incentive pays totaled $194 million in fiscal year 2008 and $259 million in fiscal year 2009, and $271 million for fiscal year 2010. These increases are having a positive effect on retention. Retention of our Dental Corps specialists has greatly improved over the last 2 years; we look forward to maintaining nearly 100 percent in the near future. Our best successes are with our Nurse Corps, where we appear to be stabilizing after precipitous losses of 11.4 percent annually from fiscal year 2005 to fiscal year 2008. With increased incentives, we lost only 9.5 percent of the Nurse Corps inventory in fiscal year 2009. Various specialties of the Biomedical Sciences Corps, including clinical psychologists and clinical social workers, have recently been funded for incentive pays. Early results indicate these programs are stabilizing also. Incentive packages help offset some of the pay disparities between the military and private sector compensation packages. Although it does not reach parity, it does help ease the burden of multiple deployments. Multi-year contracts under Title 37 allow some stability in the health care professions, especially those with high separation rates. As the incentive pay programs come closer to meeting private sector compensations, we see increased retention of our stressed career fields. At this point, we are close to maximizing the pay authorities of Title 37 for many of our most critical wartime specialties, leading us to utilize more of section 335 of Title 37. As we migrate our compensation packages under the new pay authority of section 335 of Title 37, we will finally be able to include other critical specialties previously excluded from incentive and retention pays. We will still be at the threshold ceiling for many critical specialties for the retention bonuses and board certification pay areas. We feel the eventual migration of all our pay programs under section 335 of Title 37 over the next several years will be of great benefit to the Air Force, but we will be unable to compete with private sector compensation packages for many of the critical surgical specialties.

(3) As our members grapple with decisions to remain in the service, we understand the family is greatly involved. Quality of life issues of family services, availability of schools, frequency of moves and deployments, general base services, and future opportunities are at the forefront of any discussion. We have addressed many of these issues both for the new member, the 20-plus year veteran, or the civil service employee. For those specialties with increasing wartime deployments, we are able to spread the deployment load more evenly among our bases and members. By maintaining our deployments to 6-months in duration, we can stabilize our force and retain more of our skilled assets. Other ongoing projects include the Family Health Initiative, posturing our personnel for our future medical model. We are partnering among intra-AF agencies to build force sustainment models, increase promotions, and develop a proactive approach to retaining the numbers of professionals in each specialty, providing the Air Force a valued tool to reflect our future force.

While retention of the health professions remains a challenge, we remain committed to exercise all available authorities in concert with the other Services under Health Affairs to obtain the best value in health care for our Nation's military and their family members.

PAY RAISE

18. Senator GRAHAM. Dr. Stanley, the proposed pay raise for fiscal year 2011 is only 1.4 percent, but as you point out, matches the rise in the Employment Cost Index. What would be the impact on the DOD budget, and on the personnel accounts of each of the Services, if Congress directed an increase in the pay raise by 1 percent, or even a half percent, and did not provide a top-line increase or offsetting funding?

Dr. STANLEY. While the Department must and will continue to offer a competitive compensation package that recognizes the sacrifice of military members and their families, the Department must work closely with OMB and Congress to ensure the additional cost hinder recapitalization or put additional burden on the American taxpayer.

Each time the annual pay raise is increased by an additional ½ percent, military personnel costs are increased by roughly $0.5 billion in the current year and every year thereafter. Without a top-line increase, the Department would be forced to sacrifice other programs to fund the pay raise.

The Department supports an increase in the military basic pay of 1.4 percent, corresponding to the increase in the Employment Cost Index but is opposed to an increase in excess of this amount. The pay gap between military and private sector compensation has been closed as a result of congressionally mandated military basic pay increases of ½ percent above the ECI over the past decade. Currently, the Department believes the full compensation package provided to military members compares favorably with counterparts in the private sector.

INCENTIVES FOR UAV PILOTS

19. Senator GRAHAM. Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, the importance of improving our surveillance capabilities through unmanned aircraft is well understood. Each Service, however, seems to approach the issue of who controls—or pilots—such aircraft, and the compensation they receive—differently. Please explain how your Service handles this issue, and how you are doing in making this an attractive career path or skill.

Mr. LAMONT. All Army Unmanned Aircraft Systems (UAS) are operated by enlisted personnel in the Military Occupational Specialty (MOS) 15W, UAS Operator. MOS 15W is one of the most popular MOSs, and the Army is not experiencing problems filling or maintaining its ranks. The majority of UAS operators are assigned to maneuver Brigade Combat Teams (BCTs), operating the RQ–7 Shadow UAS. These personnel directly support ground maneuver commanders, providing intelligence, surveillance, reconnaissance, and target acquisition capability. Although the UAS community has a small population of Warrant Officers who were prior UAS operators, they serve as the tactical and technical UAV systems integrators who interface with the ground commanders, and no longer function as operators.

As the Army continues to grow the UAS operator population, the capability of the Army to fill and maintain these positions has grown along with it. This is a specialty in which the Army has enjoyed tremendous success with its enlisted operator community. Given this success, there are no plans at this time to request any special or incentive pay for UAS operators.

Mr. GARCIA. Marine Corps Unmanned Aerial Vehicle (UAV) Operators are enlisted Marines, E1 through E9, assigned Primary MOS 7314. The Marine Corps currently reports PMOS 7314 as "critical" to OSD due to inventory shortages. While there is no Enlistment Bonus to become a UAV operator (the Marine Corps does not pay enlistment bonuses for specific MOSs), the Marine Corps currently pays high Selective Reenlistment Bonuses (SRB) to retain Marines with these skills. Additionally, in the fiscal year 2010 Retention Plan, the Marine Corps has opened up 7314 for qualified Marines from other PMOSs to lateral move into upon reenlistment.

Fiscal Year 2010 SRB Rates

PMOS	Zone A (E3 and Below)	Zone A (E4)	Zone A (E5 and Above)	Zone B (E5 and Below)	Zone B (E6 and Above)	Zone C (E5)	Zone C (E6)	Zone C (E7 and Above)
7314	$46,500	$53,000	$58,500	$36,000	$40,000	$38,000	$43,500	$48,000

The decision on who will pilot Navy's UAVs has not been determined as the program is still in its early development phase.

Mr. GINSBERG. Today's operational requirements for both unmanned and manned aircraft demand high level of aviation professionalism from both the rated and career enlisted aviator communities. Current resourcing methods of manning remotely piloted aircraft (RPA) authorizations with traditional undergraduate pilot trained (UPT) pilots from other manned weapon systems are unsustainable. As the AF continues to grow to 65 RPA Combat Air Patrols (CAPs) by 2013, the demand on a stressed inventory of undergraduate pilot trained (UPT) pilots competing to fill both manned and unmanned weapon systems requirements is falling short. As a result, the Air Force created a new rated officer Air Force Specialty Code (AFSC) to categorize RPA pilots in a distinct career field and created a unique RPA training pipeline, currently being refined through "BETA Test" classes. The RPA "BETA Test" is a potential future alternative to the current UPT method. In addition, the Air Force also created a new AFSC to categorize enlisted RPA sensor operators in a distinct career field.

As with other aviation career fields, having the ability to attract and retain airmen to these new RPA career fields for a military aviation career is instrumental. Due to legislative language in the monthly Aviation Career Incentive Pay (ACIP) and Career Enlisted Flyer Incentive Pay (CEFIP) authorities, the Air Force is unable to pay new RPA pilots and sensor operators ACIP or CEFIP. As a result, by memorandum, I authorized implementation of the Air Force's RPA Pilot Incentive Pay Program effective 30 November 2009 and the RPA Sensor Operator Incentive Pay Program effective 29 January 2010, both consistent with approval provided by DUSD (P&R). RPA pilot and sensor operator incentive pay is paid monthly under the assignment incentive pay (AIP) legislative authority, 10 U.S.C., 307a, and mirrors the policy and dollar amounts outlined for paying and receiving ACIP or CEFIP. As far as annual bonuses, BETA-trained RPA pilots will not be eligible for a retention bonus until the expiration of their 6-year training ADSC in 2015. However, to initially grow the enlisted RPA sensor operator career field, use of the selective re-enlistment bonus (SRB) was deemed necessary to garner volunteers from both the enlisted Intelligence and Career Enlisted Aviators (CEAs) career fields.

The Air Force will continue to evaluate monthly incentive pays and annual bonuses as both of the RPA career fields mature.

RECRUITING

20. Senator GRAHAM. Dr. Stanley and Mr. Lamont, you pointed out in your written statement that the Services achieved remarkable success in recruiting high school graduates in fiscal year 2009. You also note, however, that economic conditions will change and that the Services have to be ready to recruit the highest caliber men and women in good economic times or bad. The Army looked very hard a few years ago at the merits of individuals who wished to enlist, but did not finish high school. Similarly, waivers for drug use, minor—and not so minor—civilian criminal activities and so on, were carefully administered, but in much greater numbers than today. What is your assessment of the Services' ability to identify individuals with potential for outstanding service despite blemishes on their records?

Dr. STANLEY. We are confident processes the Services have in place to screen potential recruits are sound. Each Service realizes that youthful indiscretions not indicative of moral turpitude are not sound predictors of successful service.

The waiver process used by the Services revolves around the "whole person" concept and includes extensive screening which takes into account many factors, such as the time since the infraction, the actual events leading to the infraction, recommendations from members of the community (teachers, members of the clergy, neighbors, etc), and face-to-face interviews with senior leaders. Studies have shown that individuals granted enlistment waivers generally perform equally or better than their non-waivered counter parts.

In 2008, the Department issued policy directives that standardize the waiver processes and data collection procedures across the Services. These changes were designed to improve the process and provide the Department with more reliable data for analysis. We have recently contracted with the Center for Naval Analyses to study this issue further and to provide us with a more current assessment. The analysis will be concluded this fall.

Mr. LAMONT. The Army has an excellent process to identify individuals who display potential for military service despite blemishes on their records. Statistics clearly show there is very little risk involved in recruiting individuals with blemishes on their records.

21. Senator GRAHAM. Dr. Stanley and Mr. Lamont, if supply and demand dictates varying standards for recruitment, should we not be looking continually and over the long run at the metrics that will ensure successful recruiting of quality individuals over the long run?

Dr. STANLEY. DOD has proven, long-established Recruit Quality Benchmarks, developed under the guidance of the National Academy of Sciences. The key metrics for each fiscal year enlistment cohort are: 90 percent high school diploma graduates (because they have lower attrition rates in the first 36-months of Service than other credential holders or dropouts); and 60 percent average or above cognitive ability (as measured by the Armed Forces Qualification Test because higher scoring recruits perform better in training and on the job than lower scoring recruits). That said, the Department recognizes the potential value of other metrics—such as temperament (personality) characteristics of applicants and has been encouraging Service efforts to explore such non-cognitive attributes that may be reliably measured and predictive of military performance.

Mr. LAMONT. We are experiencing a marked increase in fiscal year 2008, 2009, and 2010 recruit quality. Part of that increase is based on screening metrics. The Army's attempts to screen recruits to predict high performance and retention continued last year as we employed the Tailored Adaptive Personality Assessment System, a non-cognitive test which can be used to predict first term attrition and other motivational performance aspects of applicants. Additionally, a recent Tier II Attrition Screen (TTAS) report completed by the United States Army Accessions Command indicated the TTAS screen could significantly reduce the Tier II (Non-High School Diploma Graduate/Alternate Credential Holder) 36-month attrition rate. These are two applications employed in an effort to sustain the Army's tremendous momentum of recruiting high quality individuals. We also commissioned a RAND study this year to develop a holistic strategy for the optimal levels and balance of recruiting resources that both accounts for the near-term recruiting environment and postures the Army for continued longer-term quality recruiting success as the environment changes. The results should assist the Army with manning the recruiting force and optimally employing incentives and deploying resources based on the recruiting mission and environment.

EDUCATIONAL OPPORTUNITIES FOR MILITARY CHILDREN

22. Senator GRAHAM. Dr. Stanley, last year we received testimony from military spouses who were concerned about access to high quality education for their children, and in particular, the problem that military families experience in moves to remote areas or communities where there are few educational options. In your statement you report that more than half of the schools serving communities with significant military populations do not meet State academic standards in reading and math. The National Defense Authorization Act for Fiscal Year 2010 required DOD to do a study on options to improve educational opportunities for military children, including the option of charter schools. A report on that study is due to the subcommittee on March 31, 2010. Are we on track for that?

Dr. STANLEY. The quality of education for the children of our servicemembers is extremely important to the Department. I share your concern that some families, based on their assignment, may have fewer educational choices.

To address the important question posed within the National Defense Authorization Act (NDAA) for Fiscal Year 2010, we are conducting a competitive procurement to obtain a reputable and experienced contractor in education and military student research. This method of conducting the study will provide an unbiased view and expert analysis to inform Congress of the Department's progress in this area.

The procurement process for developing a solicitation which includes free and open competition takes approximately 4 months. This process began in November, and included collaboration with the U.S. Department of Education as the reporting requirement in the NDAA required. The solicitation was put out for bidding on March 26. We expect to have a contract awarded in May and a report to you by December 31, 2010.

An interim response giving detailed accounts of the Department's progress is currently being reviewed and will be delivered to Congress in the near future.

23. Senator GRAHAM. Dr. Stanley, what is your opinion on the option of charter schools?

Dr. STANLEY. DOD welcomes parental and community efforts to develop and enhance the educational opportunities for all children, especially military connected

children. These opportunities can include traditional public schools, private schools, home school, and charter schools.

DOD supports charter school options on military installations as one approach to improving the public schooling of military children.

Specific examples of DOD's support of charter schools are the three Charter Schools currently on military installations, Joint Reserve Base New Orleans, Davis Monthan Air Force Base, and Vandenberg Air Force Base.

24. Senator GRAHAM. Dr. Stanley, what would be the advantages of DOD looking at this type of public option on military installations?

Dr. STANLEY. An advantage of charter schools on military installations is to provide our families with another viable public school option when considering where to educate their children. Additionally, starting a charter school takes community investment and involvement, we encourage our families and leadership to be involved in their children's education.

DOD does not have the authority to establish charter schools. There are, however 158 public schools on 68 military installations which are not DOD schools. The establishment of charter schools could be another alternative.

25. Senator GRAHAM. Dr. Stanley, can you envision a circumstance in which an opportunity scholarship program could address the concerns of military families regarding expanded educational options?

Dr. STANLEY. Yes, I can envision a circumstance in which opportunity scholarship programs could address military families' concerns for expanded educational options. I consider education opportunities for military families an important Departmental goal.

26. Senator GRAHAM. Mr. Ginsberg, I understand that the Air Force hosts two charter schools, one at Davis-Monthan in Arizona and one at Vandenberg Air Force Base in California. What have you learned in this experience; some of the best practices that could be shared, especially in terms of funding for facilities and capital expenses, drafting of a school's charter or contract, staffing, etc? What unique challenges does the Air Force face in establishing carter schools on military installations?

Mr. GINSBERG. The initiatives at Davis-Monthan AFB and Vandenberg AFB have worked for those two bases. Davis-Monthan used results from a survey of 200 parents to identify interest in, and a need for, an on-base middle school. The school liaison officer coordinated with base leadership including the Plans Office, Civil Engineering, the Legal Office, Contracting, and Security Forces to ensure smooth implementation of the charter school. The school on Davis-Monthan now has 114 students (5 are non-military connected) and is requesting future expansion (over 4 years) from grades 6–8 to grades 6–12. The school is housed in an existing facility that was previously leased to the local school district. The charter school company signed a no-fee lease and cares for the property and provides building maintenance.

Davis-Monthan reports challenges do still exist, especially ensuring installation security procedures are communicated to and followed by all school personnel, students and parents. Included in maintaining these essential procedures is the proper coordination for the entrance of non-DOD personnel and school subcontractors onto the installation. In addition faculty members who are foreign national sometimes required an extended period of time for background checks.

At Vandenberg AFB, the charter school, located on the base, operates as a public school with open enrollment. The base leases the school to the local education agency which, in turn, leases the building site to Manzanita Charter School. All facility maintenance, utilities, etc are paid by the charter school. The base does have jurisdiction for law enforcement and contingencies. Manzanita officials are very vocal about their continued desire to remain on base due to the outstanding relationship built with the military community. Military students account for approximately 100 of the 280 children enrolled. Parents of the military students are grateful to have the choice of attending a Lompoc Unified school District school or the Manzanita pubic charter school. Each entity operates off a different educational model, enabling parents to choose the best option for their child.

Headquarters Air Force Services recently issued a memo to address the establishment of charter schools on or near Air Force installations. In an effort to provide standard procedures for Air Force base leadership in working with charter school initiatives in their communities, installation commanders now contact the Headquarters Air Force office with functional responsibility for military-connected student programs.

27. Senator GRAHAM. Dr. Stanley, Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, how would you characterize the concerns of military families about the quality of education for their children?

Dr. STANLEY. The quality of K–12 education is an important factor for military families as they make career decisions on assignments and is linked to retention in the military services.

A significant element of family readiness is an educational system which provides not only a quality education but recognizes and responds to the unique needs of children of military families.

Children of military families face distinctive challenges unparalleled in the general student population. The most glaring of these challenges is the number of transitions military children undergo during their school years. Military children move on average six to nine times during their K–12 school years. Among the common stresses involved in children relocating to a new school are the differences in achievement standards, school protocol, course offerings, extracurricular activities, and academic requirements.

These school-based transitions are exacerbated by the challenges of leaving a cadre of friends, educators, and caregivers the military child has spent months or years establishing. Additionally, one of the greatest difficulties military children will face, regardless of additional stresses of relocation and school transition, is the effect of being apart from one or both parents who may be deployed. All of these factors can result in military children suffering in areas of school performance and educational attainment.

The Department offers a variety of support programs and educational opportunities to address these concerns.

Mr. LAMONT. Army parents care deeply that their children have access to quality educational opportunities despite the frequent moves and deployments. Recognizing this importance, one of the five tenets of the Army Family Covenant is our commitment to ensure excellence in schools. As our children move from State to State, school district to district, they encounter different achievement standards, school protocols, course offerings, extracurricular activities, and academic requirements that may jeopardize their educational progress to include high school graduation. These school-based transitions are further exacerbated by the challenges of leaving friends, educators, and caregivers that the military child has spent months or years establishing. Additionally, one of the greatest difficulties military children will face, regardless of additional stresses of relocation and school transition, is the effect of being apart from one or both parents who have been deployed. All of these factors can result in military children suffering in areas of school performance and educational attainment.

Army has implemented several programs and initiatives to mitigate the effects of deployments and to help ensure smooth educational transitions as our children move from one installation to another. Army School Liaison Officers serves as advocates for military-connected students and assist them through school transitions and with school-related issues. Academic support services help students compensate for parental absences with on-post homework centers, and 24/7 online tutoring support for students regardless, of where they live. The Army provides specialized training for school personnel to ensure they are prepared for the challenges our military students face when their parents are deployed. In addition, Military Family Life Consultants, licensed mental health clinicians, have been placed in many of the public schools that serve large populations of military children, to assist students to effectively handle the stress of parental deployment.

Mr. GARCIA. Marine Corps and Navy parents rank quality K–12 education very high on their priorities when making decisions that impact their families. It also gets high consideration on their career decisions, on assignments, and is linked to retention. One of the first areas many of our families explore when notified of a Permanent Change of Station (PCS) is the quality of the schools near their new installation. A significant element of family readiness is an educational system that provides not only a quality education, but also one that recognizes and responds to the unique needs of children of military families.

Military children move several times during their K–12 school years. Continuous transitions equate to increased difficulties integrating into new schools which are usually in different States; adjusting to differences in achievement standards, enrollment criteria, school policies, and course offerings; access to or eligibility for extracurricular activities; and academic requirements for graduation. The Interstate Compact for Educational Opportunity for Military Children, now signed by 28 States, focuses on leveling the field for those issues. The DoN is engaged with the DOD in supporting that Compact.

Mr. GINSBERG. Air Force families across the world include 175,000 children ages 5–18 and these children generally move more than six to nine times during their K–12 school years, often making multiple moves in high school years alone. Academic standards, promotion/graduation requirements, services for children with special needs, eligibility for sports and extracurricular activities, and transfer and acceptance for records vary greatly from State to State and even district to district. While these are not new issues, national emphasis on quality education (as exemplified by strong interest in the re-authorization of the Elementary and Secondary Education Act), and higher standards for admission to many post high school education and training institutions increase the stakes like never before. In addition, the added stress of family separation due to deployments (recent study indicates 37 percent of children worry about safety of the deployed parent) has combined with transition issues to increase the need for providing information and support to military families dealing with military child education issues.

Air Force families are no different than civilian families in that concern for the general well-being of their children is a primary driver in their lives. A major part of this sense of well-being is availability of quality education opportunities. Most of our families are fortunate to be located in areas where the local school districts (and overseas, the DODDS schools) provide a positive educational experience. In areas where that is not the case, our families have proven very proactive and resourceful in working with school liaison officers, installation leadership, local education agencies and others to find suitable educational augments or options.

28. Senator GRAHAM. Dr. Stanley, Mr. Lamont, Mr Garcia, and Mr. Ginsberg, what thoughts do you have on ideas that could lead to better options, including establishing charter schools or offering opportunity scholarships on military installations?

Dr. STANLEY. My ideas for better educational options include support for charter schools, DOD partnership with Department of Education, and an interagency collaboration.

DOD supports charter school options on military installations as one approach to improving the public schooling of military kids. Like all parents, military parents want quality education for their children. A significant element of family readiness is an educational system that provides not only a quality education but one that recognizes and responds to the unique needs of children of military families.

The Department is working on a collaborative Educational Partnership Initiative with the Department of Education in efforts to ease the transition of military students and to provide resources to local education agencies (LEA) who educate military children. DOD expanded mission is a proactive approach to addressing the issue of the availability of quality educational opportunities for military children.

The Department is represented on the National Security Council Military Family Interagency Policy Committee (IPC) that has been established as part of the President's commitment to military families. This administration-wide effort is essential to focus the strengths of the various departments and agencies toward supporting and enriching the lives of our military families, including transition, achievement, and expanding educational options for military children.

Mr. LAMONT. While Army has no authority or expertise to establish charter schools, we fully support charter school options on military installations as one avenue to improve the educational achievement of military students and meet their unique needs. Using another approach, Army is an active participant in DOD's formal partnership with the Department of Education in an effort to ease the transition of military students and provide resources to local education agencies who educate military children. In June 2008, the Deputy Secretaries of Defense and Education signed a Memorandum of Understanding (MOU) to create a formal partnership between the two departments to support the education of military students. The MOU provides a comprehensive and cohesive structure for collaboration between the two Federal agencies as well as with local, State, and other relevant entities. Through the MOU, the agencies can now leverage their coordinated strengths to improve the educational opportunities of military connected students.

Mr. GARCIA. Navy and Marine Corps parents' desire for access to a quality K12 education is no different than most other parents. With our sailors and marines already experiencing a high state of readiness, regular relocations, and multiple/extended deployments, it is particularly important that Services do all they can to support access to quality education for their children. It is essential that we explore alternatives. However, the DoN does not have the authority, nor the required resources, to establish charter schools.

Through recent improvements in the provision of civilian School Liaison Officers (SLO) at installations, an emphasis on Exceptional Family Member services, better collaboration with Local Educational Authorities (LEAs) through the Educational Partnership Initiative, and connections to the military liaisons working with States on the Interstate Compact, we've made great strides toward smoothing transitions for our students. A number of parents have opted to home school their children. While a viable option, it adds additional stressors to parents who are already experiencing difficulties and can even add to the economic burden of the family when a spouse must leave paid employment to educate their children. Our SLOs are helping by providing home school parents with linkages to networks and resources.

The DoN supported the 2008 Memorandum of Understanding between DOD and the Department of Education which created a formal partnership to support the needs of military children. The DoN continues to work closely with DOD and the Department of Defense Education Activity (DODEA) on collaboration between local, State, and other agencies to support the educational opportunities of military children.

Both the Navy and the Marine Corps will continue to place a high emphasis on collaborative relationships between military families and their LEAs and seek to find resolutions at the local level.

Mr. GINSBERG. Installation commanders are encouraged to support parental and community efforts to develop/enhance learning opportunities for all children and especially military connected students. These opportunities can include traditional public schools, private schools, virtual schools, home schools, and charter schools.

Headquarters Air Force Services recently issued a memo to address the establishment of charter schools on or near Air Force installations. In an effort to provide standard procedures for Air Force base leadership in working with charter school initiatives in their communities, installation commanders now contact the Headquarters Air Force office with functional responsibility for military connected student programs. This office provides procedural guidance and coordinates with other headquarters offices on related issues such as use/lease of Air Force facilities. This policy insures a positive, standardized approach to support of charter schools and other educational options for military-connected students.

Air Force also works closely with the DODEA Educational Partnership Initiative, providing input and advocating for grants and other support to school districts that educate military-connected students. We believe this proactive approach will strengthen educational options within local education agencies for not just Air Force children but all students within these districts.

LEGISLATION

29. Senator GRAHAM. Dr. Stanley, Mr. Lamont, Mr. Garcia, and Mr. Ginsberg, do you need any additional legislation in order for the DOD to move forward?

Dr. STANLEY. No, other than the fiscal year 2011 Omnibus legislative proposals submitted to Congress no further legislative adjustments for my organization, the Office of the Under Secretary of Defense (Personnel and Readiness), are needed at this time. If additional authority is required, the Department will follow the formal channels to work with Congress.

Mr. LAMONT. The Department is continually assessing the need for additional legislation. As we reach consensus as to what legislative changes will help DOD move forward, we will certainly communicate those recommendations to Congress.

Mr. GARCIA. The Department of Navy is not currently seeking new legislative authorities. If new legislative requirements are identified, we will propose their inclusion in the Defense Legislative Program.

Mr. GINSBERG. Yes. Compressed Orderly Rapid Equitable Replacement

DOD has transmitted a proposal to authorize the Secretary of Defense and the Air Force specifically to conduct an alternate, streamlined Equal Opportunity complaint processing system similar to a highly successful pilot program the Air Force conducted from 2005–2007 pursuant to a congressional mandate. This system is completely optional for the complainant, stresses early dispute resolution, consolidates processes in the administrative stage and preserves the complainant's full right to appeal to the Equal Employment Opportunity Commission and to bring suit in Federal court. According to a June 2008 DOD report to the Government Accountability Office report, the previous pilot cut processing times for cases that used this alternate system by approximately 50 percent (from 216 calendar days to 109). We

found this to be an effective tool in addressing the chronic problem of excessive time to process these complaints. It saves resources and leads to a quicker resolution of the complainant allowing complainants, coworkers and managers involved to return their full focus to the mission. We would ask that this legislation be favorably considered.

[Whereupon, at 12:41 p.m., the subcommittee adjourned.]

DEPARTMENT OF DEFENSE AUTHORIZATION FOR APPROPRIATIONS FOR FISCAL YEAR 2011

WEDNESDAY, MARCH 24, 2010

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

MILITARY HEALTH SYSTEM PROGRAMS, POLICIES, AND INITIATIVES

The subcommittee met, pursuant to notice, at 10:02 a.m. in room SR–232A, Russell Senate Office Building, Senator Jim Webb (chairman of the subcommittee) presiding.

Committee members present: Senators Webb, McCaskill, Begich, Graham, and Thune.

Also present: Senator Cardin.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, counsel; and Gerald J. Leeling, counsel.

Minority staff members present: Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Paul J. Hubbard and Jennifer R. Knowles.

Committee members' assistants present: Nick Ikeda, assistant to Senator Akaka; Gordon I. Peterson, assistant to Senator Webb; Tressa Guenov, assistant to Senator McCaskill; Lindsay Kavanaugh, assistant to Senator Begich; and Walt Kuhn, assistant to Senator Graham.

OPENING STATEMENT OF SENATOR JIM WEBB, CHAIRMAN

Senator WEBB. Good morning. The subcommittee meets today to receive testimony on Military Health System programs, policies, and initiatives in review of the National Defense Authorization Request for Fiscal Year 2011 and the Future Years Defense Program.

The Military Health System serves a population of more than 9.5 million eligible beneficiaries, both in military treatment facilities and through contracted private-sector care.

The primary mission of the Military Health System is to maintain the health and readiness of our Active Duty military personnel, both at home and on the battlefield. The system also provides medical care for millions of dependents of Active Duty personnel, military retirees and their dependents, certain Guard and Reserve members and their families, and others.

As one who's spent most of his life in and around the military, I note the presence of the ranking Republican.

Senator GRAHAM. Thanks for starting on time.

Senator WEBB. Yes.

I care deeply about our special obligation to provide our military servicemembers, their families, retirees, and our veterans with the finest healthcare treatment available.

For this reason, I introduced a companion bill in the Senate on Monday, when it was recognized that legislation was needed to explicitly state in the law that TRICARE and Department of Defense (DOD) nonappropriated-fund health plans meet the minimum essential coverage for individual healthcare insurance required by the healthcare reform bill. My bill was based on one introduced in the House of Representatives last Friday by Congressman Skelton.

I appreciate the support demonstrated by Senator Graham and other members of this subcommittee for this bipartisan legislation. The measure was hotlined last night. I'm hopeful that our members will agree to pass it soon so that we can take this issue off the table as a matter of concern for our servicemembers, their families, and other beneficiaries.

Nine years of conflict have stressed our military in ways that were not contemplated at the inception of the All-Volunteer Force. As I noted 3 years ago, and again 2 weeks ago, during this subcommittee's initial hearing in this session, we are in uncharted territory as a result of past rotation cycles, multiple combat deployments, and an unsatisfactory deployment-to-dwell ratio.

Many of you will remember that I introduced what was called dwell time legislation 3 years ago, trying to put a safety net underneath our military members being deployed when the rotational cycles went below 1 to 1, although traditionally they were supposed to be, and have been, around 2 to 1—2 years home for every year deployed, 1 year home for every 6 months deployed.

A lot of people at that time, I think, interpreted this legislation as politically motivated. I can say again, and reaffirm today, that it was not, that the well-being and proper leadership of our men and women in uniform is not the sole prerogative or the sole responsibility of our military commanders. The circumstances under which they serve, where, for how long, and under what conditions is very much the subject of the stewardship of Congress.

My perspective on this issue is also shaped by 4 years spent as a counsel to the House Committee on Veterans' Affairs, when we did pioneering work in the areas of post-traumatic stress disorder (PTSD) and other issues posing long-term consequences for veterans of the Vietnam war.

During the past 3 years, we've seen a marked improvement in areas such as the treatment of traumatic brain injury (TBI) and wounded warrior care management, but the Military Health System is still a work in progress. It's not enough simply to provide healthcare. It must also be the most appropriate and effective professional care given in a timely way. In this regard, I believe it's always important to point out our appreciation to the healthcare providers in each branch of the Armed Forces who treat and stabilize servicemembers wounded in battle. Our dedicated medical teams bring wounded warriors from the battlefield to the operating

room within what is called the "golden hour," enabling our medical professionals to achieve the best wartime survival rates, by far, in our Nation's history.

The budget request for fiscal year 2011 includes more than a billion dollars for research into TBI and PTSD. Last year, the Army established a Warrior Transition Command to oversee the care and management of wounded, ill, and injured soldiers. The Navy and Marine Corps created programs, such as the Marine Corps Wounded Warrior Regiments and the Navy's Safe Harbor, to support a full-spectrum recovery process for sailors, marines, and their families.

Our most pressing concern is the health of our servicemembers who are deployed, and who have been deployed repeatedly. Despite shortages of healthcare professionals, we must adequately assess the medical condition of our servicemembers, before and after they deploy, to include effective mental health screenings.

We've seen recent reports of increased prescription drug use that are deeply troubling. In fact, the data is stunning, when you look at it. According to an article published this month by the Military Times, at least one in six servicemembers is on some form of psychiatric-related drug. The newspaper reported that the use of such medications is estimated to have increased by 76 percent since combat operations began in Afghanistan and Iraq, with antipsychotic prescriptions more than tripling from 2001 to 2009. Whether these drugs are antidepressants, pain medications, muscle relaxants, or antianxiety drugs, we really do need to understand the dynamic of this problem. We look to today's witnesses to help us understand the scope of these alarming trends and to describe what is being done to address them.

I would say that there is a larger issue in play here that I have a great deal of concern about, and that is the transparency of what is actually happening to our Active Duty military when they are deployed, whether it is in the context of the combat operations that they are in, the living circumstances that they have in these deployed areas, or issues such as this.

This subcommittee is also hearing reports of increased substance abuse, growing numbers of servicemembers with emotional difficulties across the Services, and a lack of access to mental healthcare. It's not enough to address these issues piecemeal, we must approach them holistically, because their effects, clearly, tend to overlap.

At a hearing held by the Personnel Subcommittee last year, we were told by a number of military spouses that access to healthcare, including access to mental healthcare and specialty care, was a top concern. Clearly, our servicemembers must be secure in the knowledge that their family members are receiving the medical care that they need.

We must also be mindful of the cost of providing this care. Secretary Gates said last year that "healthcare is eating the Department alive." This year, he stated his desire to "work with Congress, in figuring out a way to bring some modest control to this program."

We welcome any suggestions the Department and the Services may have to address the steadily increasing costs of providing healthcare under the Military Health System.

Our military men and women in uniform and their families have given much to this country. We must do everything we can to ensure that they continue to receive the finest healthcare available. We cannot achieve that goal without open communication with DOD and with the Services. If we are not aware of a problem, we cannot be a part of a solution.

I'd like now to recognize our ranking member, Senator Graham, if he has any opening statement.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman, for holding this hearing.

I'll tell you what, I'll just work my comments in with the witnesses. I know Senator Cardin is a busy man. I look forward to hearing what he has to say.

Senator WEBB. Without objection, all witness written testimony submitted for today's hearing will be included in the record.

In addition, the National Military Family Association and Georgetown University Medical Center's Palliative Care Program have submitted testimony, and, without objection, this will also be included in the record.

[The information referred to follows:]

Statement of

Barbara Cohoon, Ph.D., R.N.
Government Relations Deputy Director

NATIONAL MILITARY FAMILY ASSOCIATION

Before the

Subcommittee on
Personnel

of the

UNITED STATES SENATE
ARMED SERVICES COMMITTEE

March 24, 2010

Not for Publication
Until Released by
The Committee

Military families serve our country with pride, honor, and quiet dedication. The National Military Family Association is the leading nonprofit organization committed to strengthening and protecting the families of the men and women currently serving, retired, wounded or fallen. We provide families of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA with information, work to get them the benefits they deserve, and offer programs that improve their lives. Our 40 years of service and accomplishments have made us a trusted resource for military families and the Nation's leaders.

Association Representatives in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteer Representatives are our "eyes and ears," bringing shared local concerns to national attention.

The Association does not have or receive federal grants or contracts.
Our website is: ***www.MilitaryFamily.org.***

Chairman Webb and Distinguished Members of the Subcommittee, the National Military Family Association would like to thank you for the opportunity to present written testimony for the record on 'Fiscal 20100 Budget: Military Health Programs.' Access to quality military health care is important for maintaining the quality of life of military families – the Nation's families. As the war has continued, the quality of life of our service members and their families has been severely impacted. Your recognition of the sacrifices of these families and your response through legislation to the increased need for support have resulted in programs and policies that have helped sustain our families through these difficult times.

In this statement, our Association will expand on several issues of importance to military families:

I. Family Readiness
II. Family Health
III. Family Transitions

I. Family Readiness

The National Military Family Association believes policies and programs should provide a firm foundation for families buffeted by the uncertainties of deployment and transformation. It is imperative full funding for these programs be included in the regular budget process and not merely added on as part of supplemental funding. We promote programs that expand and grow to adapt to the changing needs of service members and families as they cope with multiple deployments and react to separations, reintegration, and the situation of those returning with both visible and invisible wounds. Standardization in delivery, accessibility, and funding are essential. Programs should provide for families in all stages of deployment and reach out to them in all geographic locations. Families should be given the tools to take greater responsibility for their own readiness.

We appreciate provisions in the National Defense Authorization Acts and Appropriations legislation in the past several years that recognized many of these important issues. Excellent programs exist across the Department of Defense (DoD) and the Services to support our military families. There are redundancies in some areas and times when a new program was initiated before looking to see if an existing program could be adapted to answer an evolving need. Service members and their families are continuously in the deployment cycle, anticipating the next separation, in the throes of deployment, or trying to reintegrate after the service member returns. Dwell times seem shorter and shorter as training, schools, and relocation impede on time that is spent in the family setting.

"My husband will have three months at home with us between deployment and being sent to school in January for two months and we will be PCSing soon afterwards. ....This does not leave much time for reintegration and reconnection." – Army Spouse

We feel that now is the time to look at best practices and at those programs that are truly meeting the needs of families. In this section we will talk about existing programs, highlight best practices, and identify needs.

Child Care

Innovative strategies are needed to address respite care. The Army, as part of the funding attached to its Army Family Covenant, has rolled out more space for respite care for families of deployed soldiers. Respite care is needed across the board for the families of the deployed and the wounded, ill, and injured. We are pleased the Services have rolled out more respite care for special needs families, but since the programs are new we are unsure of the impact it will have on families. We are concerned, however, when we hear of some installations already experiencing shortfalls of funding for respite care early in the year.

At our *Operation Purple® Healing Adventures* camp for families of the wounded, ill and injured, families told us there is a tremendous need for access to adequate child care on or near military treatment facilities. Families need the availability of child care in order to attend medical appointments, especially mental health appointments. Our Association encourages the creation of drop-in child care for

medical appointments on the DoD or VA premises or partnerships with other organizations to provide this valuable service.

Our Association urges Congress to ensure resources are available to meet the child care needs of military families to include hourly, drop-in, and increased respite care across all Services for families of deployed service members and the wounded, ill, and injured, as well as those with special needs family members.

Working with Youth

Through our *Operation Purple* camps, our Association has begun to identify the cumulative effects multiple deployments are having on the emotional growth and well being of military children and the challenges posed to the relationship between deployed parent, caregiver, and children in this stressful environment. Understanding a need for qualitative analysis of this information, we commissioned the RAND Corporation to conduct a pilot study in 2007 aimed at the current functioning and wellness of military children attending *Operation Purple* camps and assessing the potential benefits of the *Operation Purple* program in this environment of multiple and extended deployments.

In May 2008, we embarked on phase two of the project – a longitudinal study on the experience of 1,507 families, which is a much larger and more diverse sample than included in our pilot study. RAND followed these families for one year, and interviewed the non-deployed caregiver/parent and one child per family between 11 and 17 years of age at three time points over the year. Recruitment of participants was extremely successful because families were eager to share their experiences. The research addressed two key questions:

- How are school-age military children faring?
- What types of issues do military children face related to deployment?

In December, the baseline findings of the research were published in the journal *Pediatrics*. Findings showed:

- As the months of parental deployment increased, so did the child's challenges.
- The total number of months away mattered more than the number of deployments.
- Older children experienced more difficulties during deployment.
- There is a direct correlation between the mental health of the caregiver and the well-being of the child.
- Girls experienced more difficulty during reintegration, the period of months readjusting after the service member's homecoming.
- About one-third of the children reported symptoms of anxiety, which is somewhat higher than the percentage reported in other national studies of children.
- In these initial findings, there were no differences in results between Services or Components.

What are the implications? Families facing longer deployments need targeted support – especially for older teens and girls. Supports need to be in place across the entire deployment cycle, including reintegration, and some non-deployed parents may need targeted mental health support. One way to address these needs would be to create a safe, supportive environment for older youth and teens. Dedicated Youth Centers with activities for our older youth would go a long way to help with this. Our Association, as an outgrowth of the study results, will be holding a summit in early May, where we will be engaging with experts to isolate action items that address the issues surfaced in the study. We will be happy to share these action items with you.

Our Association feels that more dedicated resources, such as youth or teen centers, would be a first step toward addressing the needs of our older youth and teens during deployment.

National Guard and Reserve

The National Military Family Association has long recognized the unique challenges our Reserve Component families face and their need for additional support. National Guard and Reserve families are often geographically dispersed, live in rural areas, and do not have the same family support programs as their active duty counterparts. The final report from the Commission on the National Guard and Reserve confirmed what we have always asserted: "Reserve Component families face special challenges because they are often at a considerable distance from military facilities and lack the on-base infrastructure and assistance available to active duty families."

This is especially true when it comes to accessing the same level of counseling and behavioral health support as active duty families. However, our Association applauds the innovative counseling and behavioral health support to National Guard and Reserve families, in the form of Military OneSource counseling, the TRICARE Assistance Program (TRIAP), and Military Family Life Consultants (MFLC). Combined, these valuable resources are helping to address a critical need for our Reserve Component families.

In the past several years, great strides have been made by both Congress and the Services to help strengthen our National Guard and Reserve families. Our Association wishes to thank Congress for authorizing these important provisions. We urge you to fully fund these vital quality of life programs critical to our Reserve Component families, who have sacrificed greatly in support of our Nation.

In addition, our Association would like to thank Congress for the provisions allowing for the implementation of the Yellow Ribbon Program, and for including reporting requirements on the program's progress in the FY2010 National Defense Authorization Act. We continue to urge Congress to make the funding for this program permanent. In addition, we ask that you conduct oversight hearings to ensure that Yellow Ribbon services are consistent across the nation. We also ask that the definition of family member be expanded to allow non-ID card holders to attend these important programs, in order to support their service member and gain valuable information.

Our Association asks Congress to fully fund the Yellow Ribbon Program, and provide oversight hearings to ensure that Yellow Ribbon services are consistent across the nation, and are accessible to all Reserve Component families.

II. Family Health

Family readiness calls for access to quality health care and mental health services. Families need to know the various elements of their military health system are coordinated and working as a synergistic system. Our Association is concerned the DoD military health care system may not have all the resources it needs to meet both the military medical readiness mission and provide access to health care for all beneficiaries. The direct care system of Military Treatment Facilities (MTFs) and the purchased care segment of civilian providers can work in tandem to meet the responsibilities given under the TRICARE contracts, meet readiness needs, and ensure access for all military beneficiaries.

Congress must provide timely and accurate funding for health care. DoD and VA health care facilities must be funded to be "world class," offering state-of-the-art health care services supported by evidence-based research and design. Funding must also support the renovation of existing facilities or complete replacement of out-of-date DoD health care facilities. As we get closer to the closure of Walter Reed Army Medical Center and the opening of the new Fort Belvoir Community Hospital and the new Walter Reed National Military Medical Center, as part of the National Capitol Region BRAC process, we must be assured these projects are properly and fully funded. We encourage Congress to provide any additional funding recommended by the Defense Health Board's BRAC Subcommittee's report.

The Military Health System

Improving Access to Care

In the question and answer period during a Senate Armed Services Committee hearing last year, Senator Lindsey Graham (R-SC) asked panel members to "give a grade to TRICARE." Panel members

rated TRICARE a "B" or a "C minus." Our Association's Director of Government Relations stated it was a two- part question and assigned a grade of "B" for quality of care and "C-" for access to care. We welcomed this discussion focused on access issues in the direct care system - our military hospitals and clinics - reinforcing what our Association has observed for years. We have consistently heard from families that their greatest health care challenge has been getting timely care from their local military hospital or clinic.

Our Association continues to examine military families' experiences with accessing the Military Health System (MHS). Families' main issues are: access to their Primary Care Managers (PCM); getting someone to answer the phone at central appointments; having appointments available when they finally got through to central appointments; after hours care; getting a referral for specialty care; being able to see the same provider or PCM; and having appointments available 60, 90, and 120 days out in our MTFs for follow-ups recommended by their providers. Families familiar with how the MHS referral system works seem better able to navigate the system. Those families who are unfamiliar report delays in receiving treatment or sometimes decide to give up on the referral process and never obtain a specialty appointment. Continuity of care is important to maintain quality of care. The MTFs are stressed from eight years of provider deployments, directly affecting the quality of care and contributing to increased costs. Our Association thanks Congress for requiring, in the FY09 NDAA, a report on access to care and we look forward to the findings. This report must distinguish between access issues in the MTFs, as opposed to access in the civilian TRICARE networks.

Our most seriously wounded, ill, and injured service members, veterans, and their families are assigned case managers. In fact, there are many different case managers: Federal Recovery Coordinators (FRC), Recovery Care Coordinators, coordinators from each branch of Service, TBI care coordinators, VA liaisons, et cetera. The goal is for a seamless transition of care between and within the two governmental agencies, DoD and the VA. However, with so many coordinators to choose from, families often wonder which one is the "right" case manager. We often hear from families, some whose service member has long been medically retired with a 100 percent disability rating or others with less than one year from date-of-injury, who have not yet been assigned a FRC. We need to look at whether the multiple, layered case managers have streamlined the process, or have only aggravated it. Our Association still finds families trying to navigate alone a variety of complex health care systems, trying to find the right combination of care. Individual Service wounded, ill, and injured program directors and case managers are often reluctant to inform families that FRCs exist or that the family qualifies for one. Many qualify for and use Medicare, VA, DoD's TRICARE direct and purchased care, private health insurance, and state agencies. Why can't the process be streamlined?

Support for Special Needs Families

Case management for military beneficiaries with special needs is not consistent because the coordination of the military family's care is being done by a non-synergistic health care system. Beneficiaries try to obtain an appointment and then find themselves getting partial health care within the MTF, while other health care is referred out into the purchased care network. Thus, military families end up managing their own care. Incongruence in the case management process becomes more apparent when military family members transfer from one TRICARE region to another and is further exacerbated when a special needs family member is involved. Families need a seamless transition and a warm handoff between TRICARE regions and a universal case management process across the MHS. Each TRICARE Managed Care Contractor has created different case management processes. The current case management system is under review by DoD and the TRICARE Management Activity.

We applaud Congress and DoD's desire to create robust health care, educational, and family support services for special needs children. But, these robust services do not follow them when they retire. We encourage the Services to allow these military families the opportunity to have their final duty station be in an area of their choice, preferably in the same state in which they plan to live after the service member retires, to enable them to begin the process of becoming eligible for state and local services while still on active duty. We suggest the Extended Care Health Option (ECHO) be extended for one year after retirement for those already enrolled in ECHO prior to retirement. If the ECHO program is

extended, it must be for all who are eligible for the program. We should not create a different benefit simply based on diagnosis.

There has been discussion over the past years by Congress and military families regarding the ECHO program. The FY09 NDAA included a provision to increase the cap on certain benefits under the ECHO program and the FY10 NDAA established the *Office of Community Support for Military Families with Special Needs*. The ECHO program was originally designed to allow military families with special needs to receive additional services to offset their lack of eligibility for state or federally provided services impacted by frequent moves. We suggest that before making any more adjustments to the ECHO program, Congress should direct DoD to certify if the ECHO program is working as it was originally designed and if it has been effective in addressing the needs of this population. We need to make the right fixes so we can be assured we apply the correct solutions. This new office will go a long way in identifying and addressing special needs. However, we must remember that our special needs families often require medical, educational and family support resources. This new office must address all these various needs in order to effectively implement change.

National Guard and Reserve Member Family Health Care

National Guard and Reserve families need increased education about their health care benefits. We also believe that paying a stipend to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan while the service member is deployed may work out better for many families in areas where the TRICARE network may not be robust.

Grey Area Reservists

Our Association would like to thank Congress for the new TRICARE benefit for Grey Area Reservists. We want to make sure this benefit is quickly implemented and they have access to a robust network.

TRICARE Reimbursement

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. As the 111th Congress takes up Medicare legislation, we request consideration of how this legislation will impact military families' health care, especially our most vulnerable service, access to mental health.

National provider shortages in the mental health field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographic challenges - for example large populations in rural or traditionally underserved areas. Many mental health providers are willing to see military beneficiaries on a voluntary status. However, these providers often tell us they will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. More must be done to persuade these providers to participate in TRICARE and become a resource for the entire system, even if that means DoD must raise reimbursement rates.

Pharmacy

We caution DoD about generalizing findings of certain beneficiary pharmacy behaviors and automatically applying them to our Nation's unique military population. We encourage Congress to require DoD to utilize peer-reviewed research involving beneficiaries and prescription drug benefit options, along with performing additional research involving military beneficiaries, before making any recommendations on prescription drug benefit changes, such as co-payment and tier structure changes for military service members, retirees, their families, and survivors.

We appreciate the inclusion of federal pricing for the TRICARE retail pharmacies in the FY 2008 NDAA. However, we still need to examine its effect on the cost of medications for both beneficiaries and DoD. Also, we will need to see how this potentially impacts Medicare, civilian private insurance, and the National Health Care Reform affecting drug pricing negotiations.

We believe it is imperative that all medications available through TRICARE Retail Pharmacy (TRRx) should also be available through TRICARE Mail Order Pharmacy (TMOP). Medications treating

chronic conditions, such as asthma, diabetes, and hypertension should be made available at the lowest level of co-payment regardless of brand or generic status. We agree with the recommendations of *The Task Force on the Future of Military Health Care* that over-the-counter (OTC) drugs be a covered pharmacy benefit and there be a zero co-pay for TMOP Tier 1 medications.

The new T3 TRICARE contract will provide TRICARE Managed Care Contractors and Express-Scripts, Inc. the ability to link pharmacy data with disease management. This will allow for better case management, increase compliance, and decrease cost, especially for our chronically ill beneficiaries. However, this valuable tool is currently unavailable because the T3 contract is still under protest and has not yet been awarded.

National Health Care Proposal

Our Association is cautious about the recent passage of National Health Care Reform. We request consideration of how this legislation will also impact TRICARE.

The perfect storm is brewing. TMA will probably be instituting the new T3 contract in 2011. Currently, there is the possibility that two out of three TRICARE Managed Care Contractors could change. This means that the contracts of 66 percent of our TRICARE providers would need to be renegotiated. Add the demands and uncertainties to providers in regards to health care reform and Medicare reimbursement rate changes. This leads to our concern regarding the impact on providers' willingness to remain in the TRICARE network and the recruitment of new providers. The unintended consequences may be a decrease in access to care due the lack of available health care providers.

DoD Must Look for Savings

We ask Congress to establish better oversight for DoD's accountability in becoming more cost-efficient. We recommend:

- Requiring the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality health care in a cost-effective manner;
- Creating an oversight committee, similar in nature to the Medicare Payment Advisory Commission, which provides oversight to the Medicare program and makes annual recommendations to Congress. *The Task Force on the Future of Military Health Care* often stated it was unable to address certain issues not within their charter or the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.
- Establishing a Unified "Joint" Medical Command structure, which was recommended by the Defense Health Board in 2006 and 2009.

Our Association believes optimizing the capabilities of the facilities of the direct care system through timely replacement of facilities, increased funding allocations, and innovative staffing would allow more beneficiaries to be cared for in the MTFs, which DoD asserts is the most cost effective. The Task Force made recommendations to make the DoD MHS more cost-efficient which we support. They conclude the MHS must be appropriately sized, resourced, and stabilized; and make changes in its business and health care practices.

We suggest additional funding and flexibility in hiring practices to address MTF provider deployments.

Our Association recommends a one year transitional active duty ECHO benefit for all eligible family members of service members who retire.

We believe that Reserve Component families should be given the choice of a stipend to continue their employer provided care during deployment.

Behavioral Health Care

Our Nation must help returning service members and their families cope with the aftermath of war. DoD, VA, and state agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs. Partnering will also capture the National Guard and Reserve member population, who often straddle these agencies' health care systems.

Full Spectrum of Care

As the war continues, families' need for a full spectrum of behavioral health services—from preventative care and stress reduction techniques, to counseling and medical mental health services—continues to grow. The military offers a variety of psychological health services, both preventative and treatment, across many agencies and programs. However, as service members and families experience numerous lengthy and dangerous deployments, we believe the need for confidential, preventative psychological health services will continue to rise. It will remain high even after military operations scale down. Our study on the impact of the war on caregivers and children found the mental health of the caregiver directly affects the overall well-being of the children. Therefore, we need to treat the family as a unit rather than as individuals because the caregiver's health determines the quality of life for the children.

Access to Behavioral Health Care

Our Association is concerned about the overall shortage of mental health providers in TRICARE's direct and purchased care network. DoD's *Task Force on Mental Health* stated timely access to the proper psychological health provider remains one of the greatest barriers to quality mental health services for service members and their families. The Army Family Action Plan (AFAP) identified mental health issues as their number three issue for 2010. While families are pleased more mental health providers are available in theater to assist their service members, they are disappointed with the resulting limited access to providers at home. Families are reporting increased difficulty in obtaining appointments with social workers, psychologists, and psychiatrists at their MTFs and clinics. The military fuels the shortage by deploying some of its child and adolescent psychology providers to combat zones. Providers remaining at home report they are overwhelmed by treating active duty members and are unable to fit family members into their schedules. This can lead to provider compassion fatigue, creating burnout and exacerbating the provider shortage problem.

We have seen an increase in the number of mental health providers joining the purchased care side of the TRICARE network. However, the access standard is seven days. We hear from military families after accessing the mental health provider lists on the contractors' websites that the provider is full and no longer taking TRICARE patients. The list must be up-to-date in order to handle real time demands by families. We need to continue to recruit more mental health providers to join the TRICARE network and we need to make sure we specifically add those in specialty behavioral health care areas, such as child and adolescence psychology and psychiatrists.

Families must be included in mental health counseling and treatment programs for service members. Family members are a key component to a service member's psychological well-being. Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. We recommend an extended outreach program to service members, veterans, and their families of available mental health resources, such as DoD, VA, and State agencies. We appreciate the VA piloting programs that incorporate active duty service members and their families into their newly established OIF/OEF health care clinics. The family is accessed as a "unit" and educated about the VA's benefits and services. These initiatives need to be expanded throughout the VA and fully funded.

Frequent and lengthy deployments create a sharp need in mental health services by family members and service members as they get ready to deploy and after their return. There is also an increase in demand in the wake of natural disasters, such as hurricanes and fires. We need to maintain a flexible pool of mental health providers who can increase or decrease rapidly in numbers depending on demand on the MHS side. Currently, Military Family Life Consultants and Military OneSource counseling are providing this type of service for military families on the family support side. The recently introduced web-based TRICARE Assistance Program (TRIAP) offers another vehicle for non-medical counseling, especially for those who live far from counselors. We need to make the Services, along with military

family members, more aware of resources along the continuum. We need the flexibility of support in both the MHS and family support arenas, as well as coordination of support between these two entities. We must educate civilian network providers about our culture. Communities along with nongovernment organizations are beginning to fulfill this role, but more needs to be done.

Availability of Treatment

Do DoD, VA and State agencies have adequate mental health providers, programs, outreach, and funding? Better yet, where will the veteran's spouse and children go for help? Many will be left alone to care for their loved one's invisible wounds resulting from frequent and long combat deployments. Who will care for them when they are no longer part of the DoD health care system?

The Army's Mental Health Advisory Team (MHAT) IV report links reducing family issues to reducing stress on deployed service members. The team found the top non-combat stressors were deployment length and family separation. They noted soldiers serving a repeat deployment reported higher acute stress than those on their first deployment and the level of combat was the major contribution for their psychological health status upon return. Our study on the impact of deployment on caregivers and children found it was the cumulative time deployed that caused increased stress. These reports demonstrate the amount of stress being placed on our troops and their families.

Our Association is especially concerned with the scarcity of services available to the families as they leave the military following the end of the service members' activation or enlistment. Due to the service member's separation, the families find themselves ineligible for TRICARE and Military OneSource, and are very rarely eligible for health care through the VA. Many will choose to locate in rural areas lacking available mental health providers. We need to address the distance issues families face in finding mental health resources and obtaining appropriate care. Isolated service members, veterans, and their families do not have the benefit of the safety net of services and programs provided by MTFs, VA facilities, Community-Based Outpatient Centers, and Vet Centers. We recommend:

- using alternative treatment methods, such as telemental health;
- modifying licensing requirements in order to remove geographic practice barriers that prevent psychological health providers from participating in telemental health services outside of a VA facility;
- educating civilian network psychological health providers about our military culture as the VA incorporates Project Hero; and
- encouraging DoD and VA to work together to provide a seamless "warm hand-off" for families, as well as service members transitioning from active duty to veteran status and funding additional transitional support programs if necessary.

National Guard and Reserve Members

The National Military Family Association is especially concerned about fewer mental health care services available for the families of returning National Guard and Reserve members. Some are eligible for TRICARE Reserve Select, but, as we know, National Guard and Reserve members are often located in rural areas where there may be fewer mental health providers available. Policy makers need to address the distance issues that families face in linking with military mental health resources and obtaining appropriate care. Isolated National Guard and Reserve families do not have the benefit of the safety net of services provided by MTFs and installation family support programs. Families want to be able to access care with a provider who understands or is sympathetic to the issues they face. We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture. We urge DoD to expand information outreach about the new TRIAP program, which provides access to non-medical counseling via phone and web through the TRICARE managed care support contractors. We hear the National Guard Bureau's Psychological Health Services (PHS) is not working as designed to address members' mental health issues. This program needs to be evaluated to determine its effectiveness.

Children

Our Association is concerned about the impact of deployment and/or the injury of the service member is having on our most vulnerable population, children of our military service member and veterans. Our study on the impact of the war on caregivers and children found deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not "rock the boat." They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve members face unique challenges since there are no military installations for them to utilize. They find themselves "suddenly military" without resources to support them. School systems are generally unaware of this change in focus within these family units and are ill prepared to lookout for potential problems caused by these deployments or when an injury occurs. Also vulnerable are children who have disabilities that are further complicated by deployment and subsequent injury of the service members. Their families find stress can be overwhelming, but are afraid to reach out for assistance for fear of retribution to the service member's career. They often choose not to seek care for themselves or their families. We appreciate the inclusion of a study on the mental health needs of our children in the FY10 NDAA and hope the research we commissioned will provide useful information as the study is designed.

The impact of the wounded, ill, and injured on children is often overlooked and underestimated. Military children experience a metaphorical death of the parent they once knew and must make many adjustments as their parent recovers. Many families relocate to be near the treating MTF or the VA Polytrauma Center in order to make the rehabilitation process more successful. As the spouse focuses on the rehabilitation and recovery, older children take on new roles. They may become the caregivers for other siblings, as well as for the wounded parent. Many spouses send their children to stay with neighbors or extended family members, as they tend to their wounded, ill, and injured spouse. Children get shuffled from place to place until they can be reunited with their parents. Once reunited, they must adapt to the parent's new injury and living with the "new normal." We appreciate the inclusion in the FY10 NDAA of a study to assess the impact on children of the severely wounded.

We encourage partnerships between government agencies, DoD, VA and State agencies and recommend they reach out to those private and non-governmental organizations who are experts on children and adolescents. They could identify and incorporate best practices in the prevention and treatment of mental health issues affecting our military children. We must remember to focus on preventative care upstream, while still in the active duty phase, in order to have a solid family unit as they head into the veteran phase of their lives. School systems must become more involved in establishing and providing supportive services for our nation's children.

Caregiver Burnout

In the eighth year of war, care for the caregivers must become a priority. There are several levels of caregivers. Our Association hears from the senior officer and enlisted spouses who are so often called upon to be the strength for others. We hear from the health care providers, educators, rear detachment staff, chaplains, and counselors who are working long hours to assist service members and their families. They tell us they are overburdened, burnt out, and need time to recharge so they can continue to serve these families. These caregivers must be afforded respite care, given emotional support through their command structure, and be provided effective family programs.

Education

The DoD, VA, and State agencies must educate their health care and mental health professionals of the effects of mild Traumatic Brain Injury (mTBI) in order to help accurately diagnose and treat the service member's condition. They must be able to deal with polytrauma—Post-Traumatic Stress Disorder (PTSD) in combination with multiple physical injuries. We need more education for civilian health care providers on how to identify signs and symptoms of mild TBI and PTSD.

The families of service members and veterans must be educated about the effects of TBI, PTSD, and suicide in order to help accurately diagnose and treat the service member/veteran's condition. These

families are on the "sharp end of the spear" and are more likely to pick up on changes attributed to either condition and relay this information to their health care providers. Programs are being developed by each Service. However, they are narrow in focus targeting line leaders and health care providers, but not broad enough to capture our military family members and the communities they live in. As Services roll out suicide prevention programs, we need to include our families, communities, and support personnel.

Reintegration Programs

Reintegration programs become a key ingredient in the family's success. Our Association believes we need to focus on treating the whole family with programs offering readjustment information; education on identifying mental health, substance abuse, suicide, and traumatic brain injury; and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties. We appreciate the inclusion in the FY10 NDAA for education programs targeting pain management and substance abuse for our families.

Successful return and reunion programs will require attention over the long term, as well as a strong partnership at all levels between the various mental health arms of DoD, VA, and State agencies. DoD and VA need to provide family and individual counseling to address these unique issues. Opportunities for the entire family and for the couple to reconnect and bond must also be provided. Our Association has recognized this need and successfully piloted family retreats in the National Parks promoting family reintegration following deployment.

We recommend an extended outreach program to service members, veterans, and their families of available psychological health resources, such as DoD, VA, and State agencies.

We encourage Congress to request DoD to include families in its Psychological Health Support survey and perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members).

We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.

Caregivers must be afforded respite care; given emotional support through their command structure; and, be provided effective family programs.

Wounded Service Members Have Wounded Families

Our Association asserts that behind every wounded service member and veteran is a wounded family. It is our belief the government, especially the DoD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded, ill, and injured service member must also consider the needs of the spouse, children, parents of single service members and their siblings, and the caregivers. DoD and VA need to think proactively as a team and one system, rather than separately; and addressing problems and implementing initiatives upstream while the service member is still on active duty status.

Reintegration programs become a key ingredient in the family's success. For the past two years, we have piloted our *Operation Purple® Healing Adventures* camp to help wounded service members and their families learn to play again as a family. We hear from the families who participate in this camp, as well as others dealing with the recovery of their wounded service members that, even with Congressional intervention and implementation of the Services' programs, many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences

and successful coping methods. Our Association believes we need to focus on treating the whole family with DoD and VA programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process. We must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

Brooke Army Medical Center (BAMC) has recognized a need to support these families by expanding in terms of guesthouses co-located within the hospital grounds and a family reintegration program for their Warrior Transition Unit. The on-base school system is also sensitive to issues surrounding these children. A warm, welcoming family support center located in guest housing serves as a sanctuary for family members. The DoD and VA could benefit from looking at successful programs like BAMC's, which has found a way to embrace the family unit during this difficult time.

The Vet Centers are an available resource for veterans' families providing adjustment, vocational, and family and marriage counseling. The VA health care facilities and the community-based outpatient clinics (CBOCs) have a ready supply of mental health providers, yet regulations have restricted their ability to provide mental health care to veterans' families unless they meet strict standards. Unfortunately, this provision hits the veteran's caregiver the hardest, especially if they are the parents. We recommend DoD partner with the VA to allow military families access to mental health services. We also believe Congress should require the VA, through its Vet Centers and health care facilities to develop a holistic approach to care by including families when providing mental health counseling and programs to the wounded, ill, and injured service member or veteran.

The Defense Health Board has recommended DoD include military families in its mental health studies. We agree. We encourage Congress to direct DoD to include families in its Psychological Health Support survey; perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members). We appreciate the FY10 NDAA report on the impact of the war on families and the DoD's Millennium Cohort Study including families. Both will help us gain a better understanding of the long-term effects of war on our military families.

Transitioning for the Wounded and Their Families

Transitions can be especially problematic for wounded, ill, and injured service members, veterans, and their families. The DoD and the VA health care systems, along with State agency involvement, should alleviate, not heighten these concerns. They should provide for coordination of care, starting when the family is notified that the service member has been wounded and ending with the DoD, VA, and State agencies working together, creating a seamless transition, as the wounded service member transfers between the two agencies' health care systems and, eventually, from active duty status to veteran status.

Transition of health care coverage for our wounded, ill, and injured and their family members is a concern of our Association. These service members and families desperately need a health care bridge as they deal with the after effects of the injury and possible reduction in their family income. We have created two proposals. Service members who are medically retired and their families should be treated as active duty for TRICARE fee and eligibility purposes for three years following medical retirement. This proposal will allow the family not to pay premiums and be eligible for greater access to care at certain MTFs and for certain benefits offered to active duty families for three years. Following that period, they would pay TRICARE premiums at the rate for retirees. Service members medically discharged from service and their family members should be allowed to continue for one year as active duty for TRICARE benefits and then move into the Continued Health Care Benefit Program (CHCBP) if needed.

Caregivers

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded service members and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DoD and VA health care providers because they tend to the needs of the service members and the veterans on a regular basis. And, their daily involvement saves DoD, VA, and State agency

health care dollars in the long run. Their long-term psychological care needs must be addressed. Caregivers of the severely wounded, ill, and injured service members who are now veterans have a long road ahead of them. In order to perform their job well, they will require access to mental health services.

The VA has made a strong effort in supporting veterans' caregivers. The DoD should follow suit and expand their definition. We appreciate the inclusion in FY10 NDAA of compensation for service members with assistance in everyday living. However, our Association believes this provision does not go far enough. In order to perform their job well, caregivers must be taught the skills to be successful.

Compensation of caregivers should be a priority for DoD and the Secretary of Homeland Security. Caregivers must be recognized for their sacrifices and the important role they play in maintaining the quality of life of our wounded service members and veterans. Financial compensation must be established for caregivers of injured service members and veterans that begin while the hospitalized service member is still on active duty and transitions seamlessly to a VA benefit. Current law creates a potential gap in compensation during transition from active duty to veteran status. Our Association proposes that compensation should reflect the types of medical and non-medical care services provided by the caregiver. The caregiver should be paid directly for their services. Non-medical care should be factored into a monthly stipend tied to severity of injury –cognitive and physical injury and illness—and care provided. In order to perform their job well, caregivers must be taught the skills to be successful. This will require the caregiver to be trained through a standardized, certified program. Compensation for medical care should be an hourly wage linked to training and certification of the caregiver paid for by the VA and transferrable to employment in the civilian sector if the care is no longer needed by the service member or veteran.

Consideration should also be given to creating innovative ways to meet the health care and insurance needs of the caregiver, with an option to include their family. Current proposed legislation does not include a "family" option. Additional services caregivers need are: respite care, such as 24 hour in-home care, mental health services, and travel and lodging expenses when accompanying service members and veterans for medical care.

There must be a provision for transition benefits for the caregiver if the caregiver's services are no longer needed, chooses to no longer participate, or is asked by the veteran to no longer provide services. The caregiver should still be able to maintain health care coverage for one year. Compensation would discontinue following the end of services/care provided by the caregiver. Our Association looks forward to discussing details of implementing such a plan with Members of this Subcommittee.

The VA currently has eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. DoD should evaluate these pilot programs to determine whether to adopt them for caregivers of service members still on active duty. Caregivers' responsibilities start while the service member is still on active duty.

Relocation Allowance and Housing

Active Duty service members and their spouses qualify through the DoD for military orders to move their household goods when they leave the military service. Medically retired service members are given a final PCS move. Medically retired married service members are allowed to move their family; however, medically retired single service members only qualify for moving their own personal goods.

Our Association suggests that legislation be passed to allow medically retired single service members the opportunity to have their caregiver's household goods moved as a part of the medical retired single service member's PCS move. This should be allowed for the qualified caregiver of the wounded service member and the caregiver's family (if warranted), such as a sibling who is married with children or mom and dad. This would allow for the entire caregiver's family to move, not just the caregiver. The reason for the move is to allow the medically retired single service member the opportunity to relocate with their caregiver to an area offering the best medical care, rather than the current option that only allows for the medically retired single service member to move their belongings to where the

caregiver currently resides. The current option may not be ideal because the area in which the caregiver lives may not be able to provide all the health care services required for treating and caring for the medically retired service member. Instead of trying to create the services in the area, a better solution may be to allow the medically retired service member, their caregiver, and the caregiver's family to relocate to an area where services already exist.

The decision on where to relocate for optimum care should be made with the Federal Recovery Coordinator (case manager), the service member's medical physician, the service member, and the caregiver. All aspects of care for the medically retired service member and their caregiver shall be considered. These include a holistic examination of the medically retired service member, the caregiver, and the caregiver's family for, but not limited to, their needs and opportunities for health care, employment, transportation, and education. The priority for the relocation should be where the best quality of services is readily available for the medically retired service member and his/her caregiver.

The consideration for a temporary partial shipment of caregiver's household goods may also be allowed, if deemed necessary by the case management team.

Provide medically-retired wounded, ill and injured service members and their families a bridge of extended active duty TRICARE eligibility for three years, comparable to the benefit for surviving spouses.

Service members medically discharged from service and their family members should be allowed to continue for one year as active duty for TRICARE and then start the Continued Health Care Benefit Program (CHCBP) if needed.

Caregivers of the wounded, ill and injured must be provided with opportunities for training, compensation and other support programs because of the important role they play in the successful rehabilitation and care of the service member.

The National Military Family Association is requesting the ability for medically retired single service members to be allowed the opportunity to have their caregiver's household goods moved as a part of the medically retired single service member's PCS move.

Senior Oversight Committee

Our Association is appreciative of the provision in the FY2010 NDAA establishing a DoD Task Force on the Care, Management, and Transition of Recovery, Wounded, Ill, and Injured Members of the Armed Forces to access policies and programs. We understand the Office of Wounded Warrior Care and Transition Policy (WWCTP), a permanent structure for the Senior Oversight Committee, is in the process of being established and manned. This Task Force will be independent and in a position to monitor DoD and VA's partnership initiatives for our wounded, ill, and injured service members and their families, while this organization is being created.

The National Military Family Association encourages the all Committees with jurisdiction over military personnel and veterans matters to talk on these important issues. We can no longer continue to create policies in a vacuum and be content on focusing on each agency separately because this population moves too frequently between the two agencies, especially our wounded, ill, and injured service members and their families.

III. Family Transitions

Survivors

In the past year, the Services have increased their outreach to surviving families. In particular, the Army's SOS (Survivor Outreach Services) program makes an effort to remind these families that they are not forgotten. DoD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need, through all of VA's venues. New legislative language

governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement or grief counseling. The goal is the right care at the right time for optimum treatment effect. DoD and the VA need to better coordinate their mental health services for survivors and their children.

We thank Congress for extending the TRICARE active duty family dental insurance benefit to surviving children. The current TRICARE Management Activity policy directive allows for the surviving children of Reserve Component service members who had not previously been enrolled to be eligible for the expanded benefit. We ask that eligibility be expanded to those active duty family members who had not been enrolled in the active duty TRICARE Dental insurance program prior to the service member's death.

Our Association recommends that eligibility be expanded to active duty survivors who had not been enrolled in the TRICARE Dental Program prior to the service member's death. We also recommend that grief counseling be more readily available to survivors.

Military Families – Our Nation's Families

We would like to thank you again for the opportunity to provide information on the health care needs for the service members, veterans, and their families. Military families support the Nation's military missions. The least their country can do is make sure service members, veterans, and their families have consistent access to high quality mental health care in the DoD, VA, and within network civilian health care systems. Wounded service members and veterans have wounded families. The caregiver must be supported by providing access to quality health care and mental health services, and assistance in navigating the health care systems. The system should provide coordination of care with DoD, VA, and State agencies working together to create a seamless transition. We ask Congress to assist in meeting that responsibility. In our testimony, we believe we have identified improvements and additions that can be made to already successful programs while introducing policy or legislative changes that address the ever-changing needs of our military families. Working together, we can improve the quality of life for all these families

SUBMISSION BY
DR. ANDREW T. PUTNAM
DIRECTOR OF THE LOMBARDI PALLIATIVE CARE PROGRAM
GEORGETOWN UNIVERSITY MEDICAL CENTER

TO THE
SENATE COMMITTEE ON ARMED SERVICES
HEARING ON MILITARY HEALTH SYSTEM PROGRAMS,
POLICIES AND INITIATIVES
MARCH 24, 2010

A NEW PROPOSAL FOR COLLABORATION ON RETURNING TO WELLNESS THOSE IN PAIN

Submitted for consideration by the
Senate Committee on Armed Services
In its review of effective and innovative steps that can be taken to help restore injured and wounded Soldiers and Veterans to Wellness

SENATE COMMITTEE ON ARMED SERVICES
HEARING ON MILITARY HEALTH SYSTEM PROGRAMS, POLICIES AND INITIATIVES
MARCH 24, 2010

Statement by Dr. Andrew T. Putnam,
Director of the Lombardi Palliative Care Program,
Georgetown University Medical Center

A NEW PROPOSAL
-RETURN TO WELLNESS FOR THOSE IN PAIN-

ISSUE:

How to ensure that the patients who are treated every year with high-impact pain killers can be safely and promptly moved off those medications when they are no longer needed, minimizing adverse side effects and risk of addiction, accelerating the return to wellness and productivity, and reducing costs to individuals, their families, healthcare systems and the community.

This challenge applies to millions of patients with illness or injury, to civilians and those in the military, to infants and young adults and our senior population. The situation is critical and urgent; we need to act now.

BACKGROUND:

Pain management and return to wellness are rapidly increasing in importance not only to patients but also to their physicians, families, colleagues, employers, and ultimately their communities as a whole. Debilitating pain disrupts the lives of millions of people in this country every day, ranging from cancer patients to diabetics, from children with accidental injuries to ill and wounded Soldiers, from transplant patients to those with chronic diseases.

The nature and duration of such pain are difficult to diagnose, and treatment is individualized and the effects are difficult to measure. The impact of such pain can be devastating and the demand for relief is urgent, both from patients who suffer and also from their physicians who need to manage the pain either before or while treating the underlying causes. In many cases, the most immediate and effective treatment requires the use of powerful pain killers, often narcotics, which themselves can cause intense complications and dependencies, outlasting the root cause of the pain. Ironically, these complications themselves can result in continued pain and disability, indefinite delays in returning to wellness and productivity, and major burdens on individuals, the healthcare system and communities as a whole. The risks and costs of continued dependency reach across our society.

An exciting, innovative national initiative to help patients reduce and move safely off their pain medications when they are no longer required is being established by the Georgetown University Medical Center, one of the nation's leading medical research and treatment institutions.

The Medical Center is seeking partners to expand the impact of this highly promising program, and has initiated discussions with medical teams from Walter Reed Army Medical Center to explore how these techniques could apply to the particular needs of our injured and wounded Soldiers and Veterans as well as to those of the general public.

SPECIFIC CHALLENGE

Both the prescription and the reduction of high-dose pain killers demand skilled, coordinated and continuous professional management. Illness and injuries that require such medicines are generally complex and severe and involve treatment by experts from different medical disciplines. In addition, such conditions are often accompanied by levels of continuing pain for either brief or long periods of time.

- First, in order to avoid excessive medication, and to ensure that the application of high dose painkillers meets the individual and changing needs of the patient, responsibility for coordinating the use of all such prescriptions should be assigned to a specific specialist on the patient's treatment team
    - At the outset, it will be the treating physician who initially orders and escalates the pain medication. Many physicians, however, are not comfortable increasing the doses of narcotic pain medications beyond a certain level in a given patient.
    - If necessary to progress through that level, it would be more effective for the patient and the physician to have a designated expert take an increasingly greater role in the management of the patient's pain.
- Second, once involved, it is essential that the expert continue to manage the use of such pain killers both throughout treatment for the underlying cause and also following such treatment after the patient leaves the hospital or other care site.
    - Experience confirms that it is not adequate to leave management of the reduction or cessation of use of such medicines to the decision of the patient alone, particularly in light of the profound physical and psychological impact that most such medicines inevitably incur.

PLAN OF ACTION:

Georgetown University Medical Center has approved the development of a new and innovative ("Pain Management to Wellness Clinic") devoted to

- Identifying and applying state of the art pain management techniques and expertise at GUMC and other institutions specifically to the challenge of maximizing efficiency and effectiveness in the prescription of high impact pain killers, particularly including narcotics;
- Identifying and applying state of the art practices in effective reduction and cessation of high impact pain killers, and the development of new techniques that will permit patients to reduce and move safely off their narcotic pain killers at the earliest feasible time;

- Developing an international clearing house for the identification and sharing of such practices from the best research and practices in this field;
- Initiating new research with other partners in the field to develop improved tools for meeting these challenges
- Establishing partnerships with others, including in particular medical institutions and care givers who are treating and working with ill and injured Soldiers and Veterans, to ensure that the best standards of care are shared between our private and public sectors, for the mutual benefit of both.

Under the leadership of **Dr. Andrew T. Putnam, Director of the Lombardi Palliative Care Program, the Georgetown University Medical Center** has initiated both internal planning and external partnership development efforts to establish the foundation for this new multi-department Clinic, with a view to formal establishment and initial operation of the Clinic at the earliest feasible time.

March 23, 2010

Senator WEBB. I'm very pleased to introduce our colleague, Senator Ben Cardin, who is the lone witness on our first panel. Senator Cardin shares with me a great concern about the dramatic increase in the use of prescription drugs by servicemembers. I would like to express my appreciation to Senator Cardin, for having really gotten out in front of this issue and helped make all of us aware of the data that ended up being reported in USA Today. I invited him. I sought his testimony today. I would like to welcome you, this morning.

Senator Cardin.

STATEMENT OF HON. BENJAMIN L. CARDIN, U.S. SENATOR FROM THE STATE OF MARYLAND

Senator CARDIN. Chairman Webb, first of all, thank you very much for holding this hearing and for your interest in this subject.

Senator Graham, thank you for your continued interest in fighting for our soldiers in so many different ways. I'm honored to be before your committee, and I bring to your attention a serious issue concerning the health of our combat troops and how the military is dealing with the stress of combat and repeated deployments.

There are some very disturbing statistics that the chairman mentioned in his opening statement. Let me try to just fill in a few more of the details. In 2009, there were 160 Active Duty Army suicides. That's a 15 percent increase from the previous year. We have an alarming use in the increase of antidepressants. In 2005, there were a little over 4,000 combat troops using antidepressants. That's about 1 percent. By 2007, it grew to over 19,000, or 5 percent, of our troops on antidepressants. That's a huge increase in the use of antidepressants, and that number remained pretty constant for 2008.

We do know that there is information that's been made available to us. I can cite just one source. The Army's Fifth Mental Health Advisory Team tells us that the use of antidepressants and sleeping pills of our combat troops in Iraq is 12 percent, and our combat troops in Afghanistan is 17 percent. Mr. Chairman, as you said, one out of every six. We know that there's a huge number of those that are using these types of medications.

There's a real question as to whether they're receiving the proper medical supervision, the proper monitoring. This is particularly true during the first 6 weeks, when medications are taken and when your body adjusts to the medicines that you're taking, so that the adverse reactions are less likely.

In combat, the antidepressant that's most likely used is selective serotonin reuptake inhibitors (SSRI). Since 2004, the Food and Drug Administration (FDA) has required a warning on the use of these types of antidepressants by the increased risk of suicidal thoughts. The vulnerable age that the FDA tells us is 18 to 24. Forty-one percent of those deployed in Iraq and Afghanistan fall within that age group, which should have all of us concerned.

I want to say, I think DOD has made some strides in the right direction. As part of the National Defense Authorization Act for Fiscal Year 2010, I offered an amendment that requested information to be made available to our congressional committees on the numbers taking these drugs over the next 5-year period. It was in-

cluded in the Senate version. It was not included in the conference version. I did send a letter to Secretary Gates, and I want to compliment Secretary Gates. He supplied the information to my office. I have had a chance to talk to him personally. I think he understands the seriousness of this matter.

There's been significant improvements in the predeployment screening for healthcare issues for our soldiers before they go to combat. There's been post-deployment healthcare assessment and treatment. I acknowledge that. But, I still think we need DOD's help in trying to understand what is happening, as far as the use of these prescribed drugs.

We have a lot of dots, but we haven't connected the dots. I really do ask this committee, and I'll be asking my colleagues in the Senate, to help in trying to understand what is happening here. Why has there been such a large increase in the use of antidepressants? I think we need to have the answers to the questions. We need to know whether there is proper medical supervision for those who are taking prescribed antidepressants. We need to know what the policy is for those soldiers that are in combat. If they start on antidepressants, what is the policy of the military during those first 6 weeks? Are they to be sent into combat itself, again, there is a particular vulnerability during that 6-week period. I'm not aware if there is a policy, and I think this committee needs to know, and the U.S. Senate needs to know.

I think we need to have a better understanding of the relationship between the use of antidepressants and suicide within the military. I would urge us to make the resources available for a scientific study, with peer review, so that we can try to connect the dots. I think we need to know whether there are other treatment options, rather than the use of prescribed medicines. I certainly would urge us to request relevant data be made available to Congress on the use of antidepressants, so that we can be part of the oversight responsibilities that we have as Members of the U.S. Senate.

I look forward to working with the committee. I look forward to working with my two colleagues. I think this is an important issue, and I thank you for giving it attention.

[The prepared statement of Senator Cardin follows:]

PREPARED STATEMENT BY SENATOR BENJAMIN L. CARDIN

Chairman Webb, Ranking Member Graham and distinguished members of the subcommittee: thank you for your invitation to appear before you this morning.

I am pleased to have this opportunity to discuss with you the issue of the deteriorating mental health of so many of our combat troops. On behalf of the American families whose loved ones have gone into harms way I come before you today to discuss the strains that have been placed upon our All-Volunteer Force.

In 2009, an unprecedented 160 Active-Duty Army suicides were reported, representing a 15 percent increase over the previous year. In response to this growing concern I proposed an amendment (#1475) to the 2010 National Defense Authorization Act (NDAA) which would have required the Department of Defense to report to Congress annually, for the next 5 years, the number and percentage of servicemembers who were prescribed antidepressant medications while serving in Iraq and Afghanistan. It would have also required that a study be initiated to investigate the relationship between the increased number of suicides and attempted suicides by members of the Armed Forces and the increased number of antidepressants and other behavior modifying prescriptions being used to treat anxiety for our combat troops.

This amendment was successfully accepted into the Senate's version of the NDAA, but was unfortunately removed during the conference process.

As a follow-up to my amendment, I also sent a letter to Defense Secretary Gates last November, asking him to provide details on the number of troops being prescribed antidepressant medications while serving in Iraq and Afghanistan. The intent of this letter was to get a preliminary assessment of the number of troops being affected by the Department of Defense's (DOD) policies on mental health care in theater. This information, when coupled with the committee's requirement for the DOD to demonstrate their policies on how they manage patients prescribed antidepressants in-theater, would begin to provide insight into how the DOD was addressing this significant issue.

As background to this discussion, I would like to first invite your attention to the following information. In October 2004, the Food and Drug Administration (FDA) directed manufacturers of a certain class of anti-depressants known as Selective Serotonin Reuptake Inhibitors—commonly referred to as SSRIs—to add a black box warning that alerted the public to the increased risk of suicidal thoughts by children and adolescents. By May 2007, the FDA further directed that the warning be extended to include young adults from ages 18 to 24, with an emphasis towards the first 6 weeks of initiating treatment.

The FDA's decision to extend the black box warning was the result of scientific findings that children with major depressive disorders showed significant increases in the risk of "possible suicidal ideation and suicidal behavior." An additional analysis indicated a one-and-a-half fold increase in the potential for suicide in the 18–24 year old age group. For the purpose of today's hearing, it is critically important to understand that this same age group—18–24 year olds—comprises about 41 percent of our young men and women currently deployed to Iraq and Afghanistan.

Now, during the 2005 to 2008 time period (the last year full data were provided by the DOD) there was a 400 percent increase in the prescription of antidepressants and other drugs used to treat anxiety—a disproportionate number of which are the SSRIs I just described. Of the 18,155 troops taking antidepressants while on deployment in 2008, 98.5 percent of them initiated the use of the drug while on deployment.

Data contained in the Army's Fifth Mental Health Advisory Team Report indicate that roughly 12 percent of combat troops in Iraq and 17 percent of those in Afghanistan were taking prescription antidepressants or sleeping pills to help them cope with the stress of their deployments. While the sixth report—released in late 2009 from this same group of mental health professionals—shows that the suicide rate in Iraq had since stabilized, it more tellingly indicates that the suicide rate in Afghanistan doubled during the same timeframe.

It bears repeating that military personnel, who are being called upon to serve in a forward deployed combat area, often for up to a year-long deployment, are being prescribed medications with a warning that indicates potential side effects which include an increased risk of suicide as well as aggressive, angry, or violent behavior.

This deeply concerns me, and it should equally concern those who are responsible for the long-term mental health of our servicemembers.

I submit, for your consideration, the following questions that I hope you will agree merit a response from those charged with caring for these young men and women:

- If the DOD is medicating personnel in forward deployed combat areas, how are they maintaining the necessary oversight of these soldiers, sailors, and marines, especially during the initial 6-week window when the increased risk of suicidal thoughts is said to occur?
- Are these personnel removed from combat status? (At least during the first 6 weeks of medication).
- Who makes the determination of whether a servicemember undergoing mental health treatment in-theatre is deemed fit-for-duty? Is it the physician or mental health professional, or is it the servicemember's operational commander, and if so, is this the right person to make that decision? Why?

Let me in closing recognize that the DOD has made significant strides in addressing both its pre-deployment health care screenings and its post-deployment health care follow-ups and treatment when necessary. It has also achieved many positive steps towards destigmatizing the process of seeking and obtaining mental health care for our troops.

In light of this, I recognize that to move forward with a review of DOD's procedures, great caution must be exercised so as to avoid undoing the progress that has been made. Due diligence, however, dictates that Congress utilize its oversight authority in this matter and investigate whether the DOD's current policies regarding the use of prescription antidepressant drugs—most notably those known adverse

side effects—pose an unacceptably high risk to our troops—especially while they are serving in forward operating areas.

Since the beginning of the current conflicts there has been a steady increase in the number of suicides and suicide attempts by current and past members of our Armed Forces. We have been told that there is no one reason for this increase, but rather a combination of causes and stressors. However, we cannot ignore that this has occurred at the same time as we have witnessed a four-fold increase in the number of psychiatric medications being prescribed to our men and women serving in combat areas.

Admittedly, much debate continues within the scientific and mental healthcare communities over the potential relationship and extent between the use of psychiatric medication and suicide.

Mr. Chairman, we owe it to our servicemembers—past, present, and future—and to their families, to do everything in our power to ensure that the mental healthcare they receive is the best our Nation can offer. For this reason, I ask that you and the rest of my Senate colleagues will again consider requiring the implementation of an annual reporting mechanism for DOD to come before Congress and disclose the extent to which it is employing antidepressant medications to treat the wartime stress and overall mental health of our service men and women. I would also ask that the DOD be directed and sufficiently funded to contract for a scientific, peer-reviewable study of the potential relationship between this increased use of antidepressant medications and the increased number of military suicides.

I thank you again Mr. Chairman, Ranking Member Graham, and the distinguished members of this subcommittee. I hope that my testimony before you today has been truly enlightening, and will serve as a call to action on this important issue.

Senator WEBB. Senator Cardin, thank you very much for having worked so hard to bring this matter to the attention of the Senate and of Congress. You have our commitment that we will be working on it. We will actually be seeking observations of the witnesses that follow you today.

Thank you for being with us.

Senator CARDIN. Thank you.

Senator GRAHAM. Thank you, Senator. What you're pointing out is very important to the country, and I appreciate your interest, and we'll get some answers to these real legitimate questions.

Senator CARDIN. Appreciate it.

Senator WEBB. I'm pleased now to welcome and introduce the witnesses for our second panel. They are Dr. Charles L. Rice, who is performing the duties of the Assistant Secretary of Defense for Health Affairs and Acting Director of TRICARE Management Activity—you could join us as we announce your names—Rear Admiral Christine Hunter, U.S. Navy, Deputy Director of TRICARE Management Activity; Lieutenant General Eric B. Schoomaker, U.S. Army, Surgeon General of the Army and Commander of U.S. Army Medical Command; Vice Admiral Adam Robinson, Jr., U.S. Navy, Surgeon General of the Navy, and Chief of the Navy Bureau of Medicine and Surgery; Lieutenant General Charles B. Green, U.S. Air Force, Surgeon General of the Air Force; and Rear Admiral Richard R. Jeffries, U.S. Navy, who is the Medical Officer of the U.S. Marine Corps.

I'd like to thank all of you for joining us today to discuss the vital issues associated with military healthcare. I would like to ask Dr. Rice to begin the panel's opening statements. Unless there's some special protocol, maybe we could just work across the table.

Senator GRAHAM. Sounds good to me.

Senator WEBB. Welcome to you all.

Dr. Rice, the floor is yours.

STATEMENT OF CHARLES L. RICE, M.D., PERFORMING THE DUTIES OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, AND ACTING DIRECTOR, TRICARE MANAGEMENT ACTIVITY

Dr. RICE. Thank you, Mr. Chairman, Senator Graham, for the opportunity to come before you today.

Late February, I was asked by Dr. Stanley, the Under Secretary of Defense for Personnel and Readiness, to perform the duties of the Assistant Secretary of Defense for Health Affairs, stepping away from my permanent position as the President of the Uniformed Services University until President Obama's choice for this job is confirmed by the Senate and sworn in, whereupon I will happily return to Uniformed Services University.

I'm honored to be here and to be able to represent the men and women who serve in our Military Health System and deeply appreciative of the support you have always provided military medicine and for your unwavering support to the University.

I have submitted my written comments to the committee, and with your indulgence, I'd like to make just some very brief opening remarks.

I approach my role as the senior medical advisor to Secretary Gates and Secretary Stanley with advantages of multiple perspectives. As a trauma surgeon, as an educator, as a retired Navy medical officer, and, like you, Mr. Chairman, as the father of an Active Duty servicemember, this issue is personal to me.

There is much to be proud of in the Military Healthcare System. The performance of our military medics in combat remains nothing short of remarkable. In addition to the lifesaving care on the battlefield, we're continuously improving the medical readiness of the total force.

We monitor and record the health of servicemembers in the most comprehensive manner ever witnessed throughout the cycle of deployment, before, during, and after their service in combat theaters. Despite the breakneck pace of combat, our medical personnel have responded heroically to natural disasters in Haiti and Chile.

I know that you share this pride in the people who serve our Nation, and so, today I want to focus on those areas where greater attention is required from me, so that you will understand where I focus my energies.

First, our deepest obligations are reserved for the casualties returning to the United States and to their families and the caregivers who support them. Substantial progress has been made since problems with wounded warrior support first came to light in 2007. This committee has played an important role for driving change, standing up new programs, and ensuring substantial new resources to address any shortcomings. We are grateful for that.

More needs to happen on our end to ensure that the programs, services, health information, and communication are knitted together more tightly so that we can provide more clear and cohesive services to those families who continue to sacrifice so much.

Second, I am intently focused on the performance and the perception of our electronic health record, AHLTA. My intent is not to micromanage the many technological issues, but to determine whether our proposed solutions will result in better capability for

our providers—nurses, physicians, pharmacists—all the key members of the healthcare team, and to deliver value for patients. The key test for a successful electronic health record is whether it leads to better quality care. If our current effort fails that test, we will find one that can deliver on that crucial expectation.

Third, the Department continues to implement the broad changes required by the 2005 Base Realignment and Closure Commission. Our approach to the right organizational construct and how we build medical facilities design must result in better service, better quality, and better access for our patients. Investments in evidence-based design concepts for our new facilities are critically important. They offer a better healing environment for patients and for their families.

The hospital at Fort Belvoir will be a showcase for this new approach. I was there last week with General Schoomaker and was truly dazzled by the design concepts that have been incorporated to create an unmatched healing environment. If you haven't been down to see it, I urge you to try to work a visit in to your busy schedules.

In addition to design, we need to better integrate service delivery across the military branches, an effort that will require sustained effort in decisions in the months ahead to better serve our patients.

Fourth, we're working to resolve the serious matters identified in the protests upheld by the Government Accountability Office (GAO) regarding the TRICARE system contract awards. While the issues that we must address are serious, I am reassured, and want to reassure you, that the internal issues affecting these awards have not affected the day-to-day service for our beneficiaries. Nonetheless, our efforts to control TRICARE cost growth are closely linked to the effective implementation of new contracts. It is in the best interests of the government and of the organizations who are involved in these contract decisions to move toward a definitive conclusion. I'm grateful to Admiral Hunter for her leadership in this area.

Finally, I'd like to briefly comment on the larger issue of national healthcare reform that you alluded to, Mr. Chairman. It has been the focus of much attention this week. Although the Military Health System is in many ways a unique system of care, we do not function apart from the civilian healthcare system used by the American people. In fact, almost 70 percent of the care our beneficiaries receive is delivered by our civilian colleagues.

TRICARE benefits will not be affected at all by the passage of reform. We know that the DOD medical benefit is, appropriately, one of the most comprehensive medical benefits of any employer. One visit to Walter Reed or Bethesda demonstrates why this should be so more than any words I can offer here.

Yet, there are other potential benefits that will accrue to the Department when more Americans are covered by insurance. This includes a more medically fit recruiting pool, greater investments in comparative effectiveness research that will help all practitioners of care with delivering scientifically valid approaches to medicine, and a more secure transition for those members of our Armed Forces who decide to separate prior to full retirement.

I will be working with my healthcare colleagues at the Department of Health and Human Services and elsewhere to ensure that we're appropriately involved in the implementation of healthcare reform initiatives that both reassure our beneficiaries and promote the goals of reform.

Mr. Chairman, I want to thank you again for your steadfast support of the Military Health System. I look forward to your questions.

[The joint prepared statement of Dr. Rice and Rear Admiral Hunter follows:]

JOINT PREPARED STATEMENT BY CHARLES L. RICE, M.D., AND RADM CHRISTINE S. HUNTER, USN

Mr. Chairman, members of the committee, thank you for the opportunity to discuss the Military Health System's (MHS) priorities and budget for fiscal year 2011.

We have enduring obligations to the men and women of our Armed Forces, and to their families who serve with them, and to the millions of retired military personnel who have served us in the past.

This obligation begins the moment a recruit walks through our doors. In our budget for the coming year, we acknowledge that lifetime commitment we have to those who serve today or have served in the past, and to their families.

For those servicemembers who honorably conclude their service before reaching military retirement, we have an obligation to ensure their medical experience is fully captured and easily shared with the Department of Veterans Affairs (VA) or with their own private physician. For those who retire from military service, our obligation to them and their families often extends for a lifetime.

For those who have borne the greatest burden, through injury or disease suffered in our Nation's conflicts, we have an even higher obligation to the wounded and their families. As Secretary Gates stated with the introduction of the Defense budget, "Recognizing the strain that post-September 11 wars have put on so many troops and their families, the department will spend more than $2 billion for wounded warrior initiatives, with a special focus on the signature ailments of current conflict, such as post-traumatic stress disorder (PTSD) and traumatic brain injury. We will sustain health benefits and enlarge the pool of medical professionals. We will broaden electronic information-sharing between the Department of Defense (DOD) and VA for wounded warriors making the transition out of military service."

The budget we are putting forward reflects our commitment to the broad range of responsibilities of the MHS—the medical readiness requirements needed for success on today's battlefield; the medical research and development necessary for success on tomorrow's; the patient-centered approach to care that is being woven through the fabric of the MHS; the transformative focus we are placing on the health of our population; the public health role we play in our military community and in the broader American community; the reliance we have on our private sector health care partners who provide indispensable service to our servicemembers and families; and our responsibility to deliver all of these services with extraordinary quality and service.

As our military forces in Afghanistan are engaged in combat operations to expand the security, governance, and development environment for the people of Afghanistan; as we continue with the careful hand-off of responsibilities to the elected leaders of Iraq; and, as marines provide security and the joint medical team provides care for the people of Haiti, we are mindful of the trust and investment that the American people have made in military medicine. We will continue to honor that trust.

MHS MISSION AND STRATEGIC PLAN

The MHS overarching mission remains as in years past: to provide optimal health services in support of our Nation's military mission—anytime, anywhere.

Over the last 12 months, the Office of the Assistant Secretary of Defense for Health Affairs has worked with our Service Surgeons General and the entire Joint MHS leadership team to update and refine the MHS Strategic Plan.

In the process, we sought the expertise and advice from leaders both within our system and external to the MHS, to include renowned experts at the Mayo Clinic, Kaiser Permanente, Geisinger Health System, the Cleveland Clinic, Intermountain Health, and the Institute for Healthcare Improvement.

This effort resulted in unanimous support for adopting "The Quadruple Aim" as the foundation for our strategic plan in the coming years.

The Quadruple Aim borrows liberally (and with permission) from the Institute for Healthcare Improvement's "Triple Aim," and is further tailored to the unique mission of the MHS. The four core components of the Quadruple Aim are:

- Readiness—Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including combat support, defense support to civil authorities, and humanitarian assistance/disaster relief missions as we witnessed most recently in Haiti.
- Population Health—Improving the health of our population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.
- Experience of Care—Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe, evidence-based, and always of the highest quality.
- Cost—Creating value by focusing on measuring and enhancing quality healthcare; eliminating inefficiencies; reducing unwarranted variation; and emphasizing investments in health that reduce the burden and associated cost of preventable disease in the long term.

The outcome of this strategic planning effort is more than the plan itself. The values and strategies we have articulated in our plan are reflected in our proposed budget.

Whereas we take great pride in the past accomplishments of the joint MHS team, the overview we provide in the following pages for our fiscal year 2011 strategic priorities is forward-looking, not merely a reflection of past accomplishments. By aligning this testimony with our strategic plan, we link our budget proposal and priorities to our strategic focus inherent in the four core components of the Quadruple Aim.

READINESS

A fit, healthy, and protected force is the starting point in ensuring a medically ready force. We have a core set of individual medical readiness (IMR) measures that inform both our line commanders and our medical teams about the individual preparedness of a servicemember to deploy.

We will continue to use our monitoring systems so that we reduce the rate of deployment limiting conditions. We will also focus on disparities between the active and Reserve Components in terms of IMR, and improve the medical readiness of the Total Force.

A critical companion strategic matter for the Department is the psychological health of our people. Between 20–30 percent of our servicemembers who have deployed to Operation Iraqi Freedom or Operation Enduring Freedom (OIF/OEF) have reported some form of psychological distress. As has been widely noted, suicide rates in the Armed Forces have also been rising. DOD and the individual Services are studying every suicide or suicide attempt closely, and we have collectively introduced a number of new programs and initiatives to reduce the occurrence of suicide. We are engaging commanders, the medical research community and fellow servicemembers in a multi-tiered effort to understand and implement effective strategies to deter suicide; to reduce the stigma of seeking professional help and counseling; and to ensure there are adequate personnel resources to meet a clear and growing demand for mental health services.

We remain focused on accelerating our research into and the adoption of evidence-based care treatments for personnel with PTSD and traumatic brain injury. Secretary Gates continues to be personally interested in seeing us move information from the research realm to the field in a much more rapid manner.

We are proposing another $669 million to support our requirements in meeting these critical needs in support of psychological health. Significant funds are also directed to other critical battlefield medical research and development needs.

In addition, our investments in Defense Centers of Excellence and the Defense and Veterans Brain Injury Center are funded and poised for delivering world-class care and service to our military and veteran populations.

Finally, in fiscal year 2010 and fiscal year 2011, we will be undertaking actions to expand our measures of "readiness." Specifically, we will be assessing how to better measure "family readiness." There is no question that the health and resiliency of the entire family is tied to the readiness of the individual soldier, sailor, airman, and marine. Our efforts will be directed toward measures that help us proactively identify and address health risks within a family prior to deployment.

POPULATION HEALTH

There are few organizations in the world that compare to the DOD in having the right incentives to truly invest in population health efforts. A significant number of military personnel and their families will have their health care managed by DOD or other Federal and private sector partners for their lifetimes. Accordingly, we will continue to develop and employ the best tools and programs to transform our culture to one focused not just on expertly treating disease and injury, but to one focused on sustaining the health and well-being of our population.

There are a number of tools and programs at our disposal to improve overall population health. The Department will continue to invest deeply in our preventive service programs. We will improve our provider support tools so that opportunities for education or preventive treatment can be engaged at all patient-provider opportunities.

We will closely track our performance in delivering preventive services using the Health Employer Data Information System (HEDIS) measures. HEDIS allows us the opportunity to compare ourselves among each Service or MTF, but equally importantly, to compare ourselves against our private sector counterparts. In 2009, we witnessed impressive gains in preventive service delivery as compared to both national norms and national benchmarks, particularly in the Army and Navy, after introducing pay for performance incentive programs.

We recognize, however, that not all measures are moving in the right direction. For example, we are seeing continued high levels of tobacco usage among our youngest servicemembers. We are also seeing rising rates of obesity in our non-active duty population (along with the related morbidities, particularly diabetes).

As an aspect of our strategic imperatives, we are seeking to more directly and more personally engage patients to take a more active role in managing their health. We will seek to influence behaviors through increased positive actions (better nutrition and increased physical activity) and reduced negative habits (tobacco use and excessive alcohol intake).

Our efforts to improve the overall health status of our population do not operate in a vacuum. Improvements are made one patient at a time; one patient visit at a time. In this regard, our efforts in this strategic arena are directly tied to our efforts at the individual level with their experience with the care received—and the topic of the next section.

EXPERIENCE OF CARE

One of our foremost and sustained priorities is to improve the experience of care for those who are most intimately interacting with our MHS every day—the wounded, ill, and injured from our current conflicts who are moving through the joint patient evacuation system, from point of injury in the theater of operations, to the point of definitive care in the United States, where many are recovering at our flagship military medical centers in the National Capital Area and other medical centers around the country.

We remain grateful for the support of Congress, and especially this committee, to ensure we have the resources to provide the very best health care for our forces and their families, and in particular for the wounded, ill, and injured.

We propose a budget of more than $670 million to support the spectrum of services for the wounded, ill, and injured—services which include enhanced case management, improvements to our Disability Evaluation System, and greater data sharing with the VA and other private sector medical organizations.

Central to our efforts is the obligation to expedite the administrative elements of our disability cases, and work to get our Wounded Warriors to the best possible location to facilitate their recovery. We are expediting our Medical Evaluation Board (MEB) process toward a goal of completing all MEBs within 30 days.

We have also successfully piloted efforts with the VA to have both Departments' medical examination requirements completed in a single exam—which increases the timeliness of processing and increases satisfaction with the entire experience for the servicemember.

Enhancing the care experience is not limited, however, to our wounded warriors. It is imperative that we offer solutions and improvements for our entire beneficiary population we serve.

The overriding issue in our system has historically been and continues to be "access to care." Simply put, access is about getting the right care for the right patient at the right time.

Our efforts to improve access in the coming year will be focused on expanding our "Medical Home" initiatives. The Patient Centered Medical Home provides patients with a known provider or small team of providers, who will get to know that patient

and her or his medical problems. The continuity of care offered by this model, when coupled with enhanced access to the provider through telephone messaging or secure electronic communication and timely appointing, will enhance the quality and safety of care and improve the patient experience. This model has been endorsed by professional medical societies (the American Academy of Pediatrics and the American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association), several large third party payers, employers, and health plans. Its adoption in the MHS reflects the continuation of a journey toward improving patient access and satisfaction.

We will be providing our enrolled population with clear communications about how to access the appropriate level of medical care to meet their needs at any time, 24 hours a day, 7 days a week. We will offer our patients with multiple modes of accessing care, to include expansion of telephone access, and secure, web-based patient-provider messaging service.

PER CAPITA COST CONTROL

We are proposing a fully funded budget for fiscal year 2011. The MHS serves 9.5 million beneficiaries, to include active duty members and their families, members of the Reserve Component and their families, and retired military personnel and their families. It is important to note that this number that has grown with the increased active duty end strength as well as the expansion of health benefits to members of the Reserve Component. Thus, while real cost growth will continue to rise, we, nonetheless, will be focused on controlling per capita costs within our system.

Our primary and most strategically important bulwark against unmanaged cost growth for the coming year is quality. Our efforts to develop, proliferate and adhere to evidence-based guidelines will have the most dramatic effect on our costs. In this instance, we will again compare ourselves against each other and against private sector data using the Dartmouth Atlas as our guide. Our goal is to reduce inappropriate variation in the utilization of services.

The urgency of addressing costs in fiscal year 2011 is clear from our budget request. A major increase in the budget request includes $1.2 billion for private sector care costs due to an increase in users of TRICARE and an increase in utilization of the TRICARE benefit.

We recognize that this focus on quality and utilization does not diminish the need for wise and informed management actions to also control costs. In fiscal year 2011, we will also:

- continue implementation of Federal Ceiling Pricing of retail pharmaceuticals;
- continue implementation of the Outpatient Prospective Payment System, which reduces the reimbursement paid for outpatient care at inpatient private sector care facilities;
- standardize medical supply chain management across the full range of military health care operations;
- increase efforts to identify and detect fraud, waste, abuse, and overpayments to civilian medical providers; and
- pursue the first fully integrated Joint DOD/VA healthcare collaboration consisting of the North Chicago Veterans Affairs Medical Center and the Navy Health Clinic, Great Lakes, IL.

Through improved access to care from the medical home initiative and adherence to evidence-based care guidelines, we are hoping to reduce the need for referrals to private sector sources wherever possible, and to decrease utilization of emergency room services (when used as a source for non-emergent primary care).

We recognize that the MHS is not immune from the cost growth challenges faced by our private sector peers. The ever-increasing value of the TRICARE benefit against private sector plans and premiums will likely place additional pressure on the MHS budget. Yet, along with the civilian and military leadership of the Department, we are mindful of the trade-offs being made every day to sustain this system of care.

LEARNING AND GROWTH

Fiscal year 2011 promises to be both exciting and challenging, as many of the Department's most significant health efforts will be advanced in bold and meaningful ways. The 2005 Base Realignment and Closure actions, which impact medical facilities in multiple joint medical markets, the joint Medical Education and Training Campus, and co-location of medical headquarters, will come to fruition in September 2011. Additionally, work on the Electronic Health Record (EHR) will continue on the trajectory toward improved system effectiveness and interoperability. The Depart-

ment will continue to address and resolve governance issues related to emerging requirements to organize, execute, and oversee joint peacetime health care activities.

In this dynamic environment, supporting the Quadruple Aim is an objective that must continue to grow and support the people who serve the MHS. Our major initiatives for this year center on: (1) furthering the MHS, contribution to medical science; (2) delivering information to enable better healthcare decisions; and (3) ensuring a fully capable workforce most prepared to support our strategic initiatives.

Our medical research program continues to grow, with the leadership of Secretary Gates and the ongoing support of Congress. Significant funding has been dedicated to TBI and psychological health; battlefield medicine; threats from the full range of chemical, biological, radiobiological and nuclear threats. Our EHR continues to serve a vital function in support of our clinicians and patients. The incredibly rich clinical data repository is capturing care delivered throughout our system, to include outpatient services in the combat theaters. In each successive year, we are able to transfer more health information more easily with our counterparts in the VA.

Yet, our EHR has not been without its technical challenges. For fiscal year 2011, we are proposing a total of $875 million for modernization efforts and to enable data interoperability with the Virtual Lifetime Electronic Record (VLER), being jointly led by DOD and the VA. VLER is an ambitious and needed undertaking to integrate medical, personnel benefits, and financial information in a single virtual record for veterans.

Finally, vital to our ability to deliver a high quality, accessible and cost-effective health system is a workforce that is trained and ready to operate in a fast-paced environment. We are investing in recruitment and retention programs to sustain our system. We have proposed legislation that will allow us to offer post-graduate scholarships for MHS civilians. We are partnering with universities, marketing our job opportunities to their graduates. Outreach activities include attending job fairs, speaking at professional conferences, and marketing through our MHS website. Partnering with the VA has allowed us to share recruiting opportunities, improving our mutual ability to recruit scarce medical professionals. In all, our MHS human capital programs will continue to allow us to extol the benefits of public service while supporting our strategic initiatives.

We are proud to serve with the talented, dedicated and resourceful team of public servants and military volunteers who comprise the MHS. We are committed to enhancing their professional experience in service to the country.

UNIFIED MEDICAL BUDGET REQUEST FOR FISCAL YEAR 2011

The Defense Health Program (DHP), the appropriation that supports the MHS, is under mounting financial pressure. The DHP has more than doubled since 2001—from $19 billion to $50.7 billion in fiscal year 2010.

The majority of DOD health spending supports health care benefits for military retirees and their dependents, not the active force. We project that up to 65 percent of DOD healthcare spending will be going toward retirees in fiscal year 2011—up from 45 percent in fiscal year 2001. As civilian employers' health costs are shifted to their military retiree employees, TRICARE is seen as a better, less costly option and they are likely to drop their employer's insurance. These costs are expected to grow from 6 percent of the Department's total budget in fiscal year 2001 to more than 10 percent in fiscal year 2015.

Despite these fiscal challenges, the fiscal year 2011 budget request provides realistic funding for projected health care requirements.

The Unified Medical Budget, the Department's total request for healthcare in fiscal year 2011, is $50.7 billion. This includes the DHP appropriation, including Wounded, Ill and Injured Care and Rehabilitation; Military Personnel, Military Construction, and normal cost contributions for the Medicare-Eligible Retiree Healthcare.

89Defense Health Program

The largest portion of the request, or $30.9 billion, will be used to fund the DHP, which is comprised of Operation & Maintenance (O&M), Procurement and Research, Development, Test & Evaluation (RDT&E). A little over $29.9 billion is for O&M, which funds most day-to-day operational costs of healthcare activities;

MILITARY PERSONNEL AND CONSTRUCTION

For Military Personnel, the Unified Medical Budget includes $7.9 billion to support the more than 84,000 military personnel who provide healthcare services in military theaters of operations and fixed health care facilities around the world. These services include medical and dental care, global aeromedical evacuation, shipboard, and undersea medicine, and global humanitarian assistance and response.

Funding for medical Military Construction (MILCON) includes $1.0 billion to improve our medical infrastructure. We are committed to building new hospitals using the principles of Evidence-Based Design (EBD). We are excited to be able to open a national showcase in EBD, the new Fort Belvoir Hospital, in 2011.

MILCON funding will also be directed toward infrastructure enhancements at the National Interagency Biodefense Campus at Fort Detrick, MD—a vital resource for the Nation.

DOD MEDICARE-ELIGIBLE RETIREE HEALTH CARE FUND

The estimated normal cost of the Medicare-Eligible Retiree Health Care Fund in fiscal year 2010 is $10.9 billion. This funding includes payments for care in MTFs, to private health care providers, and to reimburse the Services for military labor used in the provision of healthcare services.

CONCLUSION

Mr. Chairman, the Military Health System continues to provide world-class medical care for a population that demands and deserves the best care anywhere. We are proud to represent the men and women who comprise the MHS. We are proud to submit to you and your committee members a budget that is fully funded and that we can successfully execute in the coming year.

We are pleased that we are able to provide you a budget with a direct and specific link to our strategic planning efforts of the last year.

Thank you again, Mr. Chairman, for the opportunity to be with you today. We look forward to your questions.

Senator WEBB. Thank you very much, Dr. Rice.

Admiral Hunter, welcome.

STATEMENT OF RADM CHRISTINE S. HUNTER, USN, DEPUTY DIRECTOR, TRICARE MANAGEMENT ACTIVITY

Admiral HUNTER. Thank you, Mr. Chairman, Senator Graham. I'm really honored to be able to appear before you today.

Together with Dr. Rice, I have the responsibility for operating the TRICARE Management Activity (TMA) and administering the TRICARE benefit.

As you said, 9.6 million Americans rely on us to ensure they receive high-quality healthcare whenever they need it and wherever they are in the world. Along with the growth in the Army and Marine Corps, our program has grown by over 370,000 servicemembers, families, and retirees since 2008.

Since assuming my responsibilities 10 months ago, I've been fortunate to work closely on many critical initiatives with DOD leaders, the Service Surgeons General, and key stakeholders who represent our beneficiaries.

Initially, we focused our efforts on the care of wounded warriors, access to care, particularly behavioral healthcare, and services for families whose children have special needs.

More recently, we introduced the construct of the Quadruple Aim and carefully examined how we're performing in each domain. The Quadruple Aim builds on the Institute for Healthcare Improvements Triple Aim for Health Systems, which advocates that we achieve excellence in population health, the patient experience, and responsibly manage the costs.

In the Military Health System, our Quadruple Aim adds the fourth aim, a specific emphasis on our core mission of readiness. I'm pleased to report that we're making progress. To support readiness, certainly the Surgeons General will share many of their observations. But, at TMA we have concentrated on our Reserve and Guard populations, as well as behavioral health.

Participation in our TRICARE Reserve Select product is growing, ensuring that reservists and guardsmen have coverage to maintain their health between mobilizations. We've also made it easier for physicians around the country to participate in this plan and receive timely payment.

Our efforts to reduce the stigma associated with seeking mental healthcare have been accompanied by an increase in providers to meet the growing demand. Together with the Surgeons General and our TRICARE contractors, we've added over 1,900 providers to the military hospitals and clinics, and more than 10,000 added to the networks. Visits have increased dramatically, with 112,000 behavioral health outpatients now seen every week. In addition, servicemembers and their families can access the TRICARE Assistance Program for supportive counseling via Web cam from their homes, 24 hours a day.

To improve health overall, we're putting a priority on prevention, eliminating copays for preventive services under TRICARE standard, recently adding immunizations like flu vaccine to our retail pharmacy program, and tracking our performance. Since 2007, we can demonstrate significant improvement in the number of patients who receive cancer screening that's appropriate to their age, immunizations, and medications to control diabetes, asthma, and cholesterol.

Patients are beginning to notice the difference. On surveys, they're telling us that they receive timely care, needed care, and see their assigned primary care manager more often. We certainly still have room to improve, but this is a very encouraging beginning trend.

To address the costs of care, we're focused on ensuring that patients with acute minor conditions visit their primary care site or an urgent care clinic, rather than the emergency room, and choose the convenience and lower out-of-pocket cost, as well as lower government cost, of our mail-order pharmacy, rather than the retail pharmacy, whenever that's possible.

Our partnerships at the interface between the direct care and private-sector care are thriving. On a regular basis, TRICARE regional directors engage with Army MTF commanders in rehearsal of capability drills. We work together to develop the medical capacity that's needed as the Army grows and shifts its population concentrations.

When Navy medical personnel ably responded to the disaster in Haiti, we staffed a fusion cell to make daily adjustments to network referrals and assist with interservice crossleveling, to ensure that all patients continue to receive timely care.

The Air Force has led the other Services to articulate the challenges with access to care in Alaska, and we've been able to stabilize reimbursement to encourage more providers to participate.

We appreciate the Senate's leadership in this area, and we're engaged with the Veterans' Affairs (VA) Department and other Federal partners to develop comprehensive solutions.

In the months ahead, we'll work diligently to address all concerns cited by the GAO and move forward to delivery of healthcare under the TRICARE third-generation contracts.

We proudly anticipate the introduction of our TRICARE Reserve Retiree Program for those gray-area reservists who have served our Nation so honorably, and are excited by pending improvements to our overseas and dental programs.

There's certainly much more to do, but my staff and I come to work every day mindful of all those that we serve and striving to make a positive difference.

Thank you again, Mr. Chairman, for your advocacy on behalf of our servicemembers, and I look forward to your questions.

Senator WEBB. Thank you, Admiral Hunter.

General Schoomaker.

STATEMENT OF LTG ERIC B. SCHOOMAKER, USA, SURGEON GENERAL OF THE U.S. ARMY, AND COMMANDER, U.S. ARMY MEDICAL COMMAND

General SCHOOMAKER. Chairman Webb, Senator Graham, and distinguished members of the Personnel Subcommittee, thank you for inviting us to discuss the Defense Health Program and our respective Service medical programs.

Now in my third congressional hearing cycle as the Army Surgeon General and Commanding General of the U.S. Army Medical Command, I can tell you that these hearings are valuable opportunities for me to talk about the accomplishments and challenges of Army Medicine, and to hear your collective perspectives regarding military health promotion and healthcare.

I'm pleased to tell you that the President's budget submission for fiscal year 2011 fully funds the Army Medical Department's needs. Your support of the proposed President's budget is greatly appreciated.

I know, in your recent hearing with the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretaries for Manpower and Reserve Affairs, that much concern was expressed regarding the increasing size of the defense health budget within the overall defense budget. I'd like to share with you some of the efforts that we are making in Army Medicine that complement what Admiral Hunter just discussed, to maximize the value in health services that we deliver, of our Army Medicine's five strategic themes.

This theme is built on a belief that providing high-quality evidence-based services is not only right for soldiers and families, it results in the most efficient use of resources within the healthcare system, thus delivering value not only for our patients, but indeed for the Nation as a whole. In fact, what we really want to do is move from a healthcare system, one that is focused on delivering care, simply, to one that is a system of health and a system for health, which optimizes health and well-being through enhanced prevention and in a holistic approach.

We've resisted simply inventing new processes and inserting new diagnostic tests or therapeutic options, although we are keeping abreast of all of the cutting-edge changes in the American healthcare and international healthcare terrain. Or we've resisted adding just more layers of bureaucracy, but we're really, truly adding value to the products we deliver, the care we provide, and the training of our people.

This requires focusing on the clinical outcome for the patient and the community, and maintaining or even reducing the overall resource expenditure that's needed to achieve this objective. My own wife reminds me, she's not interested in sitting in waiting rooms or going through the turnstile of medicine, she wants to know, at the end of the day, is she better for what she came to seek care for? I think we can tell here unequivocally, and all of our patients and soldiers and families, that we are.

This has occurred, for us, through adoption of evidence-based practices, that you heard both of my colleagues here talk about, and reducing unwarranted variation in our practices, even unwarranted administrative practice variation for all the transactional processes that go on in our work.

One example of this in Army Medicine is that, we are expanding upon a performance-based budget model that links resources to clinical and quality outputs. Since 2007, we've been providing financial incentives to our hospitals, our clinics, our clinical commanders, and our clinicians for superior compliance in key preventive measures and other measures of evidence-based practices.

Currently, we track nine measures and compare our performance to a national benchmark. Our performance has improved on every measure, in one case by 63 percent. We've demonstrated that these incentives work to change organizational behavior to achieve desired outcomes in our health system.

Put quite simply, our beneficiaries, our patients, and our communities are receiving not only better access to care, but for better care once they get that access, that we can objectively measure.

We've undertaken major initiatives to improve both access and continuity of care. This is one of the Army Chief of Staff's and my top priorities, and it's reflected in what you've heard Admiral Hunter talk about. After conducting thorough business-case analyses, Army Medicine is expanding healthcare product lines in some communities, and we're expanding clinical space in others. In 14 locations across the country, we're establishing community-based primary care clinics by leasing and operating clinics located in off-post communities that are close to where our Active Duty families live and work and go to school. These clinics will provide a Patient-Centered Medical Home for families, an effort which is warmly embraced and resourced by all three of the medical services in the Military Health System and will provide a range of benefits, to include improved readiness for our Army and our Army family, improved access to and continuity of care, reduced emergency room visits, and improved patient satisfaction, which is growing.

Both our community-based Primary Care Clinic Initiative and the three medical services Patient-Centered Medical Home implementation have been well-supported by Rear Admiral Hunter and the TRICARE Management Agency and the Assistant Secretary of Defense for Health Affairs. We are very appreciative and are working closely on these efforts.

I look for 2010 to be the year that Army Medicine achieves what we set out to improve 2 years ago in access and continuity, key elements of our covenant with the Army family, led by our Chief of Staff and by the Secretary of the Army.

Army leadership is also engaged in an all-out effort to change DOD culture regarding TBI, or mild TBI, as it's called, especially the milder form, or what we call concussion TBI, which has a very wide spectrum, from concussive injury to much more unusual penetrating injuries or moderate crush injuries, of those, we are really focusing very, very closely on concussive injury, the most common injury. Our goal is nothing less than a cultural change in the management of soldiers after potential concussive events in combat or, frankly, on the football fields or sports fields or in motor vehicle accidents.

Every warrior requires appropriate treatment to minimize concussive injury and maximize recovery. To achieve this goal, we're educating the force so as to have a trained and prepared soldier, a leader, and our medical professional and personnel to provide early recognition, treatment, and tracking of these concussive injuries, ultimately designed to protect warrior health.

The Army is issuing very direct standards and protocols to commanders and healthcare providers, similar to aviation incident actions. There's an automatic grounding and medical assessment which is required for any soldier that meets specified criteria. The end state of these efforts is that every servicemember sustaining a possible concussion will receive early detection, state-of-the-art treatment, and return-to-duty evaluations, with long-term digital health-record tracking of their management.

We're combining our efforts to identify and manage concussive brain injury as close as possible, both in time and geographic proximity, to the actual blast event, with more aggressive battlefield management of post-traumatic stress symptoms. Our experts tell us that the closer we can manage those symptoms as they emerge in combat, the more likely we are to reduce long-term PTSD problems.

Treatment of concussive injuries is an emerging science. The Army is leading the way in implementing these new treatment protocols for DOD, and the DOD is leading the Nation.

I brought with me today our Brain Injury Awareness Toolkit. I'd like to share this with you and your staff. If you don't have any other time, I'd really urge you to look at the DVD that we've put together with our senior leadership, because this is really a commanders-led program—the Chief of Staff, George Casey; the Vice Chief of Staff, Pete Chiarelli; and our Sergeant Major of the Army are very actively involved in. They contain patient information materials, as well as this DVD, which we're using to educate soldiers before they deploy overseas. We're training them as to what they should do, should they have a concussion.

[The information referred to follows:]

What Should I Do?

- Seek medical attention as soon as possible after any injury where there may be a chance of a concussion
- Be honest with your provider
- Your provider will evaluate you and will determine when it's safe for you to return to duty

Warning Signs

After initial evaluation, if you experience any of the following, seek *immediate* medical attention:

- Worsening headache
- Worsening balance
- Double vision or other vision changes
- Decreasing level of alertness
- Increased disorientation
- Repeated vomiting
- Seizures

Additional Information:
Defense and Veterans Brain Injury Center
www.dvbic.org

Developed by:
Battlemind Transition Office
&
Proponency Office for
Rehabilitation & Reintegration

Version 3.0
25 January 2010
Reviewed by SME Panel 5 and 10

Concussion / mTBI Information

For the Time of Injury (Acute)

What Happened to Me?

You had a concussion, which is also called a "mild traumatic brain injury" (mTBI).

What is a Concussion?

- A concussion is a head injury from a hit, blow, or jolt to the head that briefly knocks you out (loss of consciousness), or makes you confused or "see stars" (change in consciousness)
- Immediately or soon after the concussion, you may have disorientation, headaches, dizziness, balance difficulties, ringing in the ears, blurred vision, nausea, vomiting, irritability, temporary gaps in your memory, sleep problems, or attention and concentration problems

How Long Does It Last?

- Almost everyone recovers from concussion
- Symptoms usually begin to improve within hours to days and in most cases completely resolve
- Even if you've had more than one concussion, full recovery is expected; however, with each additional concussion your healing could take longer

Recovery

- Recovery is different for each person and is dependent on the nature of the injury
- The most important thing you can do is to allow yourself time to heal
- It's very important to be honest about your symptoms and let your medical provider decide when it's time to return to duty

Why is Concussion Important?

- Often after a concussion, Service members think they are OK, yet they've actually had an injury that needs attention
- Symptoms after concussion reduce your effectiveness which could impair your performance and endanger your mission
- If you get another concussion before healing from the first one, you are at greater risk for a more serious injury

Healing from a Concussion

Things that Enhance Healing

- Get a medical evaluation as soon as possible and let your medical provider decide when it's time to return to duty
- Get plenty of rest and sleep
- Protect yourself from another concussion: avoid contact sports, combatives, etc
- Let others know that you've had a concussion so they can watch out for you
- Return *immediately* to your medical provider if you're feeling worse or experiencing any warning signs

Things that Impair Healing

- Another concussion before healing from this one
- Alcohol and drug use
- Caffeine or "energy-enhancing" products
- Aspirin, ibuprofen, and other over-the-counter pain medications unless instructed by your doctor
- Sleeping aids and sedatives unless instructed by your doctor

Recovery

- Full recovery is expected even if you've had more than one concussion during deployment.
- However, with each additional concussion healing may take a little more time.
- It's important to know that treatment is available for your post-deployment health problems, including those related to concussion.
- Most health problems resulting from concussion or deployment can be addressed by a primary care provider who is supported by a team of specialists.
- Speak with your provider about each of your health concerns.
- Understand that recovering from a concussion may take longer if you have other medical conditions such as depression, PTS, sleep problems, or are using alcohol or drugs.

The most important things *you* can do:

- Relax and give yourself time to heal
- Get plenty of sleep and rest
- Be honest with your provider
- Avoid further head injury
- Expect a full recovery

Additional Information:

Defense and Veterans Brain Injury Center
www.dvbic.org

Developed by:
Battlemind Transition Office
&
Proponency Office for
Rehabilitation & Reintegration

Version 5.0
25 January 2010
Reviewed by SME Panels 5 and 10

Concussion / mTBI Information

For use >1 month after injury or at Post Deployment Health Assessment

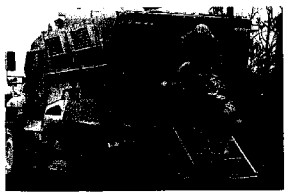
(Not For Acute Period)

What is a Concussion?

- Concussion is an injury from a hit, blow, or jolt to the head that briefly knocks you out (loss of consciousness) or makes you confused or "see stars" (change in consciousness).
- It can result in headaches, irritability, fatigue, balance difficulties, sleep disturbance, dizziness, ringing in the ears, blurred vision, concentration or memory difficulties, and other problems.

Have I Had a Concussion?

- Your assessment indicates that you may have had a concussion/mTBI.
- It is important to understand that "mTBI" - mild Traumatic Brain Injury - is just another way of saying "concussion."
- We refer to your injury as a concussion because we want to make sure you realize that it's different from the other more severe "traumatic brain injuries" (TBIs).



How Long Does it Last?

- Almost everyone recovers from concussion within hours to days.
- Sometimes Service members are concerned that concussions sustained during deployment will lead to lasting effects after return home, but in fact, concussions usually heal quickly.
- Occasionally, symptoms may persist longer than expected.
- The time it takes to heal depends on the individual, the nature of the injury, the number of concussions, and other conditions that may exist.

What Else is Important?

- Persistent symptoms post-deployment may result from physical injuries, other significant events, or conditions such as sleep deprivation and operational stress reactions.
- Conditions such as post-traumatic stress (PTS), depression, anxiety, and alcohol use can make it more difficult to fully recover.
- Talk to your provider about significant events you experienced in theater and any symptoms you have.
- Communicate accurately detailed information about all injury events; the sooner you do this the better.

What Will Help Your Recovery?

- Talk to your provider about the problems you're experiencing
- Take only medications prescribed for you, take them as directed, and report any side effects
- Abstain from alcohol and drug use
- Limit your use of caffeine and "energy-enhancing" products
- Avoid contact sports that can lead to another concussion
- Avoid aggressive driving that can lead to more severe traumatic brain injuries
- Get plenty of sleep every day - at least 7-8 hours

Brain Injury Awareness Tool Kit

Proponency Office for Rehabilitation and Reintegration

Health Policy and Services, Army Medical Department
Office of The Surgeon General
703.681.3051 www.armymedicine.army.mil/prr

Tool Kit Includes:

- TBI 101—Army DVD
- Large Military Acute Concussion Evaluation (MACE) card
- HEADS card
- Concussion Brochures:
  - For the Time of Injury (Acute)
  - For use >1 month after injury or at PDHA (Not for Acute Period)
- Patient Education handouts for Dizziness, Mood Changes, Headache and Neck Pain, Memory and Healthy Sleep
- TBI Program Validation fact sheet

Defense and Veterans Brain Injury Center

Concussion / Mild Traumatic Brain Injury Rehabilitation: Head Injury and Dizziness

Why Am I Dizzy?
Dizziness is one of the symptoms that you may experience after a head injury. Often this is related to a problem with the inner ear, which is where balance is controlled. The dizziness may also be related to other problems with the inner ear or problems with your neck. It is common to also experience ringing / buzzing in your ears, ear pain, hearing loss, neck pain / stiffness or headaches.

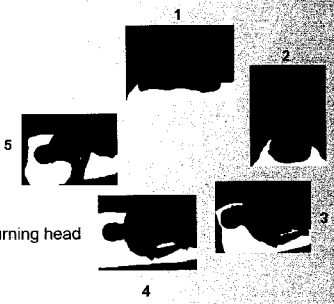
What Can I Do?
Neck stretches - See additional handout out on "Headache & Neck Pain."

Modify activities - If your dizziness is brought on by a change in position (for example, sitting to standing, bending forward, etc.), move slowly and allow yourself a minute in the new position before moving again. Avoid sleeping on the "bad" side.

Change sleep position - If you are dizzy getting out of bed in the morning, consider sleeping in a semi-recumbent position, as shown in the picture.

At-Home Vestibular Rehabilitation Exercises
Hold each of these positions for 30 seconds:

1. Start by sitting upright in bed.
2. Turn head to the left.
3. Lie back.
4. Turn head to the right.
5. Roll over to the right side.
6. Sit up straight again.
7. Repeat in the opposite direction (ie: start by turning head to the right).
8. Repeat the entire sequence three times.



What to Expect?
The vestibular rehabilitation exercises will likely bring on your typical dizziness symptoms, but over time these exercises help train your body to overcome the dizziness. It is best to do these exercises on your bed right before bedtime. If your symptoms get worse after these exercises and do not return to baseline within an hour or two, consult your health care provider.

What Next?
If these exercises do not help your dizziness in about two weeks, talk to your health care provider, who will evaluate your dizziness and set up a treatment plan.

This tool is to be used as a patient education resource during a visit with your provider.
Developed by Subject Matter Experts from the DoD and VA
Version 2: 4 May 2009

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www.dvbic.org

Defense and Veterans Brain Injury Center

Concussion / Mild Traumatic Brain Injury Rehabilitation: Mood Changes

Having trouble concentrating?

Easily irritated or on edge?

Feeling overwhelmed, anxious, sad or depressed?

Understand that it is OK to have these feelings. There are things you can do to help manage these feelings. Take deep breaths, and know that the feeling will pass. Do not focus on your worries or troubles. Do something you enjoy.

This is normal and very common after a concussion / mild traumatic brain injury. Fortunately, these feelings get better with time.

Replace the negative thoughts or actions with positive ones. If you are in a situation that is upsetting you, get out of it. Go for a walk. Take a few minutes without disruption to settle yourself.

Do not call yourself bad names or put yourself down. You are not your concussion / mild traumatic brain injury. Life will get better. Stay positive.

Talk to someone you love or trust about these feelings. Many people have felt the same way you have at some point in time. Don't be afraid to express yourself. Your health care provider can also help, so be sure to share your feelings with him or her.

If you have thoughts or feelings of hurting yourself or others, seek emergency care. You can contact the Veterans Administration Suicide Prevention Hotline: 800-273-TALK (8255). This number is established for both Veterans and Active Duty personnel.

Symptoms associated with TBI are similar to psychological stress. If these mood changes are causing problems at work or home, seek help.

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Concussion / Mild Traumatic Brain Injury Rehabilitation: Headache and Neck Pain

Why Does it Hurt?
After a blast exposure, jump injury, car accident or other way that you might get a head injury, your neck may have experienced some trauma as well. Some people recover quickly from this type of injury, while others continue to have pain or stiffness in their necks related to poor posture. This neck pain can become head pain.

1. Ice / Heat:
Ice your neck and head at least 2-3 times a day. Leave it there as you relax for about 20 minutes (or until the pack is no longer cold).

Heat is good for relaxing muscles. You can use a warm gel pack. A 10-20 minute shower will just as well. Most respond to ice better than heat. Try both to see which one works best for you. When using heat or ice with neck stretches (below), use heat to relax muscles before stretching, then use ice after stretching to calm the muscles.

2. Neck Stretches:
Before stretching in any direction, pull up your spine as straight as possible, then "retract" your chin towards your neck. The muscles you are stretching are small and delicate: start low, and go slow. Tips: keep your head level (not bending forward or back), do not tug or shove neck, and gently press on your chin for a deeper stretch:

Pull up:

Retract:

Deeper stretch:

Directions: Start by holding for only about 5-10 seconds, then more each day:

Flexion (chin to chest):

Lateral flexion (ear to shoulder):

Rotation (turn):

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Concussion / Mild Traumatic Brain Injury Rehabilitation: Headache and Neck Pain

3. Sleep Posture:
Consider how you sleep: on your stomach, back, side? Now take away the pillow, bring your arms to your sides, and sit up. How does your neck position look? Is it twisted and strained? Does is look or feel like a good position to keep your neck for 6-8 hours every night? And keep in mind, flipping to the other side doesn't make it "even!"

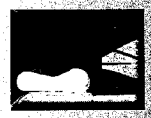
First, lying on your side is where to start. Then, consider your pillow. Neutral is the key.

Too fluffy:

Too flat:

Just right:

Next, as you lie on your side on your neutral pillow, pull your entire body completely straight. Once your neck is straight, rest your arms, bend your knees, relax your body to a comfortable position. But RECHECK your neck position. Most people tend to curl up once they relax. If you have tucked your chin, pull your neck back up. This might feel awkward to start, but will become part of your bedtime routine and natural after about 1-2 weeks. Here's how it looks.



4. Massage:
Massages can be relaxing. Ask for a therapeutic massage. Explain that you get headaches from neck tension. Relax and enjoy.

5. Medication:
Be sure to tell your health care provider about all of the medications and supplements you are taking. Consult with a health care provider prior to using any over-the-counter (OTC) medications. Be advised that OTC medications may make your headaches worse. If you are prescribed headache and/or neck pain medication, take it only as directed and be aware that it may take 2-4 weeks to show improvement.

What Next?
If these conservative approaches are not effective after 2-4 weeks of consistent use, talk to your health care provider.

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Defense and Veterans Brain Injury Center

Concussion / Mild Traumatic Brain Injury Rehabilitation: 10 Ways to Improve Your Memory

1. Get 7 to 8 hours of sleep - Keep a quiet, cool environment. Go to sleep at the same time nightly. No napping. Avoid high energy video games/movies/television prior to bedtime. Avoid exercise before bedtime.
2. Write it down - Keep a notebook and pen with you and write things down, it will keep you on track and help remind you of important things, like taking your medication. Day planners or small calendars help also.

3. Avoid alcohol, tobacco, excessive caffeine and energy drinks - These increase sleep problems, anxiety, blood pressure levels, and overall stress.
4. Prioritize - Make a list of things that need to be taken care of, place them in order of importance, and check them off when completed.
5. Get a routine - Put your keys in the same spot every day. Park in the same areas. Being consistent helps memory and lowers anxiety.
6. Keep mentally active - Work crossword puzzles. Read a book. Play a board or card game like solitaire or concentration. Try to learn something new every day.
7. Decrease your stress level - Don't take on too much at one time. Keep stress to a minimum. Stress hormones can damage your brain and add to depression and anxiety. Learn to say "no" when feeling overwhelmed. It's also OK to ask for help when you need it. Make time for you.
8. Stay physically active - Take the dog for a walk. Take the stairs instead of the elevator. Small spurts of exercise add up. The higher blood flow to your brain helps promote cell growth. Exercising is also a mood booster and helps with mental clarity.
9. Feed your brain - Eat high quality foods at regular intervals. Fish, colorful fruits and veggies, milk, eggs, whole grain breads, nuts, and beans all help to keep the brain and body healthy.
10. Avoid further brain injury - Consider swimming, walking, or running instead of playing football or boxing. Wear a helmet when riding your bike or motorcycle. Drive safely. Stay sober.

This tool is to be used as a patient education resource during a visit with your provider.

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Defense and Veterans Brain Injury Center

Concussion / Mild Traumatic Brain Injury Rehabilitation: Healthy Sleep

Getting a good night's sleep has to do with many factors. The following are helpful hints for good sleep hygiene and treatment of insomnia.

1. No caffeine-containing foods or drinks three hours prior to bedtime
2. No heavy exercise three hours prior to bedtime
3. No alcohol, nicotine or heavy meals within three hours of bedtime
4. Avoid bright light exposure near bedtime
5. Keep regular bedtime and wake-up hours, even on the weekend
6. Foster a quiet, pleasant sleep environment - a cool room and soft lighting
7. Have a relaxing bedtime routine - warm soak in the tub or warm shower, relaxing thoughts, meditation, progressive muscle relaxation exercises, or Yoga
8. Stop work or TV viewing of disturbing or stimulating television shows at least one hour before bedtime
9. Use of the bed is for sleep and sex, which means no watching TV, work, or reading
10. Go to bed only when sleepy
11. Go to another room if sleep does not come within 20-30 minutes
12. Get up at the same time each morning
13. Do NOT take naps
14. If you have been prescribed sleep medications, take them as instructed and at the same time every night
15. Consult with a health care provider before taking any over-the-counter medications or supplements

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The primary operational TBI component of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

Brainwaves

DVBIC Brainwaves • Fall/Winter 2009
DVBIC Phone: (800) 870-9244 • Website: www.DVBIC.org

Message from

Col Michael S. Jaffee, MD

USAF, MC, FS
National Director, DVBIC

It is a time of tragic loss for our extended family. We have worked with the US Army Surgeon General's office and the leadership at Fort Hood to rapidly respond to the needs of our Fort Hood colleagues and to sustain the traumatic brain injury (TBI) mission during this challenging time. This event reinforces the importance of home and family.

It has been an honor for DVBIC to explore new frontiers by serving on the tri-service, multi-agency "Gray Team," dedicated to improving systems of care for in-theater TBI. In October, the Gray Team returned to Afghanistan with the mission to focus on improved implementation of TBI assessment and care of our Service Members. This mission was critical to transition our system of care for concussion/mTBI in the deployed setting from a self-report system to an incident-based system. I subsequently had the privilege of serving as the senior military US delegate to the North Atlantic Treaty Organization (NATO) concussion/mTBI committee, where it was reported that more of our allies had adapted DVBIC's deployed screening and evaluation system for concussion/mTBI.

As the holidays approach, we remember those who are far from home on battlefields and duty stations around the world, as well as those who have returned and are adjusting to a new life. We also honor their family members and friends.

Our condolences are extended following the loss of one of the original congressional architects of DVBIC, Senator Edward M. Kennedy. We hope that DVBIC's efforts in the field of TBI contribute to his lasting legacy.

The DVBIC network always stands ready to assist those who need our help, through evidence-based care, education and research. We wish you all the best, now and always.

"No single entity has done more to advance our knowledge, increase our understanding, and improve our ability to diagnose and treat traumatic brain injury than the Defense and Veterans Brain Injury Center. Through its cutting edge research, state-of-the-art clinical care, and innovative initiatives, the DVBIC is fulfilling the Nation's promise to care for those injured in the service of our country."

Ellen P. Embrey
Performing the Duties of Assistant Secretary of Defense for Health Affairs

Nursing Management of Adults With Severe TBI

Nurses offer a unique perspective on the full impact of traumatic brain injury (TBI) due to their significant role in the course of a patient's recovery. Because TBI is currently a diagnosis of significant interest among researchers – particularly related to blast injury – new medical, nursing and rehabilitation treatments continue to emerge.

In order to provide resources and recommendations for best practices based on current evidence, the American Association of Neuroscience Nurses (AANN), with support from DVBIC, has developed a new clinical practice guideline, *Nursing Management of*

...continued on page 2

DVBIC Site Profile: Virginia NeuroCare (VANC)

Virginia NeuroCare (VANC), a DVBIC site in Charlottesville, Virginia, opened in 2000 as a congressionally mandated pilot program for community re-entry and rehabilitation, funded by the Department of Defense through DVBIC. Programs are offered exclusively to injured active duty Service Members, Veterans, active duty dependents, and members of the National Guard or Reserve who sustained a TBI and have received care in a military treatment facility. VANC assists these individuals in preparing for return to home, work and/or duty.

Up to eight residents stay in a home in the community staffed by a full-time house manager and round-the-clock direct care supervision. Residents may select from 27 vocational trial positions in the community (including VANC's own bookstore and art gallery, Paintings and Prose), where their volunteer work provides real-life work experience.

VANC serves as a model of innovative community re-integration and collaborates closely with the University of Virginia School of Medicine. It is centrally located in the community and utilizes cutting edge technology. On September 25, 2009, VANC hosted the dedication and grand opening of its greenhouse and onsite "limnasium," named in honor of a donor. The greenhouse will offer horticulture

...continued on page 2

2009 TBI Military Training Conference

DVBIC Headquarters staff organized the TBI military training conference.

On behalf of the Department of Defense, DVBIC was pleased to organize and convene the Third Annual Military Training Conference on Traumatic Brain Injury (TBI), held September 17-18, 2009 in Washington, DC.

Adm Michael Mullen, USN, Chairman of the Joint Chiefs of Staff, provided the opening address and stressed the importance of work being done to standardize the assessment, treatment and management of TBI among injured Service Members. He emphasized the urgency of the need for these tools and protocols now. Next on the agenda were

...continued on page 2

A traumatic brain injury (TBI) is caused by a blow/jolt to the head or penetrating head injury that disrupts the normal function of the brain. Not all blows/jolts to the head result in a TBI. TBI severity may range from **mild** (a brief change in mental status or consciousness) to **severe** (an extended period of unconsciousness or amnesia after injury). The terms **concussion** and **mild TBI** are interchangeable.

Top Awards for Excellence Received by DVBIC Multimedia Partners

DVBIC has been proud to facilitate and support multimedia excellence. DVBIC collaborated with the DoD's own Center of Excellence for Medical Multimedia (CEMM), headquartered at the US Air Force Academy, in the development of the online educational resource, *Traumatic Brain Injury: The Journey Home*, available at www.TraumaticBrainInjuryAtoZ.org.

The International Health and Medical Media Awards, known as the Freddies, recognize high quality websites and products that address health or medical issues for consumers or healthcare professionals. This CEMM multimedia program, with many features to include an interactive brain, received the top industry award, a Freddie, in the 2009 Neurological Disorders category.

Brainline.org, a multimedia website that offers information and resources on preventing, treating and living with traumatic brain injury (TBI), is funded by DVBIC and produced by WETA-TV-FM, a Washington, DC area public broadcasting company. Brainline.org has received six awards, including a prestigious 2009 Freddie for Best Web Site.

Additional recent awards for brainline.org include:

- 2009 Interactive Media Award for Best in Class in Health/Nutrition
- 2009 Web Marketing Association's Non-Profit Standard of Excellence WebAward
- 2009 American Speech-Language-Hearing Association (ASHA) Media Award
- 2009 International Academy of the Visual Arts Silver W3 Award for creative excellence, in the Health category
- Bronze 2009 World Wide Web Health Award in the Health Promotion/Disease & Injury Prevention Information category.

Nursing Management of Adults With Severe TBI ...con't from pg 1

Adults With Severe TBI (available at www.aann.org/pubs/). This essential resource translates the latest research into an easy-to-use reference for registered nurses, intensive care unit personnel and institutions in providing safe, effective and optimal care to adults with severe TBI. It parallels the *Guidelines for the Management of Severe TBI*, published in 2007 by leading TBI physicians (available at www.braintrauma.org).

The new clinical practice guideline is not intended to replace formal learning, but rather to augment the clinician's knowledge base and serve as a readily accessible reference tool.

DVBIC Recognized for TBI Work in DoD Technical Report

A recent technical report commissioned by the Department of Defense (DoD) recognized DVBIC for its role in developing the criteria, instruments and measures used by military and veterans medical facilities to assess and diagnose concussion/mild traumatic brain injury (mTBI).

The Survivability/Vulnerability Information Analysis Center issued the 44-page document, *Screening and Diagnosis of Military mTBI: Review and Analysis*, on behalf of the US Army Medical Research & Materiel Command. Findings were based on a search of more than 10 years of peer-reviewed research literature involving concussion/mTBI patients treated at DoD or Department of Veterans Affairs (VA) facilities.

According to the report, "Even within the limited existing literature, it is evident that researchers are now making use of screening criteria, instruments, and other resources developed and made available through DVBIC. The DVBIC now plays a central role in performing and advancing research that will directly benefit military Service Members and Veterans with TBI."

Noting that "new and additional methods are needed to improve the accuracy and efficiency of mTBI diagnosis, and to inform prognosis, symptom treatment, and functional recovery," the report recommended several areas for further research, including biomarkers, electroencephalographic (EEG) testing, neuropsychological and behavioral tests, emerging neuroimaging technology, mathematical modeling and computer/numerical simulation, and comorbidities such as post traumatic stress disorder (PTSD).

The report concluded that "the optimal approach to mTBI diagnosis is to provide an inclusive multidisciplinary assessment and adjunctive testing tailored to the context of the patient.... Many if not all of these objectives are implicit if not yet fully realized in DoD case management guidance."

TBI

DoD Releases Official TBI Numbers on DVBIC.org: Using electronic medical records, the Department of Defense has compiled the number of Service Members diagnosed with TBI and determined the severity of the injury on an annual basis dating back to 2000. For details, visit www.DVBIC.org/TBI-Numbers.aspx.

DVBIC Brainwaves is a quarterly publication of the Defense and Veterans Brain Injury Center (DVBIC), the primary operational TBI component of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). Point of Contact: Sheryl C. Chasson, MBA/HA, BSW, Editor. Email: brainwaves@DVBIC.org

DVBIC Site Profile: Virginia NeuroCare (VANC) ...con't from pg 1

therapy and the gymnasium will provide modern equipment for exercise and physical rehabilitation.

VANC offers the following transitional services: comprehensive evaluation, outpatient therapy, vocational training, vocational counseling services through the University of Virginia and innovative community re-entry services. The length of stay in the program varies according to the needs of the resident but averages three months. A full complement of healthcare professionals is available, including an internal medicine physician, occupational therapists, physical therapists, clinical behavioral psychologists, neuropsychologists, a speech-language-hearing therapist, case managers, substance abuse counselors, a vocational specialist and a community outreach education coordinator.

This pilot program has been considered a success, with a solid return-to-duty rate. These results helped to inform the Department of Veterans Affairs (VA) decision to incorporate community re-entry programs at their polytrauma centers. For more information, please visit www.DVBIC.org/Locations/Sites/Charlottesville,-VA.aspx.

2009 TBI Military Training Conference ...con't from pg 1

Dr. Thomas McAllister received a plaque from Col Michael S. Jaffee, MD after delivering the Deborah L. Warden, MD Lecture.

the keynote speakers, Bob and Lee Woodruff, who shared their inspiring story of how, as a couple and family, they weathered the storm of TBI sustained by Mr. Woodruff in Iraq in 2006.

Dr. Thomas McAllister, Millennium Professor of Psychiatry and Director of Neuropsychiatry at Dartmouth Medical School, was awarded the Deborah L. Warden, MD Lectureship, which honors excellence in research and education in TBI.

Conference scientific and clinical presenters were experts in TBI and provided the audience with the most up-to-date information on this topic. Breakout sessions provided skills in assessment and management of symptoms associated with TBI such as sleep issues, headaches, substance abuse and neuropsychological problems.

The conference was attended by 832 military and veterans health providers, 70% of whom were attending this training conference for the first time. Military health providers from The Netherlands, United Kingdom and Canada also were present.

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DCoE Website: www.dcoe.health.mil
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Proponency Office for Rehabilitation & Reintegration

Traumatic Brain Injury (TBI) Program Validation

Army Medical Treatment Facility TBI Validation Program
In efforts to enhance the quality of care being provided to our Soldiers and to make sure the facilities are delivering care with all the necessary guidance and tools, the TBI validation program was established. This validation program came as a recommendation from the TBI Task Force Report, released 17 January 2008. The Chief of Staff for the Army Medical Command (MEDCOM) is the validating authority.

Since September 2007, more than 350 staff have been funded across the MEDCOM to support TBI care. The funding for this staff resource is from the supplemental funds that were provided to the Army 2007 through 2009, and core funds in 2010. Based on mission, current staff available, and projected TBI patient population, the following teams were developed:

- **Every facility has a TBI Program Manager**
- **Category 1 Teams**

  Augmented Teams at six medical centers. Medical center Teams consist of 16-30 personnel and may include audiologists, case managers, clinical nurse specialists, LPNs/LVNs, neurologists, neurosurgeons, nurse practitioners, occupational therapists, occupational therapy assistants, optometrists, pharmacists, physical therapists, physical therapist assistants, physician assistants, physical medicine and rehabilitation physicians, primary care physicians, psychiatrists, psychiatric technicians, psychologists, recreation therapists, social workers, speech language pathologists, program directors, and administrative support staff.
- **Category 2 and 3 Teams**

  Augmented Teams at high troop density sites and/or sites with a high number of patients with TBI. The staff, which consists of 5-31 personnel, may include audiologists, case managers, LPNs/LVNs, neurologists, nurse practitioners, occupational therapists, occupational therapy assistants, physical therapists, physical therapist assistants, physician assistants, physical medicine and rehabilitation physicians, primary care physicians, psychiatrists, psychiatric technicians, psychologists, social workers, speech language pathologists, program directors, and administrative support staff.
- **Category 4 Teams**

  The staff ranges from 1-4 and may include a case manager, nurse practitioner, occupational therapist, occupational therapy assistant, pharmacist, physical therapist, physical therapist assistant, physician assistant, primary care physician, psychiatrist, psychiatric technician, psychologist, social worker, program director, and administrative support staff.
- **Surge Capability** to ensure TBI care is available at sites with limited organic TBI assets.

The program management requirements for validation are divided into two phases: Initial validation and full validation. Initial validation is awarded upon completion of Phase 1 requirements, while full validation is awarded upon implementation of Phase 2 requirements and Operational Order (OPORD) tasks.

As of 5 March 2010, 12 programs have been fully validated, 20 programs have received initial validation, and the remaining programs are undergoing the validation process. We anticipate full validation of all MTFs by 30 September 2010.

Strengthening Soldiers for a Lifetime...Army Strong!

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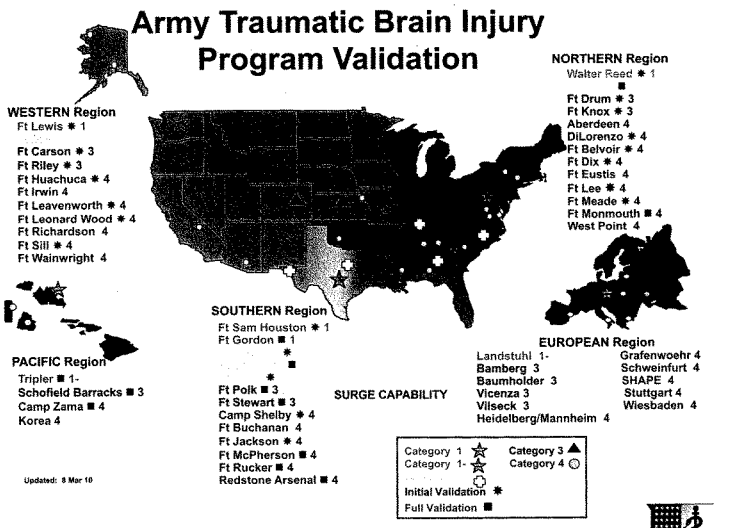
Proponency Office for Rehabilitation & Reintegration

Traumatic Brain Injury (TBI) Program Validation

The Proponency Office for Rehabilitation and Reintegration (PR&R), in collaboration with the Defense Veterans Brain Injury Center (DVBIC), established a validation program for all Army Medical Department (AMEDD) Medical Treatment Facilities (MTFs) that provide care for Soldiers with mild, moderate, severe or penetrating TBIs. This validation program was designed to establish standards of care for beneficiaries with TBI and to ensure that services, physical facilities, and staffing levels are consistent across the Army MTFs based on the level of care provided at the facility.

Program categories are based on Soldier population, which drives the scope and depth of care offered. The programs are divided into four categories:

Category 1: Providing inpatient and outpatient care for the full spectrum of TBI severity (mild, moderate, and severe).
Category 2. Providing inpatient and outpatient care for mild and moderate TBI.
Category 3. Providing outpatient medical and rehabilitative care for Soldiers with mild and mild-moderate TBI.
Category 4. Providing outpatient medical care for Soldiers with mild TBI and refer for additional services as needed.



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General SCHOOMAKER. I truly believe that this evidence-based directive approach to concussive management will change the military culture regarding head injuries and significantly impact the well-being of our force.

In closing, I'm very optimistic about the next 2 years. I feel very privileged to serve with the men and women of Army Medicine, as soldiers, as Americans, and as global citizens.

Thank you for holding this hearing and your unwavering support of the Military Health System and Army Medicine.

I look forward to answering questions. In particular, I'd be happy to discuss the Army's approach to pain management, to the treat-

ment of post-traumatic stress, and the use of medications across the force, those other concerns that were raised by Senator Cardin.

Thank you.

[The prepared statement of General Schoomaker follows:]

PREPARED STATEMENT BY LTG ERIC B. SCHOOMAKER, USA

Chairman Webb, Senator Graham, and distinguished members of the Personnel Subcommittee, thank you for inviting us to discuss military medicine and our respective Service medical programs. Now in my third Congressional hearing cycle as the Army Surgeon General and Commanding General, U.S. Army Medical Command (MEDCOM), I can tell you that these hearings are valuable opportunities for me to talk about the accomplishments and challenges of Army Medicine and to hear your collective perspectives regarding military healthcare. You and your staff members ask some difficult questions, but these questions help keep us focused on those we serve—the soldiers, sailors, marines, airmen, coastguardsmen, family members, and retirees as well as the American public. I hope you also find these hearings beneficial as you review the President's budget submission, which this year fully funds the Army Medical Department's needs, and determine priorities and funding levels for the next fiscal year.

The U.S. Army Medical Department is a complex, globally-deployed, and world class team. My command element alone, the MEDCOM, is an $11 billion international health improvement, health protection, emergency response and health services organization staffed by 70,000 dedicated Soldiers, civilians, and contractors. I am in awe at what these selfless servants have done over the past years—their accomplishments have been quietly, effectively, powerfully successful. While we have experienced our share of crises and even tragedies, despite 8 years of continuous armed conflict for which Army medicine bears a heavy load, every day our soldiers and their families are kept from injuries, illnesses, and combat wounds through our health promotion and prevention efforts; are treated in cutting-edge fashion when prevention fails; and are supported by an extraordinarily talented medical force to include those who serve at the side of the Warrior on the battlefield. We mourn the loss of 26 teammates in the Fort Hood shootings—6 dead and 20 wounded—but are inspired by the resolve shown by their units to continue their missions and the exemplary performance of the 467th and 1908th Medical Detachments serving in Afghanistan today.

One area of special interest to Congress is our comprehensive effort to improve warrior care from point of injury through evacuation and inpatient treatment to rehabilitation and return to duty. I am convinced the Army has made some lasting improvements, and I was recently heartened to read the comments of a transitioning warrior that reinforced these perceptions. She commented:

> As I look back in the past I am able to see with a reflective eye ... the people that have helped me fight this battle, mostly my chain of command, who have always stood beside me instead of in front of me. They have gone out of their way to do what was best for me and I cannot say I would be here still if I hadn't had such wonderful support.... This is my story at the WTB and all in all, I just had to make aware to everyone that has helped that I am very grateful and I truly appreciate all of the work you have done for me.

There is nothing more gratifying than to care for these wounded, ill, and injured heroes. We in Army medicine continue to focus our efforts on our warriors in Transition and I want to thank Congress for its unwavering support. The support of this committee has allowed us to hire additional providers, staff our warrior transition units, conduct relevant medical research, and build healing campuses. In the remainder of my testimony today, I will discuss how we are providing optimal stewardship of the investment the American public and this Committee has made in Army medicine.

We lead and manage Army medicine through the Kaplan & Norton Balanced Scorecard performance improvement framework that I introduced to you in last year's testimony. The Scorecard balances missions and resources across a broad array, while ensuring that near-term measures of success are aligned with longer-term, more strategic results. This balancing is depicted on the Scorecard's Strategy Map, which shows how we marshal our resources, train and develop our people, and focus our internal processes and efforts so as to balance competing goals. Ultimately our means, ways, and ends contribute toward accomplishing our mission and achieving our strategic vision. The five strategic themes that guide our daily efforts are:

- Maximize Value in Health Services
- Provide Global Operational Forces
- Build the Team
- Balance Innovation with Standardization
- Optimize Communication and Knowledge Management

Although distinct themes, they inevitably overlap and weave themselves through everything we do in Army medicine.

The first strategic theme—Maximize Value in Health Services—is built on the belief that providing high quality, evidence-based services is not only the right for our soldiers and families; it results in the most efficient use of resources within the healthcare system, thus delivering value to not only our patients, but indeed, the Nation. In fact, what we really want to do is move from a healthcare system to a system for health.

We have resisted simply inventing a new process, inserting a new diagnostic test or therapeutic option in vacuo or adding more layers of bureaucracy but are truly adding value to the products we deliver, the care we provide, and the training of our people. This requires focusing on the clinical outcome for the patient and the community and maintaining or even reducing the overall resource expenditure needed to achieve this objective. It has occurred through adoption of evidence-based practices and reducing unwarranted practice variation—even "unwarranted administrative practice variation" for the transactional processes in our work. As one example of this, Army Medicine is expanding upon our Performance Based Budget model to link resources to clinical and quality outputs. The Healthcare Effectiveness and Data Information Set (HEDISR) is a tool used by more than 90 percent of America's health plans (> 400 plans) to measure performance on important dimensions of care, namely, the prevention of disease and evidence-based treatments for some of the most common and onerous chronic illnesses. The measures are very specifically defined, thus permitting comparison across health plans. Since 2007, we have been providing financial incentives to our hospitals, clinics and clinicians for superior compliance in key HEDIS measures. Currently, we track nine measures and compare our performance to national benchmarks. Our performance has improved on each measure, in one case by 63 percent. We have demonstrated that these incentives work to change organizational behavior to achieve desired outcomes in our health system. Put quite simply, our beneficiaries, patients and communities are receiving not only better access to care but better care—objectively measured.

As the DOD budget and health-/healthcare-related costs come under increasing scrutiny, this element of our strategy will be even more critical for us. As the United States struggles to address improvements in health and healthcare outcomes while stabilizing or reducing costs of our national system of care, we in Army Medicine and the Military Health System will surely keep the goal of maximizing value in our cross-hairs . . . or we will find our budgets tightening without a way to measure the effects on our patients' and our communities' health and well-being.

All of these remarkable achievements would be without meaning or importance to our soldiers, their families, and our patients if we do not provide access and continuity of care, especially within the direct care system of our medical centers, community hospitals, health centers, and clinics. I am looking carefully at my commanders' leadership and success in ensuring that their medical and dental treatment facilities provide timely access and optimize continuity of care. We have undertaken major initiatives to improve both access and continuity—this is one of the Army Chief of Staff's and my top priorities. After conducting thorough business case analyses, Army Medicine is expanding product lines in some markets and expanding clinical space in others. At 14 locations, we are establishing Community-Based Primary Care Clinics by leasing and operating clinics located in off-post communities that are close to where active duty families live, work, and go to school. These clinics will provide a patient-centered medical home for Families and will provide a range of benefits:

- Improve the readiness of our Army and our Army Family
- Improve access to and continuity of care
- Reduce emergency room visits
- Improve patient satisfaction
- Implement Best Practices and standardization of services
- Increase physical space available in military treatment facilities (MTFs)
- Improve physical and psychological health promotion and prevention

Along with the rest of the Military Health System, Army Medicine is embracing the Patient-Centered Medical Home concept, which is a recommended practice of the National Committee for Quality Assurance and is endorsed by a number of medical associations, several large third-party payers, and many employers and health

plans. The Patient-Centered Medical Home improves patient satisfaction through its emphasis on appropriate access, continuity and quality, and effective communication. The goal is simple: consult with one consistent primary care provider-nurse team for all your medical needs. The seven core features of the Medical Home are:

- Personal Primary Care Provider (primary care manager/team)
- Primary Care Provider Directed Medical Practice (the primary care manager is team leader)
- Whole Person Orientation (patient centered, not disease or provider centered)
- Care is Coordinated and/or Integrated (across all levels of care)
- Quality and Safety (evidenced-based, safe medical care)
- Enhanced Access (meets access standards from the patient perspective)
- Payment Reform (incentivizes the development and maintenance of the medical home)

I look for 2010 to be the year Army medicine achieves what we set out to improve 2 years ago in access and continuity, key elements of our covenant with the Army Family, led by our Chief of Staff and Secretary of the Army.

Unlike civilian healthcare systems that can focus all of their energy and resources on providing access and continuity of care, the Military Health System has the equally important mission to Provide Global Operational Forces.

The partnership between and among the medical and line leadership of Operations Iraqi Freedom and Enduring Freedom, Central Command, Army Forces Command, U.S. Army Reserve Command, National Guard Bureau, Army Medical Department Center & School, Medical Research and Materiel Command, Army G3/5/7, and others has resulted in a dynamic reconfiguration of the medical formations and tactics, techniques, and procedures required to support the deployed Army, joint and coalition force. Army Medicine has never missed movement and we continue to achieve the highest survivability rate in the history of warfare. Army medicine leaders have never lost sight of the need to first and foremost make a difference on the battlefield.

This will not change—it will even intensify in 2010 as the complexity of the missions in Afghanistan increases. This is occurring even while the need to sustain an Army and joint force which is responsibly withdrawing from Iraq puts more pressure on those medics continuing to provide force health protection and care in Operation Iraqi Freedom. This pressure on our All-Volunteer Army is unprecedented. Healthcare providers, in particular, are subject to unique strains and stressors while serving in garrison as well as in deployed settings. The MEDCOM has initiated a defined program to address provider fatigue with current efforts focused on sustaining the healthy force and identifying and supporting higher risk groups. MEDCOM has a healthy healthcare workforce as demonstrated by statistically significant lower provider fatigue and burnout than: The Professional Quality of Life Scale (ProQol) norming sample of 1187 respondents; and Sprang, Clark and White-Woosley's study of 222 civilian behavioral health (BH) providers. But as our Chief of Staff of the Army has told us: this is not an area where we just want to be a little better than the other guy—we want the healthiest and most resilient healthcare provider workforce possible.

The Provider Resiliency Training (PRT) Program was originally designed in 2006, based on Mental Health Advisory Team findings. The U.S. Army Medical Department Center and School (AMEDDC&S) developed a military-specific model identifying "provider fatigue" as the military equivalent of compassion fatigue. In June 2008, MEDCOM implemented a mandated PRT program to educate and train all MTF personnel to include support staff on the prevention and treatment of signs and symptoms of provider fatigue. The stated goal of PRT is to mitigate the negative effects of exposure to combat, to deployment, to secondary trauma from caring for the casualties of war as well as the unremitting demand for healthcare services and from burnout. All will ultimately improve organizational effectiveness. The AMEDDC&S currently offers three courses in support of the MEDCOM PRT: the Train the Trainer Course; the Professional Resiliency Resident Course; and the PRT Mobile Training.

None of our goals and themes would be achievable without the right mix of talented professionals within Army Medicine and working with Army Medicine; what our Balanced Scorecard refers to as Build The Team: a larger, more inclusive joint medical team; an adaptive and responsive interagency team (VA, DHS, DHHS/NIH/NIAID, CDC, USDA, etc.); an effective coalition team; and a military-civilian/academic-operational team. The teams we build must be aligned with the Army, Defense, and National Military Strategy and long-term goals, not based solely on personalities and the arcane interests of a few. My Deputy Surgeon General, subordi-

nate leaders, and others have been increasingly more deliberate and disciplined in how we form and sustain these critical partnerships.

Effective joint, interagency and coalition team-building has been a serious challenge for some time now. I see the emphasis on our ability to craft these teams grow in 2010. The arrival of September 15, 2011—the deadline for the 2005 BRAC—will be one of the key milestones and tests of this skill. My regional commanding generals in San Antonio and Washington, DC have taken lead roles in this endeavor. Let there be no question among those who underestimate our collective commitment to working as a team and our shared vision to serve the Nation and protect and care for the warriors and his or her family—we are one team!

In addition to building external teams, we need to have the right mix and quality of personnel internal to Army medicine. In fiscal year 2010 and continuing into fiscal year 2011 the Army requested funding for programs to improve our ability to attract and retain the professional workforce necessary to care for our Army. Our use of civilian hiring incentives (Recruiting, Retention, and Relocation) increased in fiscal year 2010 by $90 million and should increase by an additional $30 million in fiscal year 2011. In fiscal year 2011, civilian hiring incentives will equate to 4.8 percent of total civilian pay. We have instituted and funded civilian recruiting programs at the MEDCOM, regional, and some local levels to seek qualified healthcare professionals. For our military workforce, we are continuing our successful special salary rates, civilian nurse loan repayment programs, and civilian education training programs. Additionally, our Health Professional Scholarship Program and loan repayments will increase in fiscal year 2010 by $26 million and continue into fiscal year 2011. This program supports 1,890 scholarships and 600 participants in loan repayments—it is as healthy a program as it has ever been. Let me point out that our ability to educate and train from within the force—through physician, nursing, administrative, medic, and other programs in professional education—is a vital capability which we cannot permit to be degraded or lost altogether. In addition to providing essential enculturation for a military healthcare provider, administrator and leader, these programs have proven to be critical for our retention of these professionals who are willing to remain in uniform, to deploy in harm's way and to assume many onerous duties and assignments in exchange for education in some of the Nation's best programs. Army and Military Graduate Medical, Dental, Nursing, and other professional education has undoubtedly played a major role in our remaining a viable force this far into these difficult conflicts.

The theme of evidence-based practice runs through everything we do in Army Medicine and is highlighted throughout our Balanced Scorecard. Evidence-based practices mean integrating individual clinical expertise with the best available external clinical evidence from systematic research. Typical examples of evidence-based practices include implementation of clinical practice guidelines and dissemination of best practices. I encourage my commanders and subordinate leaders to be innovative, but across Army medicine we Balance Innovation with Standardization so that all of our patients are receiving the best care and treatment available. Standardization efforts include:

- The MEDCOM Armed Forces Health Longitudinal Technology Application (AHLTA) Provider Satisfaction (MAPS) initiative
- Care of combat casualties through the Joint Theater Trauma System (JTTS), enabled by the use of a Joint Theater Trauma Registry (JTTR)—both of which I will discuss further below—which examines every casualty's care and outcome of that care, including en route care during medical evacuation (MEDEVAC) with an eye toward standardizing care around the best practices
- The Virtual Behavioral Health Pilot (aka Comprehensive Behavioral Health Integration) being conducted at Schofield Barracks and Ft. Richardson
- Our initiative to reduce Ventilator Associated Pneumonia events in our ICUs by adopting not only industry best practices, but sending out an expert team of MEDCOM professionals to evaluate our own best practices and barriers to success
- Our standardized events-driven identification and management of mild TBI/concussion on the battlefield coupled with early diagnosis and treatment of Post-Traumatic Stress Reactions/Acute Stress Reactions as close in time and space to the events which lead to these reactions

Programs which are in the process of maturing into best practices for more widespread dissemination are:

- The Confidential Alcohol Treatment and Education Pilot

- The standardized and now automated Comprehensive Transition Plan for Warriors In Transition in our WTUs and CBWTUs
- A standardized program to "build trust in Army Medicine" through hospitality and patient/client/customer service in our medical, dental, and veterinary treatment facilities and throughout the MEDCOM
- Standardized support of our Active, National Guard, and Reserve Forces engaged in the reiterative, cyclic process of the Army Force Generation Model including but not restricted to preparation for combat medics and medical units, Soldier Readiness Processing of deploying units, ensuring full medical readiness of the force, restoration of dental and behavioral health upon redeployment, support of the total Army Family while soldiers are deployed, and provision of healthcare for mobilized and demobilizing Reserve component soldiers and their families.

These and many other standardized efforts reflect a change in how we do the business of Army medicine. We can no longer pride ourselves on engaging in a multiplicity of local "science projects" being conducted in a seemingly random manner by well-meaning and creative people but without a focus on added value, standard measures of improved outcomes, and sustainability of the product or process. Even the remarkably agile response to the behavioral health needs-assessment and ongoing requirements at Fort Hood following the tragic shooting were conducted in a very deliberate and effective fashion which emphasized unity of command and control, alignment of all efforts and marshalling of resources to meet a well-crafted and even exportable community behavioral health plan.

The emphasis which Army Medicine leaders have placed on disciplining these innovative measures so as to harvest best practices, subject them to validation at other sites, and rapidly proliferate them across the MEDCOM and Army in a standard fashion has been remarkable. It is the essence of Optimizing Communication and Knowledge Management.

Many of our goals, internal processes and enablers, and resource investments are focused on the knowledge hierarchy: collecting data; coalescing it into information over time and space; giving it context to transform it into knowledge; and applying that knowledge with careful outcome measures to achieve wisdom. This phenomenon of guiding clinical management by the emergence of new knowledge is perhaps best represented by Dr. Denis Cortese, former President and Chief Executive Officer of the Mayo Clinic. He laid out this schematic earlier this year after participating in a set of workshops which centered on healthcare reform. We participated to explore how the Federal system of care might contribute to these changes in health improvement and healthcare delivery.

What Dr. Cortese depicted is a three-domain ideal representation of healthcare delivery and its drivers. We share this vision of how an ideal system should operate. His notion is that this system of care should focus on optimizing individual health and healthcare needs, leveraging the knowledge domain to drive optimal clinical practices. This transition from the knowledge domain to the care delivery domain now takes 17 years. The clinical practice domain then informs and drives the payer domain to remunerate for effective clinical outcomes. What occurs too often today is what I call "widget-building" or "turnstile" medical care which chases remuneration for these encounters—too often independent of whether it is the best treatment aimed at the optimal outcome. To transform from a healthcare system to a system for health, we need to change the social contract. No longer should we be paid for building widgets (number of clinic visits or procedures), rather, we should be paid for preventing illness and promoting healthy lifestyles. When bad things happen to good people—which severe illness and injury and war continuously challenge us with—we should care for these illnesses, injuries and wounds by the most advanced evidence-based practices available, reducing unwarranted variation in practice whenever possible.

Our Military Health System is subtly different in that we have two practice domains—garrison and battlefield. Increasingly, we leverage the clinical domain to provide feedback into the knowledge domain—with the help of the electronic health record—AHLTA—and specialized databases. We do this in real time and all under the umbrella of the regulatory domain which sets and enforces standards.

The reengineering of combat trauma care borne of rapid turnaround of new-found, data-driven knowledge to new materiel and doctrinal solutions is one of the premier examples of this concept. The simplest example is our continuous re-evaluation of materials and devices available to soldiers, combat life savers, combat medics and the trauma team at the point of injury and in initial trauma management and the intellectual framework for their application to rapidly improve outcomes from combat-injured warriors.

After making the first major change in 40 years to the field medical kit—the Improved First Aid Kit—we have modified the contents of the kit at least three times since May 2005 based upon ongoing reviews of the effectiveness of the materials and head-to-head comparisons to competing devices or protocols. In like fashion, we have modified protocols for trauma management through active in-theater and total systemic analyses of the clinical outcomes deriving from the use of materials and protocols.

The specialized system in this endeavor is a joint and interagency trauma system which creates the equivalent of a trauma network available for a major metropolitan area or geographic region in the U.S. but spread across three continents, 8,000 miles end-to-end—the JTTS. Staffed and led by members of the Army, Navy, Marine Corps, and Air Force, it is truly a joint process. It is centered on the U.S. Army Institute of Surgical Research in San Antonio, TX. The specialized database in this effort and an essential element of the JTTS is the JTTR—a near-comprehensive standardized database which has been developed for each casualty as soon as possible in the treatment evacuation chain—usually at level II or III healthcare in theater. One of the most important critical applications of the JTTS and JTTR at present is the ongoing analysis of MEDEVAC times and the casualties being managed during evacuation. This is our effort to minimize the evacuation time for casualty in a highly dispersed force which is subjected in Afghanistan to the "tyranny of terrain and weather."

The decisions about where and how many trauma teams should be placed around the theater of operation as well as where to place MEDEVAC crews and aircraft is a delicate balancing act—one which balances the risk of putting care providers and MEDEVAC crews and helicopters at risk to the enemy and the elements with the risk of loss of life and limb to Warriors whose evacuation may be excessively prolonged. The only way to fully understand these competing risks is to know the outcomes of care and evacuation by injury type across a wide range of MEDEVAC missions. This analysis will help us understand if we still require a "Golden Hour" for every casualty between initial management at the point of injury and arrival at a trauma treatment site (like an Army Forward Surgical Team, the Marine Forward Resuscitative Surgical System or a Combat Support Hospital) or whether we now have a "Platinum 15 Minutes" at the point of injury which extends the Golden Hour.

This methodology and these casualty data are being applied to the next higher level of inquiry: how do we prevent injury and death of our combatants from wounds and accidents at the point of potential injury? Can we design improved helmets, goggles, body armor, vehicles and aircraft to prevent serious injuries? These questions are answered not only through the analysis of wound data, both survivable and nonsurvivable, through the JTTS and data from the virtual autopsy program of the Office of the Armed Forces Medical Examiner, but also by integrating these data with information from the joint operational, intelligence, and materiel communities to enable the development of improved tactics, techniques, and procedures and materiel improvements to protective equipment worn by the Warriors or built into the vehicles or aircraft in which they were riding. This work is performed by the Joint Trauma Analysis and Prevention of Injury in Combat program, a component of the DOD Blast Injury Research Program directed by the National Defense Authorization Act for 2006. To date it has been an effective means of improving the protection of warriors and preventing serious injury and death even as the enemy devises more lethal and adaptive weapons and battlefield tactics, techniques, and procedures.

We in Army Medicine are applying these knowledge management tools and approaches to the improvement of health and the delivery of healthcare back home as well. We are coupling these knowledge management processes with a funding strategy which incentivizes our commanders and clinicians to balance productivity—providing episodes of care—with optimal outcome: the right kind of prevention and care.

Among our greatest team achievements in 2009 was our effort to better understand how we communicate effectively with our internal and external stakeholders, patients, clients and customers. We adopted a formal plan to align our messages—ultimately all tied to Army goals and those on our Balanced Scorecard. Our creation of a Strategic Communications Directorate to ensure alignment of our key messages, to better understand and use social media, to expedite cross-talk and learning among such diverse groups as the Office of Congressional Liaison, Public Affairs, Protocol, Medical History, the Borden Institute, the AMEDD Regiment and others speaks directly to these efforts.

While we are still in the "advanced crawl/early walk" phase of knowledge management, we know from examples such as the JTTS and the Performance Based Budget Model that we can move best practices and newly found evidence-based approaches into common or widespread use if we aggressively coordinate and manage our ef-

forts and promote transparency of data and information and the knowledge which derives from it. We have begun a formal process under the Strategy and Innovation Directorate to move the best ideas in both clinical and transactional processes into standard practices across the MEDCOM in a timely way. This will be achieved through a process to identify, validate, and transfer best practices. We endeavor to be more agile and adaptive in response to a rapidly changing terrain of U.S. and Federal healthcare and operational requirements for a Nation at war.

In closing, I am very optimistic about the next 2 years. We have weathered some serious challenges to trust in Army Medicine. Logic would not predict that we would be doing as well as we are in attracting, retaining and career developing such a talented team of uniformed and civilian medical professionals. However, we continue to do so year after year—a tribute to all our Officer Corps, the leadership of our noncommissioned officers, and our military and civilian workforce. The results of our latest Medical Corps Graduate Medical Education Selection Board and the Human Capital Distribution Plan show continued strength and even improvements over past years. The continued leadership and dedicated service of officers, noncommissioned officers, and civilian employees are essential for Army Medicine to remain strong, for the Army to remain healthy and strong, and for the Nation to endure. I feel very privileged to serve with the men and women of Army medicine during this historic period as Army medics, as soldiers, as Americans and as global citizens.

Thank you for holding this hearing and your unwavering support of the Military Health System and Army Medicine. I look forward to working with you and your staff and addressing any of your concerns or questions.

Senator WEBB. Thank you, General Schoomaker.

Let me just very quickly thank you for those comments about TBI and concussive injuries. This really is a different phenomenon from, I think, anything we've ever seen, because of the echo effect of so many of these actually occurring inside vehicles. It's almost like shaped charge. So, you can't even directly compare this with football injuries——

General SCHOOMAKER. No, sir.

Senator WEBB.—or any of these others.

We have a great program down at Virginia Tech that's examining this concept, and I thank you for that detailed analysis.

General SCHOOMAKER. This has been a great collaborative effort with my colleagues here, too, sir.

Thank you.

Senator WEBB. Admiral Robinson, welcome.

STATEMENT OF VADM ADAM M. ROBINSON, JR., USN, SURGEON GENERAL OF THE U.S. NAVY, AND CHIEF, NAVY BUREAU OF MEDICINE AND SURGERY

Admiral ROBINSON. Good morning, Chairman Webb, Senator Graham, distinguished members of the subcommittee.

I want to thank you for your unwavering support of Navy Medicine, particularly as we continue to care for those who go into harm's way, our Marine Corps, our Navy, their families, and all beneficiaries.

I am honored to be with you today to provide an update of the state of Navy Medicine, including some of our accomplishments, our challenges, and strategic priorities.

Navy Medicine: World-Class Care, Anytime, Anywhere. This poignant phrase is arguably the most telling description of Navy Medicine's accomplishments in 2009 and continues to drive our operational tempo and priorities for the coming year and beyond.

Throughout the last year, we saw challenges and opportunities. Moving forward, I anticipate the pace of operations and demands

will continue to increase. We have been stretched in our ability to meet our increasing operational and humanitarian assistance requirements, as well as maintain our commitment to provide care to a growing number of beneficiaries. However, I am proud to say that we are responding to this demand with more flexibility and agility than ever before.

The foundation of Navy Medicine is force-health protection; it's what we do and why we exist. Nowhere is our commitment more evident than in Iraq and Afghanistan. During my October 2009 trip to theater, I again saw the outstanding work of our medical personnel. The Navy Medicine team is working side-by-side with Army and Air Force medical personnel and coalition forces to deliver outstanding healthcare to our troops and civilians alike.

As our wounded warriors return from combat and begin the healing process, they deserve a seamless and comprehensive approach to their recovery. We want them to mend in body, mind, and spirit. Our patient- and family-centered approach brings together medical treatment providers, social workers, care managers, behavioral health providers, and chaplains. We are working closely with our line counterparts in the Marine Corps Wounded Warrior Regiments, and the Navy's Safe Harbor, to support the full-spectrum recovery process for sailors, marines, and for their families.

We must act with a sense of urgency to continue to help build resiliency among our sailors and marines, as well as the caregivers who support them. We are aggressively working to reduce the stigma surrounding psychological health and operational stress concerns, which can be a significant barrier to seeking mental health services.

Programs such as Navy Operational Stress Control, Marine Corps Combat Operational Stress Control, Families OverComing Under Stress (FOCUS)—Caregiver Occupational Stress Control, and our Suicide Prevention Program are in place and maturing to provide support to personnel and to their families.

An important focus for all of us continues to be caring for our warriors suffering from TBIs. We are expanding TBI training to healthcare providers throughout the fleet and the Marine Corps. We are also implementing a new in-theater TBI surveillance system and conducting important research. This is in collaboration with our sister Services and medical colleagues.

We are also employing a strategy that is both collaborative and integrative by actively partnering with other Services, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, the Department of Veterans Affairs, and leading academic, medical, and research centers, to make the best care available to our warriors.

We must continue to recognize the occupational stress on our caregivers. They are subject to the psychological demands of exposure to trauma, loss, fatigue, and inner conflict. This is why our Caregiver Occupational Stress Control programs are so important to building and sustaining the resiliency of our providers. Mental health specialists are being placed in operational environments and forward deployed to provide services where and when they are needed. The Marine Corps is sending more mental health teams to the front lines, with the goal of better treating an emotionally

strained force. Operational Stress Control and Readiness teams known as OSCAR will soon be expanded to include the battalion level. This will put mental health support services much closer to combat troops. A mobile care team of Navy Medicine mental health professionals is currently deployed to Afghanistan, conducting mental health surveillance, command leadership consultation, and coordinate mental health care for sailors throughout the AOR.

An integral part of the Navy's Maritime Strategy is humanitarian assistance and disaster relief. In support of Operation Unified Response Haiti, Navy Medicine answered the call. We deployed the Hospital Ship *Comfort* from her homeport in Baltimore within 77 hours of the order and ahead of schedule.

Senator WEBB. Admiral?

Admiral ROBINSON. Yes, sir?

Senator WEBB. Just making an announcement, here.

Apparently, the Republicans are objecting to all hearings after 11:00 this morning, except for one. Senator Graham is going to try to see——

Senator GRAHAM. Yes, I would like to——

Senator WEBB.—if we can't get ours also excluded, but——

Senator GRAHAM. Yes, I want to hear what you have to say, if I can.

Senator WEBB. How do we do this, Senator?

Senator GRAHAM. They're checking on it, now. Let's just keep going, and we'll figure out what the rules are.

Senator BEGICH. Mr. Chairman?

Senator WEBB. Yes?

Senator BEGICH. With or without it, can we just continue on and just have it as a non-hearing hearing?

Make the rules as we go, is my rule. [Laughter.]

Why not?

I mean these guys have come——

Senator WEBB. I suppose we could go into informal conversation, if they cancel the hearing at 11 a.m. I don't know what that would do to the official transcript of the hearing, or that sort of thing. But, I——

Senator BEGICH. I think this is an important issue.

Senator GRAHAM. I want to hear what they have to say.

Senator WEBB. Okay.

Senator GRAHAM.—we'll figure out——

Senator WEBB. Let's proceed.

Senator BEGICH. I don't think you have support, bipartisan, for this effort, Mr. Chairman. [Laughter.]

Admiral ROBINSON. Thank you very much, sir.

An integral part of Navy's Maritime Strategy is humanitarian assistance and disaster response. In support of Operation Unified Response Haiti, Navy Medicine answered the call. We deployed Naval Hospital Ship *Comfort* within 77 hours of the order and ahead of schedule. She was on station in Port-au-Prince 5 days later. From the beginning, the operational tempo on board *Comfort* was high and our personnel were challenged, both professionally and personally. For many, this was a career-defining experience, and I was proud to welcome the crew home last week and congratulate them for their outstanding performance. The men and

women of *Comfort* and all involved in this mission saved lives, alleviated suffering, and brought hope in the midst of devastation.

I'm also encouraged with our recruiting efforts within Navy Medicine, and we are starting to see the results of new incentive programs. But, while overall manning levels for both officer and enlisted personnel are relatively high, ensuring we have the proper specialty mix continues to be a challenge in both the Active and Reserve components. Several wartime critical specialties, as well as advanced practice nursing and physicians' assistants are undermanned. We are also facing shortfall for general dentists, oral maxilla facial surgeons, and many of our mental health specialists, including clinical psychologists and social workers. We continue to work hard to meet this demand, but fulfilling the requirements among these specialties is expected to present a continuing challenge.

Research and development is critical to Navy Medicine's success and our ability to remain agile to meet the evolving needs of our warfighters. It is where we find solutions to our most challenging problems and, at the same time, provide some of medicine's most significant innovations and discoveries. Research efforts targeted at wound management, including enhanced wound repair and reconstruction, as well as extremity and internal hemorrhage control and phantom limb pain in amputees, present definitive benefits. These efforts support our emerging expeditionary medical operations and aid in support of our wounded warriors.

Clearly, one of the most important priorities for leadership of all the Services is the successful transition to the Walter Reed National Military Medical Center on board the campus of the National Naval Medical Center in Bethesda. We are working diligently with the lead DOD organization, Joint Task Force National Capital Region Medical, to ensure that this significant and ambitious project is executed properly and without disruption of services to our wounded warrior, our sailors, marines, and their families, and all other beneficiaries that we are privileged to serve.

In summary, I believe we are at an important crossroads for military medicine. How we respond to challenges facing us today will likely set the stage for decades to come. Commitment to our wounded warriors and their families must never waver, and our programs of support and hope must be built and sustained for the long haul. The long haul is the rest of the century, when the young wounded warriors of today mature into aging heroes in the years to come. They will need our care and support, as will their families, for a lifetime.

On behalf of the men and women of Navy Medicine, I want to thank the committee for your tremendous support, your confidence, and your leadership. It has been my pleasure to speak before you today, and I look forward to your questions.

[The prepared statement of Admiral Robinson follows:]

PREPARED STATEMENT BY VADM ADAM M. ROBINSON, JR., MC, USN

INTRODUCTION

Chairman Webb, Senator Graham, distinguished members of the subcommittee, I am honored to be with you today to provide an update on the state of Navy Medicine, including some of our accomplishments, challenges and strategic priorities. I

want to thank the committee members for your unwavering support of Navy Medicine, particularly as we continue to care for those who go in harm's way, their families and all beneficiaries.

Navy Medicine-World Class Care . . . Anytime, Anywhere. This poignant phrase is arguably the most telling description of Navy Medicine's accomplishments in 2009 and continues to drive our operational tempo and priorities for the coming year and beyond. Throughout the last year we saw challenges and opportunities; and moving forward, I anticipate the pace of operations and demands placed upon us will continue to increase. Make no mistake: We have been stretched in our ability to meet our increasing operational and humanitarian assistance requirements, as well as maintain our commitment to provide Patient and Family-Centered care to a growing number of beneficiaries. However, I am proud to say to that we are responding to this demand with more flexibility and agility than ever before. We are a vibrant, world-wide health care system fully engaged and integrated in carrying out the core capabilities of the Maritime Strategy around the globe. Regardless of the challenges ahead, I am confident that we are well-positioned for the future.

Since becoming the Navy Surgeon General in 2007, I have invested heavily in our strategic planning process. How we accomplish our mission is rooted in sound planning, sharp execution and constructive self-assessment at all levels of our organization. I challenged our leadership to create momentum and establish a solid foundation of measurable progress. It's paying dividends. We are seeing improved and sustained performance in our strategic objectives. Just as importantly, our planning process supports alignment with the Department of Navy's Strategic Plan and Operations Guidance.

Navy Medicine's commitment to Patient and Family-Centered Care is also reflected in our resourcing processes. An integral component of our Strategic Plan is providing performance incentives that promote quality and directly link back to workload and resources. We are evolving from a fiscal planning and execution process rooted in historical data, to a system which links requirements, resources and performance goals. This transformation to Performance Based Budgeting properly aligns authority, accountability, and financial responsibility with the delivery of quality, cost-effective health care.

The President's budget for fiscal year 2011 adequately funds Navy Medicine to meet its medical mission for the Navy and Marine Corps. The budget also provides for the maintenance of our facilities. We appreciate the committee's strong support of our resource requirements.

FORCE HEALTH PROTECTION

The foundation of Navy Medicine is Force Health Protection. It's what we do and why we exist. In executing our Force Health Protection mission, the men and women of Navy Medicine are engaged in all aspects of expeditionary medical operations in support of our warfighters. The continuum of care we provide includes all dimensions of physical and psychological well-being. This is our center of gravity and we have and will continue to ensure our sailors and marines are medically and mentally prepared to meet their world-wide missions.

Nowhere is our commitment to Force Health Protection more evident than in our active engagement in military operations in Iraq and Afghanistan. As these overseas contingency operations evolve, and in many respects become increasingly more dangerous, we are seeing burgeoning demand for expeditionary combat casualty care in support of joint operations. I recently returned from a trip to Afghanistan and I again saw the outstanding work of our medical personnel. The Navy Medicine team is working side-by-side with Army and Air Force medical personnel and coalition forces to deliver outstanding health care to our troops and civilians alike.

We must continue to be innovative and responsive at the deckplates and on the battlefield. Since the start of Operation Enduring Freedom and Operation Iraqi Freedom, the Marine Corps has fielded new combat casualty care capabilities which include: updated individual first aid kits with combat gauze, advanced tourniquets, use of Tactical Combat Casualty Care principles, troop training in Combat Lifesaver, and the use of Factor VII—a blood clotting agent used in trauma settings. In addition, Navy Fleet Hospital transformation has redesigned expeditionary medical facilities that are lighter, modular, more mobile, and interoperable with other Services' facilities.

Our progress is also evident in the innovative work undertaken by a Shock Trauma Platoon 2 years ago in Afghanistan. This team, comprised of 2 physicians, 2 nurses, 1 physician assistant, and 14 corpsmen, essentially created a mobile emergency room—a 7-ton truck with a Conex container and welded steel plates—that went into combat to administer more expedient and effective care in austere set-

tings. This prototype led to the creation of the Mobile Trauma Bay (MTB), a capability that both Marine Corps and Navy Medicine leadership immediately recognized as vital to the warfighter and an unquestionable lifesaver on the battlefield. MTB use has already been incorporated into our Afghanistan shock trauma platoon operations, and they are already positively impacting forward resuscitative and stabilization care. We understand that the Marine Corps has fully embraced the MTB concept and is planning to add additional units in future POM submissions.

Humanitarian Assistance and Disaster Response

An integral part of the Navy's Maritime Strategy is humanitarian assistance and disaster response. In the wake of the devastating earthquake in Haiti earlier this year, our Nation moved forward with one of the largest relief efforts in our history to save lives, deliver critically needed supplies and provide much-needed hope. The response was rapid, as Navy deployed ships and expeditionary forces, comprised of more than 10,000 personnel, to provide immediate relief and support for the Haitian people. In support of Operation Unified Response, Navy Medicine answered the call. We deployed USNS *Comfort* (T–AH 20) from her homeport in Baltimore within 77 hours and ahead of schedule—going from an industrial shipboard site to a ready afloat naval hospital, fully staffed and equipped. She was on station in Port-au-Prince 5 days later and treating patients right away. From the beginning, the operational tempo onboard USNS *Comfort* has been high with a significant trauma and surgical caseload. Medical teams from the ship are also ashore to help in casualty evaluation, triage crush wounds, burn injuries and other health issues. Providing care around the clock, our personnel were challenged both professionally and personally. For many, this was a career-defining experience and certainly reflects the Navy's commitment as a "Global Force for Good." I spoke to the crew as they were preparing to get underway, and personally related just how important this mission is and why it is a vital part of the Navy's Maritime Strategy.

Navy Medicine provided additional support that included the deployment of a Forward Deployed Preventive Medicine Unit and augmented Casualty Receiving and Treatment Ship medical staff capabilities onboard USS *Bataan* (LHD 5). We also recognized the potential psychological health impact on our medical personnel involved in this humanitarian assistance mission and ensured we had trained Caregiver Occupational Stress Control (CgOSC) staff onboard.

The ship departed Haiti on 10 March 2010. Prior to getting underway, the crew gathered for a memorial ceremony in honor of the people of Haiti. The men and women of USNS *Comfort*, and all involved in this mission, saved lives, alleviated suffering, and brought hope in the midst of devastation. Their performance and spirit of caring was exemplary.

Navy Medicine is inherently flexible and capable of meeting the call to support multiple missions. I am proud of the manner in which the men and women of Navy Medicine leaned forward in response to the call for help. In support of coordination efforts led by the Department of State and the U.S. Agency for International Development, and in collaboration with nongovernmental organizations, both domestic and international, our response demonstrated how the expeditionary character of our Naval and Marine forces is uniquely suited to provide assistance during interagency and multinational efforts.

CONCEPT OF CARE

Navy Medicine's Concept of Care is Patient and Family-Centered Care. It is at the epicenter of everything we do. This concept is elegant in its simplicity yet extraordinarily powerful. It identifies each patient as a participant in his or her own health care and recognizes the vital importance of the family, military culture and the military chain of command in supporting our patients. My goal is for this Concept of Care—this commitment to our patients and their families—to resonate throughout our system and guide all our actions. It is enabled by our primary mission to deliver force health protection and a fully ready force; mutually supported by the force multipliers of world class research and development, and medical education. It also leverages our emphasis on the health and wellness of our patients through an active focus on population health.

CARING FOR OUR HEROES

When our Warriors go into harm's way, we in Navy Medicine go with them. At sea or on the ground, sailors and marines know that the men and women of Navy Medicine are by their side ready to care for them. There is a bond of trust that has been earned over years of service together, and make no mistake, today that bond

is stronger than ever. Our mission is to care for our wounded, ill, and injured, as well as their families. That's our job and it is our honor to have this opportunity.

As our Wounded Warriors return from combat and begin the healing process, they deserve a seamless and comprehensive approach to their recovery. We want them to mend in body, mind and spirit. Our focus is multidisciplinary-based care, bringing together medical treatment providers, social workers, case managers, behavioral health providers and chaplains. We are working closely with our line counterparts with programs like the Marine Corps' Wounded Warrior Regiments and the Navy's Safe Harbor to support the full-spectrum recovery process for sailors, marines, and their families.

Based on the types of injuries that we see returning from war, Navy Medicine continues to adapt our capabilities to best treat these conditions. When we saw a need on the west coast to provide expanded care for returning Wounded Warriors with amputations, we established the Comprehensive Combat and Complex Casualty Care (C5) Program at Naval Medical Center, San Diego, in 2007. C5 manages severely injured or ill patients from medical evacuation through inpatient care, outpatient rehabilitation, and their eventual return to active duty or transition from the military. We are now working to expand utilization of Project C.A.R.E – Comprehensive Aesthetic Recovery Effort. This initiative follows the C5 model by ensuring a multidisciplinary approach to care, yet focuses on providing state-of-the-art plastic and reconstructive surgery for our Wounded Warriors at both Naval Medical Center San Diego and Naval Medical Center Portsmouth, with potential future opportunities at other treatment facilities.

We have also significantly refocused our efforts in the important area of clinical case management at our military treatment facilities and major clinics serving Wounded Warriors to ensure appropriate case management services are available to all who need them. The Clinical Case Management Program assists patients and families with clinical and non-clinical needs, facilitating communication between patient, family and multi-disciplinary care team. Our clinical case managers collaborate with Navy and Marine Corps Recovery Care Coordinators, Federal Recovery Coordinators, Non-Medical Care Managers and other stakeholders to address sailor and marine issues in developing Recovery Care Plans. As of January 2010, 192 Clinical Case Managers are assigned to Military Treatment Facilities and ambulatory care clinics caring for over 2,900 sailors, marines, and coastguardsmen.

PSYCHOLOGICAL HEALTH AND POST-TRAUMATIC STRESS

We must act with a sense of urgency to help build resiliency among our sailors and marines, as well as the caregivers who support them. We recognize that operational tempo, including the number and length of deployments, has the potential to impact the psychological health of servicemembers and their family members. We are aggressively working to reduce the stigma surrounding psychological health and operational stress concerns which can be a significant barrier to seeking mental health services for both military personnel and civilians. Programs such as Navy Operational Stress Control, Marine Corps Combat Operational Stress Control, Families Overcoming Under Stress (FOCUS), CgOSC, and our suicide prevention programs (A–C–T Ask-Treat-Care) are in place and maturing to provide support to personnel and their families.

The Navy Operational Stress Control program and Marine Corps Combat Operational Stress Control program are the cornerstones of the Department of the Navy's approach to early detection of stress injuries in sailors and marines and are comprised of:

- Line led programs which focus on leadership's role in monitoring the health of their people.
- Tools leaders may employ when sailors and marines are experiencing mild to moderate symptoms.
- Multidisciplinary expertise (medical, chaplains, and other support services) for more affected members.

Decreasing the stigma associated with seeking psychological health care requires a culture change throughout the Navy and Marine Corps. Confronting an ingrained culture will take time and active leadership support. Stigma reducing interventions span three major fronts: (1) education and training for individual sailors and marines that normalizes mental health care; (2) leadership training to improve command climate support for seeking mental health care; and (3) encouragement of care outreach to individual sailors, marines, and their commands. This past year saw wide-spread dissemination of Operational Stress Control (OSC) doctrine as well as a Navy-wide education and training program that includes mandatory Navy Knowledge Online courses, instructor led and web-based training.

Navy Medicine ensures a continuum of psychological health care is available to servicemembers throughout the deployment cycle—pre-deployment, during deployment, and post-deployment. We are working to improve screening and surveillance using instruments such as the Behavior Health Needs Assessment Survey (BHNAS) and Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA).

Our mental health specialists are being placed in operational environments and forward deployed to provide services where and when they are needed. The Marine Corps is sending more mental health teams to the front lines with the goal of better treating an emotionally strained force. Operational Stress Control and Readiness (OSCAR) teams will soon be expanded to include the battalion level, putting mental health support services much closer to combat troops. A Mobile Care Team (MCT) of Navy Medicine mental health professionals is currently deployed to Afghanistan to conduct mental health surveillance, command leadership consultation, and coordinate mental health care for sailors throughout the AOR. In addition to collecting important near real-time surveillance data, the MCT is furthering our efforts to decrease stigma and build resilience.

We are also making mental health services available to family members who may be affected by the psychological consequences of combat and deployment through our efforts with Project FOCUS, our military treatment facilities and our TRICARE network partners. Project FOCUS continues to be successful and we are encouraged that both the Army and Air Force are considering implementing this program. We also recognize the importance of the counseling and support services provided through the Fleet and Family Support Centers and Marine Corps Community Services.

Beginning in 2007, Navy Medicine established Deployment Health Centers (DHCs) as non-stigmatizing portals of care for servicemembers staffed with primary care and psychological health providers. We now have 17 DHCs operational. Our health care delivery model supports early recognition and treatment of deployment-related psychological health issues within the primary care setting. Psychological health services account for approximately 30 percent of all DHC encounters. We have also increased mental health training in primary care, and have actively partnered with Line leaders and the Chaplain Corps to develop combat and operational stress control training resources. Awareness and training are keys to our surveillance efforts. Over 4,000 Navy Medicine providers, mental health professionals, chaplains and support personnel have been trained to detect, screen, and refer personnel who may be struggling with mental health issues.

We must continue to recognize the occupational stress on our caregivers. They are subject to the psychological demands of exposure to trauma, loss, fatigue, and inner conflict. This is why our Caregiver Occupational Stress Control programs are so important to building and sustaining the resiliency of our providers. We cannot overlook the impact on these professionals and I have directed Navy Medicine leadership to be particularly attuned to this issue within their commands.

TRAUMATIC BRAIN INJURY

While there are many significant injury patterns in theatre, an important focus area for all of us remains Traumatic Brain Injury (TBI). Blast is the signature injury of OEF and OIF—and from blast injury comes TBI. The majority of TBI injuries are categorized as mild, or in other words, a concussion. Yet, there is much we do not yet know about these injuries and their long-term impacts on the lives of our servicemembers.

The relative lack of knowledge about mild TBI amongst servicemembers and health care personnel represents an important gap that Navy Medicine is seriously addressing. We are providing TBI training to health care providers from multiple disciplines throughout the fleet and the Marine Corps. This training is designed to educate personnel about TBI, introduce the Military Acute Concussion Exam (MACE) as a screening tool for mild TBI, inform providers about the Automated Neurocognitive Assessment Metric (ANAM) test, and identify a follow-up for assessment including use of a repeatable test battery for identification of cognitive status. We have recently established and are now expanding our TBI program office to manage the implementation of the ANAM as a pre-deployment test for servicemembers in accordance with DOD policy. This office will further develop models of assessment and care as well as support research and evaluation programs.

All the Services expect to begin implementation of a new in-theater TBI surveillance system which will be based upon incident event tracking. Promulgated guidelines will mandate medical evaluation for all servicemembers exposed within a set

radius of an explosive blast, with the goal to identify any servicemember with subtle cognitive deficits who may not be able to return to duty immediately.

Navy Medicine has begun implementing the ANAM assessment at the DHCs and within deploying units as part of an assistant Secretary of Defense (Health Affairs) mandate. We have also partnered with line leadership, or operational commanders, to identify populations at risk for brain injury (e.g., front-line units, SEAL units, and Navy Explosive Ordinance Disposal units). In addition, an in-theater clinical trial for the treatment of vestibular symptoms of blast-exposure/TBI was completed at the USMC mTBI Center in Al Taqqadum, Iraq.

Both our Naval Health Research Center and Navy-Marine Corps Public Health Center are engaged with tracking TBI data through ongoing epidemiology programs. Goals this year include the establishment of a restoration center in-theatre to allow injured sailors and marines a chance to recover near their units and return to the fight.

Additionally, the National Naval Medical Center's Traumatic Stress and Brain Injury Program provides care to all blast-exposed or head-injured casualties returning from theatre to include patients with an actual brain injury and traumatic stress. Navy Medicine currently has TBI clinics at San Diego, Portsmouth, Camp Pendleton, and Camp Lejeune with plans for further expansion reflecting our commitment to the treatment of this increasingly prevalent injury.

We are employing a strategy that is both collaborative and integrative by actively partnering with the other Services, Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the Veterans Administration, and leading academic medical and research centers to make the best care available to our Warriors afflicted with TBI.

EXCELLENCE IN RESEARCH AND DEVELOPMENT

Research and development is critical to Navy Medicine's success and our ability to remain agile to meet the evolving needs of our warfighters. It is where we find solutions to our most challenging problems and, at the same time, provide some of medicine's most significant innovations and discoveries. Our research and development programs are truly force-multipliers and enable us to provide world-class health care to our beneficiaries.

The approach at our research centers and laboratories around the world is straightforward: Conduct health and medical research, development, testing, evaluation and surveillance to enhance deployment readiness. Each year, we see more accomplishments which have a direct impact on improving force health protection. The contributions are many and varied, ranging from our confirmatory work in the early stages of the H1N1 pandemic, to the exciting progress in the development of a malaria vaccine. Research efforts targeted at wound management, including enhanced wound repair and reconstruction as well as extremity and internal hemorrhage control, and phantom limb pain in amputees, present definitive benefits. These efforts also support our emerging expeditionary medical operations and aid in support to our Wounded Warriors.

THE NAVY MEDICINE TEAM

Navy Medicine is comprised of compassionate and talented professionals who continue to make significant contributions and personal sacrifices to our global community. Our team includes our officers, enlisted personnel, government civilian employees, contract workers and volunteers working together in a vibrant health care community. All have a vital role in the success of our enterprise. Our priority is to maintain the right workforce to deliver the required medical capabilities across the enterprise, while using the appropriate mix of accession, retention, education and training incentives.

Overall, I am encouraged with our recruiting efforts within Navy Medicine and we are starting to see the results of new incentive programs. But while overall manning levels for both officer and enlisted personnel are relatively high, ensuring we have the proper specialty mix continues to be a challenge. Several wartime critical specialties including psychiatry, family medicine, general surgery, emergency medicine, critical care and perioperative nursing, as well as advanced practice nursing and physician assistants, are undermanned. We are also facing shortfalls for general dentists, oral maxillofacial surgeons, and many of our mental health specialists including clinical psychologists and social workers. We have increasing requirements for mental health professionals as well as for Reserve Component Medical Corps, Dental Corps, Medical Service Corps, and Nurse Corps officers. We continue to work hard to meet this demand, but fulfilling the requirements among these specialties is expected to present a continuing challenge.

I want to also reemphasize the priority we place on diversity. We are setting the standard for building a diverse, robust, innovative health care workforce, but we can do more in this important area. Navy Medicine is stronger and more effective as a result of our diversity at all levels. Our people are our most important resource, and their dignity and worth are maintained through an atmosphere of service, professionalism, trust and respect.

PARTNERSHIPS AND COLLABORATION

Navy Medicine continues to focus on improving interoperability with the Army, Air Force, Veterans Administration (VA), as well other Federal and civilian partners to bring operational efficiencies, optimal technology and training together in support of our patients and their families, our missions, and the national interests. Never has this collaborative approach been more important, particularly as we improve our approaches to ensuring seamless transitions for our veterans.

We remain committed to resource sharing agreements with the VA and our joint efforts in support of improving the Disability Evaluation System (DES) through the ongoing pilot program at several MTFs. The goal of this pilot is to improve the disability evaluation process for servicemembers and help simplify their transitions. Together with the VA and the other Services, we are examining opportunities to expand this pilot to additional military treatment facilities. Additionally, in partnership with the VA, we will be opening the James A. Lovell Federal Health Care Center in Great Lakes, IL—a uniquely integrated Navy/VA medical facility.

We also look forward to leveraging our inter-service education and training capabilities with the opening of the Medical Education and Training Campus in San Antonio in 2010. This new tri-service command will oversee the largest consolidation of service training in DOD history. I am committed to an inter-service education and training system that optimizes the assets and capabilities of all DOD health care practitioners yet maintains the unique skills and capabilities that our hospital corpsmen bring to the Navy and Marine Corps—in hospitals, clinics at sea and on the battlefield.

Clearly one of the most important priorities for the leadership of all the Services is the successful transition to the Walter Reed National Military Medical Center onboard the campus of the National Naval Medical Center, Bethesda. We are working diligently with the lead DOD organization, Joint Task Force—National Capital Region Medical, to ensure that this significant and ambitious project is executed properly and without any disruption of services to our sailors, marines, their families, and all our beneficiaries for whom we are privileged to serve.

THE WAY FORWARD

I believe we are at an important crossroads for military medicine. How we respond to the challenges facing us today will likely set the stage for decades to come. Commitment to our Wounded Warriors and their families must never waver and our programs of support and hope must be built and sustained for the long-haul—and the long-haul is the rest of this century when the young Wounded Warriors of today mature into our aging heroes in the years to come. They will need our care and support as will their families for a lifetime. Likewise, our missions of cooperative engagement, through humanitarian assistance and disaster response, bring opportunities for us, our military, and the Nation. It is indeed a critical time in which to demonstrate that the U.S. Navy is truly a "Global Force for Good."

Navy Medicine is a vibrant, world-wide health care system comprised of compassionate and talented professionals who are willing to make contributions and personal sacrifices. This team—our team—including officer, enlisted, civilians, contractors, and volunteers work together as a dynamic health care family. We are all essential to success.

Navy Medicine will continue to meet the challenges ahead and perform our missions with outstanding skill and commitment. On behalf of the men and women of Navy Medicine, I want to thank the committee for your tremendous support, confidence, and leadership. It has been my pleasure to testify before you today and I look forward to your questions.

Senator WEBB. Thank you very much, Admiral Robinson.

General Green, welcome.

STATEMENT OF LT. GEN. CHARLES B. GREEN, USAF, SURGEON GENERAL OF THE U.S. AIR FORCE

General GREEN. Thank you, sir.

Chairman Webb, Senator Graham, and distinguished members of the committee, it's an honor and a privilege to appear before you, representing the Air Force Medical Service.

I look forward to working with you and pledge to do all in my power to support the men and women or our Armed Forces and this great country. Thank you for your immeasurable contributions to the success of our mission.

"Trusted Care Anywhere" is our vision for 2010 and beyond. Our nearly 60,000 total-force medics contribute world-class medical capabilities to Air Force, joint, and coalition teams around the world. Seventeen hundred Air Force medics are currently deployed to 40 locations in 20 countries, delivering state-of-the-art preventive medicine, rapid lifesaving care, and critical air evacuation. Since November 2001, we've air-evac'd over 70,000 patients from Afghanistan and Iraq, and have lost only 4 patients during evacuation.

Air Force medics are responding globally in humanitarian missions, as well as on the battlefield, and in just the last 6 months, we contributed significant support to Indonesia, Haiti, and the Chilean earthquake victims.

This is a year of firsts. The first known successful air evacuation of a patient with traumatic lung removal was done last July. The patient is doing well in Birmingham, England, today.

In January 2010, a U.S. marine sustained dislocation of both knees, with loss of blood flow to his lower legs, following an IED attack in the Helmand Province. Air Force surgeons performed definitive vascular reconstruction within hours of the injury, and the marine is now recovering in the National Naval Medical Center in Bethesda, and is expected to have fully functional limbs.

An airman shot three times in the back will not be a diabetic, despite the absence of his pancreas, because surgeons across three continents harvested and grew his pancreatic cells then implanted the cells into his liver at Walter Reed.

These success stories are possible only because of tireless efforts of Air Force, Army, Navy, and coalition medics to continuously improve our care.

At home, our healthcare teams provide patient-centered full-spectrum healthcare to our beneficiaries. We're improving patient and provider satisfaction through our Patient-Centered Medical Home by building strong partnerships between patients and their healthcare teams. Our Family Health Initiative and Surgical Care Optimization Initiatives are improving healthcare continuity, quality, access, and patient satisfaction.

Our Air Force Suicide Prevention Program, implemented in 1997, continues to be effective, but we have noted a slowly increasing rate of suicides since 2007. We are enhancing our prevention programs to further decrease suicides by targeting the most stressed by our high operations tempo. We now target more indepth interventions and training to Air Force security forces and intelligence career fields, whom we have identified as having double the incidence of suicide, compared to the rest of the Air Force.

We continue training the entire force on suicide prevention and coping skills, to improve both airmen and family resilience. We adapted new concepts rapidly, such as "Ask, Care, and Escort" and

collaborative care, wherein mental health providers are now embedded in the majority of our family health clinics.

We have also studied and targeted interventions for our civilian workforce identified at high risk. Collaborative care, online help, mandatory post-deployment surveys, and family-life counselors at our Airman and Family Readiness centers, have decreased stigma and allowed those in need to get help earlier.

We're encouraged by the continued low indicators for stress in the Air Force. Alcohol abuse remains low and stable, as does illegal and prescription drug abuse. We target programs to further reduce underage drinking and enhance safety. Our numbers in domestic violence are trending downward. We continue to monitor these indicators carefully to target effective interventions.

To achieve our vision of "Trusted Care Anywhere," we require highly-trained, current, and qualified providers, and we're extremely grateful to this committee for your many efforts to strengthen our recruiting and retention programs.

The Air Force Medical Service is committed to the health and wellness of all entrusted to our care. We are, indeed, all in to meet our Nation's call, and will achieve our vision through determined, continuous improvement. We could not achieve our goals of better readiness, better health, better care, and best value for our heroes and their families without your support, and we thank you.

I stand ready for your questions, sir.

[The prepared statement of General Green follows:]

PREPARED STATEMENT BY LT. GEN. (DR.) CHARLES B. GREEN, USAF

Chairman Webb, Senator Graham, and distinguished members of the subcommittee, it is an honor and a privilege to appear before you representing the Air Force Medical Service and our 60,000 Total Force medics. I'm looking forward to working with you during my tenure as Air Force Surgeon General. I pledge to do all in my power to support the men and women of the Armed Forces and this great country. Thank you for your immeasurable contributions to the success of our mission.

"Trusted Care Anywhere" is the Air Force Medical Service's vision for 2010 and beyond. In the domain of Air, Space and Cyberspace, our medics contribute to the Air Force, Joint, and coalition team with world class medical capabilities. Our 60,000 high performing Total Force medics around the globe are trained and ready for mission success. Over 1,600 Air Force medics are now deployed to 40 locations in 20 countries, building partnership capability and delivering state of the art preventive medicine, rapid lifesaving care, and critical air evacuation. In all cases, these efforts are conducted with joint and coalition partners. At home, our health care teams assure patient-centered care to produce healthy and resilient airmen, and provide our families and retirees with full spectrum health care.

Today's focus is on world-class health care delivery systems across the full spectrum of our operations. From theater hospitals in Balad and Bagram, to the efforts of humanitarian assistance response teams, to the care of our families at home, we put patients first. We are transforming deployable capabilities, building patient-centered care platforms, and investing in our people, the foundation of our success. We are expanding collaboration with joint and coalition partners to collectively strengthen rapid response capabilities. Globally, Air Force medics are diligently working to balance the complex demands of multiple missions in current and expanding areas of operations.

We are committed to advancing capabilities through education and training, research, and infrastructure recapitalization. Recent efforts in these areas have paid huge dividends, establishing new standards in virtually every major category of full spectrum care including humanitarian assistance. The strategic investments assure a trained, current, and deployable medical force today and tomorrow. They reinforce a culture of learning to quickly adapt medical systems and implement agile organizations to produce healthier outcomes in diverse mission areas.

While we've earned our Nation's trust with our unique capabilities and the expertise of our people, we constantly seek to do better! I would like to highlight our areas of strategic focus and share some captivating examples of Air Force medics in action.

TRANSFORMING EXPEDITIONARY MEDICINE AND AEROMEDICAL EVACUATION CAPABILITIES

Our success on the battlefield underscores our ability to provide "Trusted Care, Anywhere." The joint and coalition medical teams bring wounded warriors from the battlefield to an operating room within an unprecedented 20 to 40 minutes! This rapid transfer rate enables medics to achieve a less than 10 percent died-of-wounds rate, the best survival rate ever seen in war.

In late July, a British soldier sustained multiple gunshot wounds in Afghanistan. After being stabilized by medical teams on the ground, who replaced his blood supply more than 10 times, doctors determined the patient had to be moved to higher levels of care in Germany. It took two airplanes to get the medical team and equipment in place, another aircraft to fly the patient to Germany, three aircrews and many more personnel coordinating on the ground to get this patient to the next level of care. Every member of the joint casualty care and aeromedical evacuation teams selflessly gave their all to ensure this soldier received the compassionate care he deserved. After landing safely at Ramstein Air Base in Germany, the soldier was flown to further medical care at a university hospital by helicopter. This case highlights the dedication and compassion our personnel deliver in the complex but seamless care continuum. This tremendous effort contributes to our unprecedented survival rate.

As evidenced in this story, our aeromedical evacuation system (AE) and critical care air transport teams are world-class. We mobilize specially trained flight crews and medical teams on a moment's notice to transport the most critical patients across oceans. Since November 2001, we have transported more than 70,000 patients from Afghanistan and Iraq.

We are proud of our accomplishments to date, but strive for further innovation. As a result of battlefield lessons learned, we have recently implemented a device to improve spinal immobilization for AE patients that maximizes patient comfort and reduces skin pressure. We are working toward an improved detection mechanism for compartment syndrome in trauma patients. The early detection and prevention of excess compartment pressure could eliminate irreversible tissue damage for patients. In February 2010, a joint Air Force and Army team will begin testing equipment packages designed to improve ventilation, oxygen, fluid resuscitation, physiological monitoring, hemodynamic monitoring and intervention in critical care air transport.

INFORMATION MANAGEMENT/INFORMATION TECHNOLOGY

Our Theater Medical Information Program Air Force (TMIP AF) is a software suite that automates and integrates clinical care documentation, medical supplies, equipment, and patient movement. It provides the unique capabilities for in-transit visibility and consolidated medical information to improve command and control and allow better preventive surveillance at all Air Force deployed locations. This is a historic first for the TMIP AF program.

Critical information is gathered on every patient, then entered into the Air Force Medical Service (AFMS) deployed system. Within 24 hours, records are moved and safely stored at secure consolidated databases in the United States. During the first part of 2010, TMIP AF will be utilized in Aeromedical Evacuation and Air Force Special Operations areas.

EXPEDITIONARY MEDICINE AND HUMANITARIAN ASSISTANCE

We have also creatively developed our Humanitarian Assistance Rapid Response Team (HARRT), a Pacific Command (PACOM) initiative, to integrate expeditionary medical systems and support functions. The HARRT provides the PACOM Commander with a rapid response package that can deploy in less than 24 hours, requires only two C–17s for transport and can be fully operational within hours of arrival at the disaster site. This unique capability augments host nation efforts during the initial stages of rescue/recovery, thus saving lives, reducing suffering, and preventing the spread of disease. So far, HARRT successfully deployed on two occasions in the Pacific. Efforts are underway to incorporate this humanitarian assistance and disaster relief response capability into all AFMS Expeditionary Medical System (EMEDS) assets.

Air Force medics contribute significant support to the treatment and evacuation of Haiti earthquake victims. The Air Force Special Operations Command sent 47 medics to support Air Force Special Operations Command troops on the ground within 12 hours following the disaster to perform site assessments, establish preventive public health measures, and deliver lifesaving trauma care to include surgical and critical care support. This team was also instrumental in working with Southern Command and Transportation Command to establish a patient movement bridge evacuating individuals from Haiti via air transport.

As part of the U.S. Air Force's total force effort, we sent our EMEDS platform into Haiti and rapidly established a 10-bed hospital to link the hospital ship to ground operations. The new EMEDS includes capabilities for pediatrics, OB/GYN and mental health. Personnel from five Air Force medical treatment facilities are supporting Operation Unified Response, as well as volunteers from the Air Reserve Forces.

BUILD PATIENT-CENTERED CARE AND FOCUS ON PREVENTION TO OPTIMIZE HEALTH

We are committed to achieving the same high level of trust with our patients at home through our medical home concept. Medical home includes initiatives to personalize care, and to improve health and resilience. We are also working hard to optimize our operations, reduce costs and improve patient access. We partner with our Federal and civilian colleagues to continuously improve care to all our beneficiaries.

Family Health Initiative

To achieve better health outcomes for our patients, we implemented the Family Health Initiative (FHI). FHI mirrors the American Academy of Family Physicians' "Patient Centered Medical Home" concept and is built on the team-approach for effective care delivery. The partnership between our patients and their health care teams is critical to create better health and better care via improved continuity, and reduce per capita cost.

Our providers are given full clinical oversight of their care teams and are expected to practice to the full scope of their training. We believe the results will be high quality care and improved professional satisfaction. Two of our pilot sites, Edwards Air Force Base (AFB), CA, and Ellsworth AFB, SD, have dramatically improved their national standings in continuity, quality, access to care, and patient satisfaction. Eleven other bases are implementing Medical Home, with an additional 20 bases scheduled to come on-line in 2010.

We are particularly encouraged by the results of our patient continuity data in Medical Home. Previous metrics showed our patients only saw their assigned provider approximately 50 percent of the time. At Edwards and Ellsworth AFBs, provider continuity is now in the 80–90 percent range.

We still have work to do, such as developing improved decision support tools, case management support, and improved training. Implementing change of this size and scope requires broad commitment. The Air Force Medical Service has the commitment and is confident that by focusing on patient-centered care through Medical Home, we will deliver exceptional care in the years ahead.

The Military Health System's Quadruple Aim of medical readiness, population health, experience of care and per capita cost serves us well. Patient safety remains central to everything we do. By focusing on lessons learned and sharing information, we continually strive to enhance the safety and quality of our care. We share our clinical lessons learned with the Department of Defense (DOD) Patient Safety Center and sister Services. We integrate clinical scenarios and lessons learned into our simulation training. We securely share de-identified patient safety information across the Services through DOD's web-based Patient Safety Learning Center to continuously improve safety.

Improving Resilience and Safeguarding the Mental Health of Our Airmen

Trusted care for our beneficiaries includes improving resilience and safeguarding their mental health and well-being. We are engaged in several initiatives to optimize mental health access and support.

Air Force post-deployment health assessment and post-deployment health re-assessment data indicates a relatively low level of self-reported stress. However, about 20–30 percent of servicemembers returning from Operation Iraqi Freedom/Operation Enduring Freedom deployments report some form of psychological distress. The number of personnel referred for further evaluation or treatment has increased from 25 percent to 50 percent over the past 4 years, possibly reflecting success in reducing stigma of seeking mental health support. We have identified our high-risk groups and can now provide targeted intervention and training.

We recently unveiled "Defenders Edge," which is tailored to security forces airmen who are deploying to the most hostile environments. This training is intended to improve airmen mental resiliency to combat-related stressors. Unlike conventional techniques, which adopt a one-on-one approach focusing on emotional vulnerability, "DEFED" brings the mental health professional into the group environment, assimilating them into the security forces culture as skills are taught.

Airmen who are at higher risk for post traumatic stress are closely screened and monitored for psychological concerns post-deployment. If treatment is required, these individuals receive referrals to the appropriate providers. In addition to standard treatment protocols for post-traumatic stress disorder (PTSD), Air Force mental health professionals are capitalizing on state-of-the-art treatment options using Virtual Reality. The use of a computer-generated virtual Iraq in combination with goggles, headphones, and a scent machine allow servicemembers to receive enhanced prolonged exposure therapy in a safe setting. In January 2009, 32 Air Force Medical Service therapists received Tri-Service training in collaboration with the Defense Center of Excellence at Madigan Army Medical Center. The system was deployed to eight Air Force sites in February 2009 and is assisting servicemembers in the treatment of PTSD.

Future applications of technology employing avatars and virtual worlds may have multiple applications. Servicemember and family resiliency will be enhanced by providing pre- and post-deployment education; new parent support programs may offer virtual parent training; and family advocacy and addiction treatment programs may provide anger management, social skills training, and emotional and behavioral regulation.

Rebuilding Our Capabilities by Recapturing Care and Reducing Costs

Our patients appropriately expect AFMS facilities and equipment will be state-of-the art and our medical teams clinically current. They trust we will give them the best care possible. We are upgrading our medical facilities and rebuilding our capabilities to give patients more choice and increase provider satisfaction with a more complex case load. In our larger facilities, we launched the Surgical Optimization Initiative, which includes process improvement evaluations to improve operating room efficiency, enhance surgical teamwork, and eliminate waste and redundancy. This initiative resulted in a 30 percent increase in operative cases at Elmendorf AFB, AK, and 118 percent increase in neurosurgery at Travis AFB, CA.

We are engaged in an extensive modernization of Wright-Patterson Air Force Base Medical Center in Ohio with particular focus on surgical care and mental health services. We are continuing investment in a state-of-the-art new medical campus for SAMMC at Lackland AFB, TX. Our ambulatory care center at Andrews AFB, MD, will provide a key capability for the delivery of world-class health care in the National Capital Region's multi-service market.

By increasing volume, complexity and diversity of care provided in Air Force hospitals, we make more care available to our patients; and we provide our clinicians with a robust clinical practice to ensure they are prepared for deployed operations, humanitarian assistance, and disaster response.

Partnering With Our Private Sector and Federal Partners

Now more than ever, collaboration and cooperation with our private sector and Federal partners is key to maximizing resources, leveraging capabilities and sustaining clinical currency. Initiatives to build strong academic partnerships with St. Louis University, Wright State University (Ohio); University of Maryland; University of Mississippi; University of Nebraska-Lincoln; University of California-Davis and University of Texas-San Antonio, among others, bolster research and training platforms and ultimately, ensures a pipeline of current, deployable medics to sustain Air Force medicine.

Our long history of collaborating with the Veterans Administration (VA) also enhances clinical currency for our providers, saves valuable resources, and provides a more seamless transition for our airmen as they move from active duty to veteran status. The Air Force currently has five joint ventures with the VA, including the most recent at Keesler AFB, MS. Additional efforts are underway for Buckley AFB, CO, to share space with the Denver VA Medical Center, which is now under construction.

The new joint Department of Defense-Veterans Affairs disability evaluation system pilot started at Malcolm Grow Medical Center at Andrews AFB, MD in November 2007. It was expanded to include Elmendorf AFB, AK; Travis AFB, CA and Vance AFB, OK; and MacDill AFB, FL, in May 2009. Lessons learned are streamlining and expediting disability recovery and processing, and creating improved treatment, evaluation and delivery of compensation and benefits. The introduction

of a single comprehensive medical examination and single-sourced disability rating was instrumental to improving the process and increasing the transparency. Services now allow members to see proposed VA disability ratings before separation.

We continue to work toward advances in the interoperability of the electronic health record. Recent updates allow near real-time data sharing between DOD and Veterans Affairs providers. Malcolm Grow Medical Center, Wright-Patterson Medical Center, and David Grant Medical Center are now using this technology, with 12 additional Air Force military treatment facilities slated to come online. New system updates will enhance capabilities to share images, assessment reports, and data. All updates are geared toward producing a virtual lifetime electronic record and a nationwide health information network.

YEAR OF THE AIR FORCE FAMILY

This is the "Year of the Air Force Family," and we are working hand in hand with Air Force personnel and force management to ensure our Exceptional Family Member Program beneficiaries receive the assistance they need.

In September 2009, the Air Force sponsored an Autism Summit where educational, medical, and community support personnel discussed challenges and best practices. In December 2009, the Air Force Medical Service provided all Air Force treatment facilities with an autism tool kit. The kit provided educational information to providers on diagnosis and treatment. Also, Wright-Patterson AFB, OH is partnering with Children's Hospital of Ohio in a research project to develop a comprehensive registry for autism spectrum disorders, behavioral therapies, and gene mapping.

The Air Force actively collaborates with sister Services and the Defense Center of Excellence for Psychological Health and Traumatic Brain injury to offer a variety of programs and services to meet the needs of children of wounded warriors. One recent initiative was the "Family Connections" website with Sesame Street-themed resources to help children cope with deployments and injured parents. In addition, DOD-funded websites, such as afterdeployment.org, providing specific information and guidance for parents/caregivers to understand and help kids deal with issues related to deployment and its aftermath.

Parents and caregivers also consult with their child's primary care manager, who can help identify issues and refer the child for care when necessary. Other resources available to families include counseling through Military OneSource, Airman and Family Readiness Centers, Chaplains, and Military Family Life Consultants—all of whom may refer the family to seek more formal mental health treatment through consultation with their primary care manager or by contacting a TRICARE mental health provider directly.

INVESTING IN OUR PEOPLE: EDUCATION, TRAINING, AND RESEARCH

Increased Focus on Recruiting and Retention Initiatives

To gain and hold the trust of our patients, we must have highly trained, current, and qualified providers. To attract those high quality providers in the future, we have numerous efforts underway to improve recruiting and retention.

We've changed our marketing efforts to better target recruits, such as providing Corps-specific DVDs to recruiters. The Health Profession Scholarship Program remains vital to attracting doctors and dentists, accounting for 75 percent of these two Corps' accessions. The Air Force International Health Specialist program is another successful program, providing Air Force Medical Service personnel with opportunities to leverage their foreign language and cultural knowledge to effectively execute and lead global health engagements, each designed to build international partnerships and sustainable capacity.

The Nursing Enlisted Commissioning Program (NECP) is a terrific opportunity for airmen. Several airmen have been accepted to the NECP, completed degrees, and have been commissioned as Second Lieutenant within a year. To quote a recent graduate, 2nd Lt. April C. Barr, "The NECP was an excellent way for me to finish my degree and gave me an opportunity to fulfill a goal I set as a young airman . . . to be commissioned as an Air Force nurse."

For our enlisted personnel, targeted Selective Reenlistment Bonuses, combined with continued emphasis on quality of life, generous benefits, and job satisfaction have positively impacted enlisted recruiting and retention efforts.

Increasing Synergy to Strengthen GME and Officer/Enlisted Training

We foster excellence in clinical, operational, joint and coalition partner roles for all Air Force Medical Service personnel. We are increasing opportunities for advanced education in general dentistry and establishing more formalized, tiered ap-

proaches to Medical Corps faculty development. Senior officer and enlisted efforts in the National Capital Region and the San Antonio Military Medical Center are fostering Tri-Service collaboration, enlightening the Services to each others' capabilities and qualifications, and establishing opportunities to develop and hone readiness skills.

The Medical Education and Training Campus (METC) at Fort Sam Houston, TX, will have a monumental impact on the Department of Defense and all Military Services. We anticipate a smooth transition with our moves completed by summer 2011. METC will train future enlisted medics to take care of our servicemembers and their families and will establish San Antonio as a medical training center of excellence.

Our Centers for the Sustainment of Trauma and Readiness Skills at St. Louis University, University of Maryland-Baltimore Shock Trauma and University of Cincinnati College of Medicine remain important and evolving training platforms for our doctors, nurses and medical technicians preparing to deploy. We recently expanded our St. Louis University training program to include pediatric trauma. Tragically, this training became necessary, as our deployed medics treat hundreds of children due to war-related violence.

Partnerships with the University Hospital Cincinnati and Scottsdale, AZ, trauma hospitals allow the Air Force's nurse transition programs to provide newly graduated registered nurses 11 weeks of rotations in emergency care, cardiovascular intensive care, burn unit, endoscopy, same-day surgery, and respiratory therapy. These advanced clinical and deployment readiness skills prepare them for success in Air Force hospitals and deployed medical facilities, vital to the care of our patients and joint warfighters.

Setting Clear Research Requirements and Integrating Technology

Trusted care is not static. To sustain this trust, we must remain agile and adaptive, seeking innovative solutions to shape our future. Our ongoing research in procedures, technology, and equipment will ensure our patients and warfighters always benefit from the latest medical technologies and clinical advancements.

Air Force Medical Service vascular surgeons, Lieutenant Colonels Todd Rasmussen and William "Darrin" Clouse, have completed 17 research papers since 2005 and edited the vascular surgery handbook. On January 10, 2009 a U.S. Marine sustained bilateral posterior knee dislocations with subsequent loss of blood flow to his lower legs following an improvised explosive device attack in the Helmand Province. Casualty evacuation delivered the marine to our British partners at Camp Bastion, a level II surgical unit within an hour. At Bastion, British surgeons applied knowledge gained from combat casualty care research and restored blood flow to both legs using temporary vascular shunts. Medical evacuation then delivered the casualty to the 455th Expeditionary Medical Group at Bagram. Upon arrival, our surgeons at Bagram performed definitive vascular reconstruction and protected the fragile soft tissue with negative pressure wound therapy. The Marine is currently recovering at the National Military Medical Center in Bethesda and is expected to have functional limbs.

In another example, a 21-year-old airman underwent a rare pancreatic autotransplantation surgery at Walter Reed Army Medical Center (WRAMC) to salvage his body's ability to produce insulin. The airman was shot in the back three times by an insurgent at a remote outpost in Afghanistan. The patient underwent two procedures in Afghanistan to stop the bleeding, was flown to Germany, then to WRAMC. Army surgeons consulted with University of Miami's Miller School of Medicine researchers on transplantation experiments. The surgeons decided to attempt a rare autotransplantation surgery to save the remaining pancreas cells. WRAMC Surgeons removed his remaining pancreas cells and flew them over 1,000 miles to the University of Miami Miller School of Medicine. The University of Miami team worked through the night to isolate and preserve the islet cells. The cells were flown back to WRAMC the next day and successfully implanted in the patient. The surgery was a miraculous success, as the cells are producing insulin.

These two cases best illustrate the outcome of our collaborations, culture of research, international teamwork, innovation, and excellence.

Shaping the Future Today Through Partnerships and Training

Under a new partnership with the University of Illinois at Chicago, we are researching directed energy force protection, which focuses on detection, diagnosis and treatment of directed energy devices. We are exploring the discovery of biomarkers related to laser eye injuries, development of films for laser eye protection and the development of a "tricorder" prototype capable of laser detection and biomarker assessment. Additional efforts focus on the use and safety of laser scalpels and the

development of a hand-held battery operated laser tool to treat wounds on the battlefield.

We continue our 7-year partnership with the University of Pittsburgh Medical Center to develop Type II diabetes prevention and treatment programs for rural and Air Force communities. Successful program efforts in the San Antonio area include the establishment of a Diabetes Center of Excellence, "Diabetes Day" outreach specialty care, and efforts to establish a National Diabetes Model for diabetic care.

Another partnership, with the University of Maryland Medical Center and the Center for the Sustainment of Trauma and Readiness Skills (C–STARS) in Baltimore is developing advanced training for Air Force trauma teams. The project goal is to develop a multi-patient trauma simulation capability using high fidelity trauma simulators to challenge trauma teams in rapid assessment, task management, and critical skills necessary for the survival of our wounded warriors. A debriefing model is being developed to assist with after action reviews for trauma team members.

Radiofrequency technology is contributing to medical process improvements at Keesler AFB, MS. Currently, Keesler AFB is analyzing the use of automatic identification and data capture (AIDC) in AFMS business processes. The AIDC evaluation focuses on four main areas: patient tracking, medication administration, specimen tracking, and asset management. Further system evaluation and data collection is ongoing in 2010 with an expansion of AIDC use in tracking automated data processing equipment.

CONCLUSION

As a unique health system, we are committed to success across the spectrum of military operations through rapid deployability and patient-centered care. We are partnering for better outcomes and increasing clinical capacity. We are strengthening our education and training platforms through partnerships and scanning the environment for new research and development opportunities to keep Air Force medicine on the cutting edge.

We will enhance our facilities and the quality of health care to ensure health and wellness of all entrusted to our care. We do all this with a focus on patient safety and sound fiscal stewardship. We could not achieve our goals of better readiness, better health, better care and reduced cost without your support, and so again, I thank you.

In closing, I share a quote from our Air Force Chief of Staff, Gen. Norton A. Schwartz, who said, "I see evidence every day the Medical Service is "All In," faithfully executing its mission in the heat of the fight, in direct support of the warfighter, and of families back home as well." I know you would agree that "All in" is the right place to be.

Senator WEBB. Thank you, General Green.

Admiral Jeffries, welcome.

STATEMENT OF RADM RICHARD R. JEFFRIES, USN, MEDICAL OFFICER OF THE U.S. MARINE CORPS

Admiral JEFFRIES. Chairman Webb, Senator Graham, distinguished members of the subcommittee, good morning.

I'm honored to be with you, the Senate Armed Services Personnel Subcommittee, today to discuss the state of Navy Medicine as it pertains to the health services support to the U.S. Marine Corps.

I want to thank the committee members for your unwavering support of Navy Medicine and the U.S. Marine Corps, particularly as it relates to our healthcare advances and continuum of quality care for marines and sailors. Our warriors who go into harm's way for this great Nation, their families, and those who have gone before in service to our country deserve the very best in care and support that we can provide.

Marine Medicine is all about a special bond—the one of complete trust between a marine and a doctor. They know that all will be given, each for the other, when the Nation's mission calls for their total commitment and potential sacrifice to the defense of our coun-

try. Corpsmen up with lifesaving skills, and yet, the potential risk of injury or death is just as real today as it was over 50 years ago.

Navy Medicine is a dedicated, fully integrated worldwide healthcare system meeting the needs of our marines and sailors, their families, retirees, and, at times, those whose fortunes are beset with a disaster. We specialize in health, prevention, and readiness, and, when called upon, casualty and humanitarian lifesaving care to all we touch.

Marine Medicine lives first and foremost at the point of injury, but is founded in primary care, prevention, wellness, and resilience, skills that are the hallmark of readiness. When called upon to deploy, they are ready to provide the best in damage control, resuscitation, and stabilization, with evacuation to a higher level of care anywhere, anytime.

The numbers speak for themselves, even now, in Afghanistan. In the toughest battle, with single-digit percentages in ultimate sacrifices, astonishing mass transfusion, lives saved, and the lowest disease/nonbattle injury levels in history.

Yes, we continue to research and advance the latest in tip-of-the-spear advances in healthcare. We focus on equipment, like tourniquets and blood-clotting combat gauze, techniques in traumatic combat casualty care, and forward-resuscitate surgical and nonsurgical care, and the skills of embedded resilient and post-traumatic stress teams, plus early treatment protocols for mild TBI.

Last year, the Commandant of the Marine Corps directed immediate development and fielding of the Mobile Trauma Bay, mini emergency rooms in protected vehicles from lessons learned in the field, and by the end of the year, several prototypes were already deployed to Afghanistan, where they're saving lives and mitigating injuries at the tip-of-the-spear today.

We continue to push for solutions to some of medicine's toughest challenges. We are fully engaged partners with our "sister scissors," the VA, and civilian experts, to advance research rapidly and PTSD treatment, casualty care, recovery, and rehabilitation for the return of our wounded warriors.

Collaboration with new innovative research consortia, like under the Armed Forces Institute for Regenerative Medicine, AFIRM, and early transitional enablers, like the DOD's Office for Technological Transition, that can quickly navigate through our complex bureaucratic systems and policies, can and are making a difference to those in the front lines, getting the latest advancements in medicine quickly to our providers and casualties.

As we all know now, today's irregular warfare in this complex, protracted war is adversely affecting our forces in many devastating ways. Most blast injuries and horrors witnessed on the battlefield are putting astonishing stresses on our warriors—mentally, emotionally, physically, and spiritually. We are seeing severe amputations, burns, traumatic stresses, and brain injuries on an unbelievable scale.

Our greatness in saving lives has a significant cost in the degree of injury and loss our warriors have suffered. Navy/Marine Corps Medicine has been a leader in changing the way our military engages the mental health challenges of this war with providers embedded in front-line units under the Marine Corps Operational

Stress Control and Readiness Program begun at the beginning of the war. The three Marine Expeditionary Force commanders demanded a Total Force Combat Operational Stress Control Program to combat stigma, mitigate suicides, and properly address stress. A Total Marine Corps Family Response has been initiated. Last year, Total Force trained suicide prevention with video vignettes, group discussions, identification and referral tools, took place in a new Marine Corps program involving a total team engaged leadership concept with OSCAR Extenders is being instituted.

The 1st Marine Expeditionary Force (1MEF) ground combat units going to Afghanistan with this current surge will have trained OSCAR Extender peer and senior mentors, besides primary care mental health embed specialists. With this patient-centered Marine and Navy Medicine team effort, stigma will be further challenged, and seeking and receiving help will become a normal part of the ever-improving Marine culture. For TBI, the Assistant Commandant of the Marine Corps and the current Marine Expeditionary Brigade commander in Afghanistan have led the advancement of a revolutionary concept in prevention and care. They have a "three strikes and you're out" policy. You will stay inside the wire if you've had three major concussions until you get a comprehensive health evaluation.

Plans have been developed for an event-driven reporting, all-involved identification, medical evaluation and recovery timeout program to enhance early identification care of TBI, protecting our warriors with care of TBI, protecting our warriors at the front, and decreasing long-term sequelae.

1MEF Forward will also be piloting a new restoration center concept for earlier recovery, rehabilitation, and care at the forward operating bases later this year.

Many challenges remain. One concern has been the high demand on many of our healthcare provider areas. The Surgeons General have identified shortfalls in key specialties and supporters that could adversely affect our abilities to care and support our forces. More demands will come as we improve TBI restorative care, enhance en route casualty care, expand OSCAR Extender, add Medical Home Patient-Centered Care initiatives, and initiate other discovered advances in healthcare.

Marine Corps is working closely with Navy Medicine and Health Affairs to address current and future needs. In the end, that special bond between marine and doctors propels us to do our very best for our warriors.

On behalf of the men and women of Navy Medicine working inside the U.S. Marine Corps, I want to thank the committee for your exceptional leadership, help, and support. We appreciate your continuing confidence in our abilities to meet mission and to show you how we continue to address and succeed in meeting the healthcare needs of our marines and sailors.

I look forward to your questions, sir.

Senator WEBB. Thank you very much, Admiral.

I appreciate all of the testimony this morning.

I assume we're going to continue.

Senator GRAHAM. Yes, Mr. Chairman. I'll take responsibility for not informing our leadership about this hearing. [Laughter.]

So, they obviously are letting a TSA nomination go forward, and I'm sure every member of the Senate would like to continue this hearing. If I need to—because the rules do matter—I'll be glad to go over to the floor, take 5 minutes, and make a unanimous consent request to continue the hearing, if that's necessary. But, I'm very much committed to allowing you to stay here to answer questions because there are a lot of things hanging in the air——

Senator WEBB. I appreciate that very much.

Senator GRAHAM.—and I want to know the outcome of where are folks at? What do we need to do here?

Senator WEBB. We'll assume we're fine, unless told otherwise.

Senator GRAHAM. Sure.

Senator WEBB. I will start with a question, and then, I suppose, among the three of us, we can rotate through questions.

Senator GRAHAM. Sure.

Senator WEBB. I would like to get into this data that I mentioned in my opening statement, with respect to prescription drug use. Let me review what I said in my statement.

From a recent Military Times article, "One-in-six servicemembers is on some form of psychiatric drug." That's a quote, "17 percent of the Active-Duty Force, and as much as 6 percent of deployed troops, are on antidepressants." That's a quote. "The use of psychiatric medications has increased about 76 percent overall since the start of the current wars."

Now, I have some other data here. I'm going to ask unanimous consent to put this chart into the record at this point, as well.

[The information referred to follows:]

2001 Data from Jul 1, 2001 to Dec 31, 2001
2009 Data from Jan 1, 2009 to Jun 12, 2009

Click and select Branch of Service
Sponsor Branch of Se (All)

Sum of # of RX	Column Labels								
Row Labels	2001	2002	2003	2004	2005	2006	2007	2008	2009
Barbiturates	3,325	7,646	9,092	10,644	11,232	12,747	19,336	22,736	26,776
Muscle Relaxers	58,884	139,423	167,497	207,409	226,858	255,137	285,452	298,807	312,297
Pain Reliever	866,773	2,023,832	2,425,717	2,674,847	2,960,377	3,081,438	3,359,893	3,487,111	3,765,674
Stimulants CII	8,190	16,485	16,672	21,642	23,026	27,019	33,296	40,598	56,651
Stimulants Non-CII	454	1,186	3,301	8,920	9,007	10,912	12,557	12,535	14,362
Tranquilizers	52,018	131,483	162,428	210,872	245,582	337,886	420,085	452,157	516,621
Grand Total	993,496	2,332,522	2,805,620	3,166,666	3,515,811	3,778,079	4,200,353	4,392,040	4,692,381

Senator WEBB. I have data here from DOD that goes from 2001 to 2009, in terms of a breakdown of different prescription drug uses. I'm going to start with 2002, just to put this in front of the panel.

I want to lay this out, because we all know that we have to be careful with statistics. I'm not going to make a judgment based simply on these statistics. There are a number of potential answers to this. I don't want to answer them. I want to hear the answers of the panel. One is, in terms of these numbers in the charts, maybe there is a larger pool of people who are receiving prescriptions. I don't know. Maybe there is a different approach that's being used in medicine over the last 8 years, in terms of people with difficulties, or maybe this is the stress of the force. But, if you

go from 2002 to 2009, barbituate usage—or prescriptions increased from 7,600 to almost 27,000; that's three and a half times. Muscle relaxers increased from 139,000 to 312,000; that's two and a half times. Pain relievers, from 2 million to 3.8 million, that's almost twice. Tranquilizers, from 131,000 to 517,000, which is about four times. On its face, it's pretty astounding and also very troubling.

Dr. Rice, I would like your thoughts on what this means.

Dr. RICE. Yes, sir. Thank you, Mr. Chairman.

First, let me echo your concern about the statistics. Most of the data here come from the Pharmacy Data Transaction Service (PDTS) that the TMA runs. This is a claims tracking system. Up until April 2007, the PDTS, the tracking system, did not lock the beneficiary's status in time. So, the last time a transaction was recorded reflected whatever the servicemember's status was at that time. So, you could have somebody who was taking an antidepressant in 2005, got another one in 2007. In 2005, we would not have known that he was Active Duty. So, the underlying denominator here that leads to the substantial increase that you talked about results from a problem that we had with the way we were tracking the data and not locking it down.

The second point I would make is, I think it's important to keep in mind that the men and women of our military are drawn from the population of the United States, and the use of psychotropic medications in the Nation as a whole has increased. It's difficult to turn on the television without becoming convinced that you're bipolar or have some other problem for which there is a drug ready made for you.

With respect to pain medications, we have placed great emphasis on dealing with pain. The Joint Commission for the Accreditation of Healthcare Organizations has had a substantial effort, in the last several years, to make sure that we recognize pain among our patients, and that we treat it appropriately.

I think there are a number of factors that enter into this apparent increase in usage that we're seeing.

But, I would defer to my colleagues for their particular perspectives on this issue, as well.

Senator WEBB. When you say "apparent," you mean apparent from the data or that the data really isn't speaking correctly to reality?

Dr. RICE. No, there's no question that there is substantial usage. What I'm referring to is that we don't know how many of the people who were getting the drug in 2005 were actually on Active Duty. So, the denominator may be a problem, since we didn't lock down their status at that time, but used the last time they were in the system to reflect what their status was at any previous time.

Senator WEBB. Are these numbers reflective of Active Duty use in the later years? They are not?

General, I see your shaking your head.

General Schoomaker.

General SCHOOMAKER. No, sir. I think, as Dr. Rice was pointing out, until the last 2 years or so, the last entry that the soldier—in our case, soldier—would have been—say, a retiree—would have characterized everything we had in the database before that. So, it was artificially lower than the actual use in 2001.

Senator WEBB. Which was artificially lower?

General SCHOOMAKER. The use of drugs.

Senator WEBB. The use of drugs——

General SCHOOMAKER. If a soldier is on——

Senator WEBB.—among Active Duty——

General SCHOOMAKER. Yes, sir.

Senator WEBB.—in the data? That's what——

General SCHOOMAKER. If a soldier was on Active Duty——

Senator WEBB. Right.

General SCHOOMAKER.—in 2001, and was on ongoing sleep medicines or using a SSRI for depression or something, or for pain relief, and then retired in a retirement physical or retirement setting, in a clinical setting, got turned into a retiree, that was then used to characterize all of the record before then. So, everything attributed to his or her Active Duty time would have disappeared from the Active Duty roster. So, it appeared much lower in use in 2001, 2002, 2003 than actually was being used by the Active Duty.

One of the things that you all have discussed here that is quite startling is the very marked increase from 2001 to 2009. Some of that, as Dr. Rice has explained——

Senator WEBB. What is the year that this adjustment was made?

General SCHOOMAKER. 2006, 2007.

Dr. RICE. It was locked in April 2007.

Senator WEBB. April 2007?

Dr. RICE. Yes, sir.

General SCHOOMAKER. So, we're looking at trends from 2007 and beyond as being much more accurately reflecting the trends in use. There's no question, sir, as Dr. Rice has said, we're all concerned about the amount of use of drugs and the stress on the force that this reflects. But, the increase is not quite as marked as the data would suggest there.

Senator WEBB. Okay. We will come back to you on this to try to get what your view of accurate data is.

What about the comment that "1 in 6 servicemembers is on some form of psychiatric drug"?

General SCHOOMAKER. Sir, we have three intersecting sources of data—independent, somewhat—that all corroborate roughly the same number. The Mental Health Advisory Team 6, which I think you referred to, or Senator Cardin referred to, that was conducted in 2009—through direct surveys—scientifically credible surveys of the force deployed, found that, in Iraq and Afghanistan, so between 3 and 6 percent of soldiers were on a drug for mental health or stress-related, so between 3 and 6 percent. At about the same time, or in the last year, we've had the release of the DOD Health-Related Behaviors Among Active Duty Military Personnel. As I recall, that's a triannual event that the Research Triangle Institute conducts for us. That's confidential and anonymous, so you get a much better, probably confidential, report on all of the Services. They report 8.6 percent being treated for depression, anxiety, or sleep. So, that's a combined——

Senator WEBB. Of the deployed.

General SCHOOMAKER. No, sir. The total force deployed and nondeployed.

We're looking at 3 to 6 percent of the deployed force. Roughly 8 percent of the total force.

Then, the last thing is this PDTS snapshot of the Army. We have, in February of this year—last month—done a snapshot of 550,000 Active Duty soldiers, deployed and nondeployed, and we find there a similar number of about 6 percent.

I'm looking at the range of between 3 and 6 percent—at most, 8 percent—of being on some sort of medication related to mental health or stress.

Now, admittedly, sleep medicines are being used in a variety of settings as an adjunct. Sleep medicines, short-term, are frequently used for problems of sleep in combat, problems——

Senator WEBB. The——

General SCHOOMAKER.—of sleep at home.

Senator WEBB. Excuse me. The data you're talking about is Army data?

General SCHOOMAKER. Yes, sir. It's Army data. The Mental Health Advisory Team 6—the second study I mentioned, the DOD Health Related Behaviors Among Active Duty, actually——

Senator WEBB. Right.

General SCHOOMAKER.—is all Services. The last——

Senator WEBB. The data from Military Times article, again, is 1 in 6 servicemembers. They did say 6 percent of those deployed.

General SCHOOMAKER. Yes, sir.

Senator WEBB. That number fairly well comports——

General SCHOOMAKER. Yes, sir.

Senator WEBB.—with what you're saying. The other number seems higher.

General SCHOOMAKER. I said, for sleep, I think that there's a broader group of people using sleep medications. Some of them are also on active drugs for stress or mental health. Frankly, sir, I probably, myself, appeared in that database, because every time I go overseas, I take a prescription for Ambien.

Senator WEBB. Right.

General SCHOOMAKER. I think many of us do that. It's a sleeper that we use transiently, and it's a prescription drug.

That's a little broader, but I think the implication that we have 1 in 6 with a serious mental disorder, I think, is a reach.

Senator WEBB. I would like to express my appreciation to Senator Graham. The cloakroom is now advised that we are legal again in our hearing. [Laughter.]

We have permission to meet.

Admiral, you wanted to say something?

Admiral ROBINSON. There's one more data source, and that's BHNAS, which is the Behavioral Health Needs Assessment Survey, which is very similar to the MHAT, which is Army, but the BHNAS is done by Navy Medicine. The numbers that General Schoomaker gives are approximately correct, we were looking at 2010—we're talking about men and women in theater—so, this is in the combat zone—with a 3.2 percent mental health psychotropic medication usage, and probably about a 20 percent—22 percent, actually—of sleeping medication. I think that corroborates, at different points, to be about that. That's all that I wanted to add.

Senator WEBB. Okay. We will work with you to see if we can't scrub this data. I think it's an extremely troubling piece of information here.

Admiral ROBINSON. The other point, which is off the data, but it's to the point, I think. It's not about the data. In the attempt, at least in the last 3 years, as my tenure as Surgeon General of the Navy, to decrease stigma—we've made a huge drive throughout the military—Navy, Army, Marine Corps—we've done it independently, but we've been together. We've tried to increase, in the Navy, Marine Corps, as an example—and I think the Army has done this, too, to a degree—to increase mental health professionals forward deployed—and the Air Force has done this, also—but, we're trying to—forward-deployed mental health experts—psychologists, psychiatrists, social workers, psychiatric nurses—those people and also our medics and corpsmen, and our primary care providers—who can, in fact, intervene in mental illnesses and emotional distress amongst our troops, no matter where they may be.

In concert with that is also the utilization of psychotropic medication. But, my point is simply that we're really making a huge desire and a huge effort to destigmatize mental health issues and their treatment and stop—and taking it out of the closet or suppressing it so that it's not coming to light, and bringing it to light, so that we can get effective treatments.

Senator WEBB. Well said. In that respect, it probably goes back to one of the possibilities that I was raising here, and that is that this is an indicator of the long-term stress of the force and also different medical practices, or more open medical practices.

Admiral ROBINSON. I think that there is stress on the force. But, I also think that there is an acknowledgment by medical professionals—by medicine and the Services that mental illnesses exist and have to be treated. We have, for a long time, as a society——

Senator WEBB. I agree. That's the second point that I was making, in terms of medical practice. So, I don't want to dominate all the time here.

Admiral ROBINSON. Yes, sir.

Senator WEBB. I appreciate your answers.

Senator Graham, do you want to——

Senator GRAHAM. Thank you, Mr. Chairman.

I think the numbers you brought up are very important, because I think most Americans want to make sure that our men and women are functioning as well as possible and getting the help they need. I know we have a shortage of mental health professionals in the military, and we're trying to address that.

But, it goes back to this—being away from your home in a combat arena is a stressful environment that—if you're not depressed at some times, you're not normal. It's just a depressing situation to have to be away from your home.

What Senator Webb indicates is very important. We want to make sure that we're tracking the health of the force. So, if each Service could provide us a breakdown of the percentage of the force, in theater and outside the theater, that's on psychotropic drugs, and break that out, versus sleep aids, because—I'm supposed to do my Reserve duty next week, overseas, and I've already

ordered some Ambien. So, I feel guilty already. I'm spiking up the numbers. [Laughter.]

Senator WEBB. Messing up the database. [Laughter.]

Senator GRAHAM. Yes. The database.

I just literally ordered it from the Navy physician.

Senator WEBB. Actually, if I may, if we're going to get a breakdown of this, perhaps you could clean up the timeline for us.

Senator GRAHAM. That's a great idea. What are the real numbers?—so we can judge apples to apples, and because this is anecdotal evidence, quite frankly, of what Senator Webb's been concerned about a long time. We have to make sure that we're not wearing these folks out beyond their ability to respond to the Nation's call. At the same time, you do have this counter-competing idea that we want to make sure that every member of the military gets the treatment they need. There's nothing wrong with going to the mental health professionals in your unit, or the doctor or the surgeon, and saying, "Hey, Doc, you know, I need a little help here. I've had a bad experience. Help me through it." That is exactly what we want to have happen. So, having that concept validated, that it's okay to do this, but, at the same time, understand how widespread these problems are, I think, will help us make some intelligent decisions.

If each Service could give us a breakdown in your Service, that would be much appreciated.

Dr. RICE. Yes, sir.

[The information referred to follows:]

Utilization of automated systems to record medications dispensed at both inpatient and outpatient theater medical facilities was not broadly available until 2008. Prior to this period, data retrieval required extensive paper reviews.

To provide a more complete picture, using current electronic systems, dispensed psychiatric and sleep aid medications were queried starting from 2008, to most current data received. This is not a standard report and requires an ad hoc query for the specific drugs. Approximately 5 million medical records were searched for these specific medications and computer processing was extensive.

The attached table provides available theater psychotropic/hypnotic prescription drug data through June 8, 2010.

Theater 'psychotropic' prescriptions from Theater Medical Data Store, All Components

Medication name	Total Number of Prescriptions			
	2007	2008	2009	2010**
ADDERALL	1,158	3,461	4,366	2,137
ALPRAZOLAM	671	1,673	1,332	392
AMBIEN*	13,427	23,306	25,161	9,052
ATARAX	2,534	3,119	2,453	344
ATIVAN	921	1,127	1,097	213
BUSPAR	99	261	259	46
BUSPIRONE HCL	0	3	1	0
CARBAMAZEPINE	52	64	83	29
CLONAZEPAM	2,323	5,498	4,134	1,808
CONCERTA	543	1,394	1,716	648
DEPAKOTE	42	75	114	38
DEXEDRINE	31	36	15	13
DEXTROAMPHETAMINE	5	30	6	0
DIVALPROEX SODIUM	7	12	47	0
GABAPENTIN	1,623	3,309	3,275	1,093
HYDROXYZINE	2,216	2,902	2,308	237
KLONOPIN	1,125	3,224	2,266	459
LORAZEPAM	2,814	5,255	4,439	1,904
LUNESTA*	36	2,836	5,283	2,233
METHYLIN/METHYLPHENIDATE	9	99	92	50
NEURONTIN	1,310	2,169	2,254	863
RESTORIL*	187	470	761	21
RITALIN	207	397	418	131
SEROQUEL	3,095	6,681	3,820	718
TEGRETOL	30	44	36	8
TEMAZEPAM*	482	991	1,213	474
TOPAMAX	165	424	675	98
TOPIRAMATE	331	876	1,160	494
VISTARIL	112	245	102	35
XANAX	417	892	805	91
ZOLPIDEM TARTRATE*	11,571	18,679	15,699	1,294
Totals	47,543	89,552	85,390	24,923

Medication name	Total Service Members with a Prescription			
	2007	2008	2009	2010**
ADDERALL	350	738	986	604
ALPRAZOLAM	260	463	440	150
AMBIEN*	4,948	7,762	8,933	3,795
ATARAX	1,005	1,167	923	145
ATIVAN	301	306	333	86
BUSPAR	26	68	61	15
BUSPIRONE HCL	0	1	1	0
CARBAMAZEPINE	25	28	36	11
CLONAZEPAM	739	1,338	1,170	615
CONCERTA	167	342	428	216
DEPAKOTE	15	29	41	13
DEXEDRINE	12	4	9	4
DEXTROAMPHETAMINE	2	2	2	0
DIVALPROEX SODIUM	3	7	13	0
GABAPENTIN	587	1,204	1,228	505
HYDROXYZINE	892	1,085	859	111
KLONOPIN	334	689	553	146
LORAZEPAM	1,219	2,009	1,925	896
LUNESTA*	19	1,057	1,882	953
METHYLIN/METHYLPHENIDATE	5	38	32	17
NEURONTIN	445	697	746	339
RESTORIL*	72	157	254	11
RITALIN	64	74	99	32
SEROQUEL	903	1,569	994	241
TEGRETOL	14	17	12	4
TEMAZEPAM*	210	373	451	215
TOPAMAX	56	96	153	41
TOPIRAMATE	118	267	382	217
VISTARIL	48	85	32	7
XANAX	136	208	212	43
ZOLPIDEM TARTRATE*	4,167	6,004	5,298	516
Totals	17,142	27,884	28,488	9,948

*** Sleep Medication**
**** Data through 08 June 2010**

Notes:
1) Capture of prescription data in theater have improved over time. Of note, inpatient prescriptions were added to TMDS in May/June 2007 and Air Force fully started reporting through AHLTA-T in May 2008.
2) No indication as to the intended purpose of the prescription, e.g. off-label use
3) Results are likely an underestimate of theater prescription drug use, for example these results do not include theater prescriptions that may have been ordered through TMOP, which are reported through Pharmacy Data Transaction Service (PDTS).
4) Increased prescriptions ('07 - '08) could reflect an increased usage, better capture of data, or greater sensitivity to the problem on the part of health care providers

Data Source: Theater Medical Data Store (TMDS, Defense Medical Surveillance System (DMSS), as of 11 June 2010 [R100278]
Prepared by: Armed Forces Health Surveillance Center (AFHSC)

Psychotropics Queried

Drug name	
ADDERALL	
ADDERALL XR	
ALPRAZOLAM	
ALPRAZOLAM ER	
ALPRAZOLAM XR	
AMBIEN	Sleep medication
AMBIEN CR	Sleep medication
AMBIEN PAK	Sleep medication
AMPHETAMINE SALT COMBO	
ATARAX	
ATIVAN	
BUSPAR	
BUSPIRONE HCL	
CARBAMAZEPINE	
CARBAMAZEPINE XR	
CARBATROL	
CLONAZEPAM	
CONCERTA	
DAYTRANA	
DEPAKOTE	
DEPAKOTE ER	
DEPAKOTE SPRINKLE	
DEXEDRINE	
DEXTROAMPHETAMINE SULFATE	
DEXTROAMPHETAMINE-AMPHETAMI	
DEXTROSTAT	
DIVALPROEX SODIUM	
DIVALPROEX SODIUM ER	
EDLUAR	Sleep medication
EPITOL	
EQUETRO	
GABAPENTIN	
HYDROXYZINE HCL	
HYDROXYZINE PAMOATE	
HYZINE	
KLONOPIN	
LORAZEPAM	
LORAZEPAM INTENSOL	
LUNESTA	Sleep medication
METADATE CD	
METADATE ER	
METHYLIN	
METHYLIN ER	
METHYLPHENIDATE ER	
METHYLPHENIDATE HCL	

Psychotropics Queried

METHYLPHENIDATE SR	
NEURONTIN	
NIRAVAM	
RESTORIL	Sleep medication
RITALIN	
RITALIN LA	
RITALIN-SR	
SEROQUEL	
TEGRETOL	
TEGRETOL XR	
TEMAZEPAM	Sleep medication
TOPAMAX	
TOPIRAMATE	
VISTARIL	
XANAX	
XANAX XR	
ZOLPIDEM TARTRATE	Sleep medication

Senator GRAHAM. About sustainability, I know we don't have all the teams in place yet, but as we look at the budget over time, the healthcare portion of the DOD budget is growing exponentially. In

2007, I had a meeting with some associations representing the retired community in different branches of the Services, as well as people who manage TRICARE. We came up with a list of a dozen or more things that we could do to make the system more efficient. Is anybody aware of that meeting? Is there any effort to implement those ideas? Where do we stand with the concept, before we ask more money from retirees, in terms of premiums increases? What have we done to make the system more efficient?

Dr. RICE. Sir, we constantly strive to find efficiencies in the system. The challenges are, as I mentioned, with respect to the use of psychotropic drugs, we exist in a system in the larger national healthcare context. I know you've been having some conversations about that issue recently, so you know what's happening on the national scene. I think it was a few years ago that Stewart Altman appeared before your committee and said that if present trends continued, healthcare costs as a fraction of the national economy would continue to grow, but he was pretty sure they could not exceed 100 percent of the gross domestic product.

We have more people in the force, we have more beneficiaries, we have more people who have been added to the beneficiary list. Seventy percent of the costs are incurred outside the direct care system, where we have less direct ability to control——

Senator GRAHAM. We haven't had a premium increase in TRICARE since, what?

Admiral HUNTER. 1995.

Dr. RICE. 1995. Right.

Senator GRAHAM. I want to be generous and fair to all those who serve, but there's a cost-containment problem within DOD's budget. Before we ask for premium increases, I think we need to try to make sure that we're telling the force, "We've done everything we can within reason to make it more efficient and to lower the cost, through efficiency, best practices, preventive healthcare."

Mr. Chairman, I don't see how we can sustain this forever, where TRICARE is never subject to adjustment, in terms of the premiums to be paid. If we're going to do that, we're going to have to come up with a lot more money for DOD, because it's going to eat away at readiness and the other things you need to run the military.

What's your view of that, Admiral Hunter and Dr. Rice? What do we do, long term?

Dr. RICE. I think there are a number of efforts that we can take to try to reduce—General Schoomaker talked about unwanted variation, and that is seen to be a major driver of the increase in healthcare costs. I think we have to focus on that. We have to focus on improving the quality of care. There's no question that better quality care tends to be less expensive care. Focusing on things like patient safety, I think, is an important dimension.

We think that the full deployment and wide utilization of the Electronic Health Record will be an important aid to us in developing that capability. A number of steps we can take.

Your comment about the TRICARE premium is exactly right; there has not been an increase since 1995, while the cost of healthcare insurance in the rest of the world has continued to rise. I would be happy to work with you on that.

Let me ask Admiral Hunter if she has anything to add to that.

Admiral HUNTER. Yes, Senator, let me add a little bit, in terms of what we're doing internally.

I appreciate all the comments about variation. We've looked very carefully, for example, at technology variation and our use of technology throughout military medicine, both in direct care and private-sector care, so that it's appropriately applied. I talked earlier about preventive measures.

I'd also like to talk a little bit about utilization of care. In the last several years, we've seen a dramatic rise in our patients using the emergency room or emergency department as a site of care. Initially, we were concerned that that meant that they didn't have access to care, that they couldn't reach their primary care provider or perhaps they didn't have one assigned. But, as we looked at the data more carefully, we see that the graph is going up in exactly the same way for people who are enrolled to private sector—have a stable primary care relationship, where the provider isn't deploying or those sorts of things, as it is in our direct care systems.

To address that, we've looked at all of the different quadrants of our Quadruple Aim that I talked about. First of all, have we maximized the relationship between provider and patient? All of the surgeons talked about the Medical Home. Second of all, have we made resources available to patients so that they know where else they can go if it's after hours? Do we reach out? Do you have the right refrigerator magnet, or information that says, "This is the urgent care"? How do we help them get to that relationship?

Our contractors are working with us. Many have even added what we call "convenience clinics," the types of clinics that are in drug stores and things like that, to some of their networks so that we are working to add more and more convenient, but lower-cost, after-hours settings of care that would be appropriate for the earache, the respiratory infection, the sore throat, the backache that really doesn't require an emergency room.

Working with all our partners to get to that effective Medical Home, and then measuring and holding accountable for continuity on our side, is important.

In our contracting area, if I may shift, working hard on the business processes. General Schoomaker also talked about administrative variation. The business processes that bring our processes of care—our back office—to be as efficient as it can: electronic funds transfer, not manual processes, automating payments and claims and all of those things to the greatest extent possible, so that the administrative dollars on the contracts are minimized. Bringing multiple contracts together into single ones. Overseas we've just combined six contracts into one, where we'll be getting streamlined services. That's better for our patients—they deal with one overseas contractor—and better for us, because we get a better deal.

Then the last thing I'd point out is fraud prevention. We know that in all major programs we need to be vigilant for others that may take advantage of the system, and how that might happen. So, we have a program integrity group that works carefully with our contractors, with others in the Federal Government—Department of Justice, Centers for Medicare and Medicard Services—and also with private providers to look for trends in claims that may suggest behavior that we need to more fully investigate.

In addition, our explanations of benefits that are mailed to patients each time they have a health encounter. We just started mailing them, even with pharmacy encounters. Patients are great policemen on behalf of the Services. They call us and say—just like a credit card bill—"There's something on my explanation of benefits"——

Senator GRAHAM. That's good. That's very good.

Admiral HUNTER.—"that I didn't get and can you look at it?"

Senator GRAHAM. Yes, I think that is a terrific idea, because all of us, now, are worried about the cost to the country and to—beyond ourselves, which is good, because we all bear these costs.

Mr. Chairman, I don't have any more questions. I'll make one brief comment to the Surgeons General and those under your command.

I think one of the unsung heroes of this war are the medical personnel on the front lines. As Senator Webb said, "the golden hour." There are people surviving attacks in this war that would never have survived in any other war. I am just amazed and just astonished at what's been able to be done in theater and at Landstuhl and other places.

There was a young man—who was a marine, who lost both legs. He's had 60-something surgeries. He is now at Harvard Law School. He just was medically discharged from the Marine Corps, I think, last year. He was a Congressional Fellow with me in my office. I think he's a testament of what people under your command have done for those who put themselves in harm's way. I just want to thank you all for your service.

Senator WEBB. Thank you very much, Senator Graham.

Also, again, I appreciate your having gone to the floor to allow us to be able to continue our hearing.

Senator GRAHAM. It's very important.

Senator WEBB. Senator Begich.

Senator BEGICH. Thank you very much, Mr. Chairman.

I have a couple of followup comments and questions.

First, with regards to painkillers and pain management and so forth, once a patient wants to try to get off of those painkillers, what are the services you have available for them? Because I do hear complaints that they don't think they're adequate, or where they have to go if they've become addicted to the painkillers. Could someone elaborate on that?

General SCHOOMAKER. Yes. Maybe I could take that one, if you don't mind.

Senator BEGICH. Sure.

General SCHOOMAKER. Sir, I would say that to follow on a lot of what we've been saying up here—one of the nonstandard areas of care right now is in pain management.

Senator BEGICH. Right.

General SCHOOMAKER. This is not a problem just for the military, it's a problem across the Nation.

I stood up a task force last year, a Pain Management Task Force, to look at practices across the Army, and, frankly, the VA has been very active in helping with this. The other Services have joined, as well as support from TRICARE Management Agency on this. I got

the latest in-progress review this week. It's going very well, and I expect the formal report to be out in the next 2 weeks.

I'm trained as an internist and a hematologist, and I can tell you that caring for acute pain and chronic pain is a problem across the country, in terms of how we standardize it, how we transition from one phase to the other. We're looking at this in a very holistic way, so that we're employing all of the tools that we have available.

Specifically within the Warrior Transition Units of the Army, we have a very good, comprehensive program which is increasingly more seamless between the inpatient to the outpatient and then to life beyond, even being within the medical system, and it addresses the issues that you're talking about.

Senator BEGICH. If I can make sure I understand what you're saying, there. Not only is it the pain management program, but it's when they get addicted on these painkillers and they want to get clean. What do you do for them? I understand you're working through it. But, what are the services that are available that they can tap into to move from being addicted to the painkillers?

General SCHOOMAKER. All the Services have substance abuse programs for those who get addicted to addicting narcotics and the like. Quite honestly, sir, most of the problems with addictions to narcotics—and I'll go out on a limb on this—are attributed to social uses, rather than those associated with painkillers for surgical pain and the like.

Senator BEGICH. We don't have to debate this much further—I would ask you to provide me, if you can at some point, some of the data that shows that, because what I'm starting to hear from are individuals who experienced an incident during their deployment, have then been prescribed painkillers and may they misuse them or excessive use, now are addicted to them. I just want to know—understand that, as you're trying to develop pain management, another step to this.

General SCHOOMAKER. Yes, sir.

Senator BEGICH. The step is, some of these are very strong prescription drugs that turn into addictive drugs. I want to get a better understanding of how you come to that conclusion so we are not missing that boat. In other words, may they no longer be in the DOD system because they've exited out or whatever, but yet, they're addicted, that our relationship with them has to continue in some way to make sure we clean them. So, that's what I want to understand.

General SCHOOMAKER. Yes, sir. My comments, quite frankly, are driven by the fear that everybody who prescribes pain medicines, and every patient who receives them, especially for surgical pain——

Senator BEGICH. Right.

General SCHOOMAKER.—and for short-term uses is concerned about addiction. We don't want to do anything that drives people into having pain and avoiding what's appropriate treatment.

Senator BEGICH. Excellent.

One thing I'll mention. I'm going to go to a very Alaskan item here. But, you were talking about the emergency room increases.

Admiral HUNTER. Yes, Senator.

Senator BEGICH. Admiral, thank you—I wasn't here at the beginning, but I know you mentioned Alaska, and I appreciate that.

There's a really interesting program that Indian Health Services does within Alaska called the "Nuka model"—N–U–K–A. They saw the exact same thing that you were describing. Significant increases in emergency room care, even though they had clinics——

Admiral HUNTER. Yes.

Senator BEGICH.—all around and available in the villages and so forth. But, they were seeing spikes in emergency care.

They created a demonstration project under Indian Health Services, and it's managed by South Central Foundation. They have reduced their emergency care access by 68 percent in the last 2½ to 3 years, and many other things. They have developed a model that—when you were describing the situation you were laying out, it was very similar to what they had described about 5 to 10 years ago, that they were experiencing—and they couldn't understand why, when they were building these clinics in their facilities—but they went through a whole process, and they saw a huge decrease in the last 2 or 3 years, I'd say, at least, maybe longer, on emergency entries, which, of course, is a huge savings, when you don't have to deal with that process.

General SCHOOMAKER. Yes, sir, we're seeing this. As we stand up the Patient-Centered, Family-Centered Medical Home concept across the Services—all of my clinic and hospital commanders track emergency room use, and in those places, like Fort Benning, where these are standing up—Fort Polk—we see emergency room use drop.

Senator BEGICH. That's great.

General SCHOOMAKER. It's a chaotic, episodic kind of care that people are tapped into.

Senator BEGICH. Right. Emergency care is expensive and, the last thing you want.

General SCHOOMAKER. Yes, sir.

Senator BEGICH. Doctor, did you have a comment?

Dr. RICE. Yes, Senator. One of the things that I think we hold out a lot of hope for is—with our Electronic Health Record—is providing patients access to their own record online. The experience of several healthcare systems has been that, as patients are able to go online, find out for themselves particular aspects that might influence their care, or get answers to questions, their use of the emergency room and their seeking appointments with their physicians drops off dramatically.

Senator BEGICH. Very good.

Mr. Chairman, I just have two quick, final comments, one for Dr. Rice or Admiral Hunter. Again, thank you for mentioning Alaska. I know we've had a conversation about this.

Admiral HUNTER. Yes, Senator.

Senator BEGICH. In the healthcare reform bill that the President signed yesterday, we have within there a task force, as we've already started the process of trying to deal with healthcare costs in Alaska. It now sets it up formally. I just want to see if you have any comment for the record, while we're here, on the idea of the task force and how you see that moving forward.

Admiral HUNTER. Thank you, Senator. We absolutely appreciate your leadership in this area and bringing all the parties together. Our TRICARE Regional West Director, Admiral Niemyer, was up in Alaska recently and visibly engaged and actively engaged all of the Federal health partners in coming together around trying to stabilize the rate schedule.

In addition, we're working to improve what we call the "back offices of care" to make it easier for us to manage the relationships with providers and to bring providers on board for TRICARE. You will see some changes to the TRICARE manual soon that reflect that change. We appreciate the opportunity to work with you and your staff in that endeavor.

Senator BEGICH. Excellent.

Then, the last question. I appreciate—you actually mentioned it, and that was on the whole issue of the reimbursement rate. We have a differential up there because of some of the high costs and capacity for certain specialties and so forth. Do you have any additional further comment you want to make on that? I know we're anxious to make that more permanent. I know you're going through a process right now.

Admiral HUNTER. Yes.

Senator BEGICH. Can you elaborate a bit on that, at this point?

Admiral HUNTER. Yes, Senator. But for the other members, we have a demonstration project in progress that allows us to pay a little bit more than the standard TRICARE rates up in Alaska, because of the difficulty in obtaining care. Primary care is obtained in the military medical treatment facilities, and specialty care goes out. For some specialties, there is truly a provider shortage, and it's difficult to get all the care that we need. Air Force has partnered with us, particularly Chief of Staff of the Air Force—an interest item for him—and Army—also Coast Guard—in looking at these issues for, what do we need and where do we need it? So, what we did for an interim, we extended the demonstration project, and then we put in what we call locality-based waivers for certain specialties, where we had to go even higher—orthopedics, ENT, rheumatology, where some of the specialties for which we have location-specific waivers.

With the other Federal partners, we're looking long-term solution to move to a Federal rate schedule, so that we don't compete with one another. We hope to at least have some interim progress on that this summer, so that we don't have to—we see extending the demo as, perhaps, a concern that we aren't committed.

Senator BEGICH. Right.

Admiral HUNTER. We want to move forward very deliberately in this area.

Thank you.

Senator BEGICH. Thank you very much.

Mr. Chairman, thank you very much.

Senator WEBB. Thank you, Senator Begich.

Senator McCaskill.

Senator MCCASKILL. Thank you, Mr. Chairman.

I had to rush down here, because the rumor all over the Hill is that Webb and Graham have gone rogue. [Laughter.]

Senator WEBB. We're getting it done.

Senator GRAHAM. We're getting it done, yes.

Senator MCCASKILL. Getting it done.

In fact, if I'd known that this could have happened—I had a hearing this afternoon on Afghanistan police training contracting in my Contracting Subcommittee—I would have asked you guys to come out with me at 2:30 so we could have gotten that hearing done.

Senator WEBB. Senator Graham has certain connections.

Senator MCCASKILL. Yes. I don't get it. I would have loved to have that hearing this afternoon. I'm trying to figure out what the point is of not being able to have a hearing this afternoon.

But, I admire you all for forging ahead, in spite of what the rules say. I think it's great we're talking about this. I think you all know that there are many things that I'm very concerned about in this particular portfolio.

Let me start with stigma about getting help, and how that stigma is such a particular problem because of the training and the appropriate peer pressure that makes our military so successful.

I know that we're doing a confidentiality study at Fort Leonard Wood, on the heels of a scandal there, where we had some problems with the substance abuse program. General Schoomaker, I'd like to know, do you have anything you can tell this committee today about the pilot program to look at a program where soldiers can come forward and say, "I need help," without it getting reported up the chain of command?

General SCHOOMAKER. Yes, ma'am. We identified, some time ago, that the soldiers would tell us, confidentially, that they had problems, say, with alcohol, and yet, would not be formally referred, because there was an automatic notification of their commanders. So, we started a pilot program in Hawaii and Alaska, in Fort Lewis. I know, ma'am, that you're aware of this in Fort Leonard Wood. Many other camps, posting stations, have signed on to the desire to have the program generalized. We call this the Confidential Alcohol Treatment and Education Program and what we find is, a much larger group of soldiers is now coming forward and getting treatment at an earlier stage, before the misconduct has been performed, before there's family violence, before they have a DUI or some other problem. The other thing that's very, very encouraging is that we're getting a spectrum of older soldiers, noncommissioned officers (NCO), and officers that are coming forward.

The interesting part of that is that—and we expected that this would happen—a part of any treatment of an alcohol or drug problem, but certainly alcohol, is that it's a chronic-disease model. You're going to have this as a problem for life. If you're really going to beat this, it's because you get your support system, to include your chain of command, involved in how to stay out of trouble. So that a large number of soldiers, even after they enter confidentially, come back later and inform their chain of command and say, "Look, I've had the treatment. I've been informed. I've been counseled. I know that I'm going to have to get more people involved in keeping me sober." So far, it's been very successful. We have great support from the rest of the Army and the Army leadership to generalize this across the force.

Senator MCCASKILL. I know that the report's due in September, and I'll be looking forward to seeing what's put on paper, because then I think it's a situation—we can look at all the branches——

General SCHOOMAKER. Yes, ma'am.

Senator MCCASKILL.—and talk about confidentiality and stigma and how we can work around the culture of the military to get us to a point that folks can get help, because many, many times, if they feel like it's going to impact their career, they wait until it's too late, and it really impacts their career. I think those are men and women that we can't afford to lose in the service of our country.

Let's talk a little bit about counselors. Does anybody have a number of how many counselors we're short right now, in terms of substance abuse counselors? I know—speaking of chronic—this is a chronic problem, having the right number of counselors available.

General SCHOOMAKER. We have the exact numbers. What we're trying to do is keep abreast of the demand. Programs like the KTAP program—the confidential—is generating more need. So, the attempt is to—we've reengineered the Alcohol and Substance Abuse Program so that it's horizontally integrated from the assessment, education——

Senator MCCASKILL. That's good.

General SCHOOMAKER.—targeted at an early intervention to full treatment. In doing that, we're beginning to see what the bow wave is, and anticipate that. We're doing, centrally, hiring of counselors. But, I can tell you, ma'am, just as in behavioral health in general, across the Army, we remain with shortages, because it's very hard, in some locations, to find counsels. It's not a money issue. It's not a problem of bureaucracy. It's a problem, quite frankly, of finding, in a Nation which is already strained for having an appropriate number of trained counselors, it's finding people willing to go to some of our locations.

Senator MCCASKILL. Has there been any thought given to some kind of pilot program to internalize this function without contractors, to have military people get the substance abuse training, so that it's peer-to-peer, as opposed to an outside contractor that you're going to and talking to about your substance abuse issues?

General SCHOOMAKER. Ma'am, I think part of the program of horizontal integration is to start employing peer-to-peer counselors and even groups like former NCOs who want to come in and participate in this, well before the need for formal counseling for treatment. If we can do targeted intervention and education early on, the intent is to obviate the need to have people fall off the cliff before they're approached.

Senator MCCASKILL. Let me talk a little bit about a specific drug, OxyContin. This is a highly addictive drug. In fact, it is not uncommon in many places in the country right now. The street value of OxyContin exceeds heroine. Let me just say that again. The street value of OxyContin exceeds heroine. As high as $80 a pill, on the street. This has really become a drug of choice that is a huge problem in this Nation. I listened to some of the testimony before I got here, and I want to make sure that everyone is aware that this is a growth industry right now, in terms of pain meds. It is something

that—in fact, too late—we're beginning to get a handle on the addictive nature of this drug.

Can you tell me, General, or can any of you tell me—I know that there was some diminishing of the data because of sleeping pills, but I have to tell you, if you guys aren't on top of this——

General SCHOOMAKER. Yes, ma'am.

Senator MCCASKILL.—I guarantee you, if you plot a graph of how much OxyContin is being prescribed, if you all had that number right now, I think it would scare the bejesus out of you.

General SCHOOMAKER. Yes, ma'am. We do track that pretty closely.

Senator MCCASKILL. What is it, in the Army?

General SCHOOMAKER. I can give you—I can take it for the record and give you the numbers. But OxyContin's been with us for almost 100 years. It's a derivative of——

Senator MCCASKILL. Morphine.

General SCHOOMAKER.—many of the drugs that are related to one another—morphine, codeine, heroin, methadone. These are all related to one another, cross-react with one another, have variations in their absorption or how they're administered and how long they last.

OxyContin is a component of a long-acting—or is a long-acting form of Oxycodone that is mixed in other formulations with nonsteroidal anti-inflammatories, like acetaminophen or Motrin or Ibuprofen. So, we use the components of that in many, many different applications for pain management. But, as I said earlier, I think one of our problems here is that prescription drugs have become increasingly used in social environments for recreational use, and have resulted in addictions that are related to morphine and heroin addictions. We're tracking them very closely in the Army, especially in that population of wounded, ill, and injured soldiers for whom we know there's a very high use. We have sole provider programs. That is, a single provider prescribes all psychotropic and potentially addictive drugs, and watches and tracks those. Those go on in our hospitals and clinics for other nonwounded, ill, and injured soldiers, where there is high use of pain medicine.

Frankly, ma'am, I go back to what I said earlier about our Pain Management Task Force. That's one of the reasons we stood it up, is we need a far more holistic and even nonpharmacologic approach to pain management.

Senator MCCASKILL. Thank you very much.

I know I'm out of time.

I would like to put one question on the record, though, about a young man, Lance Corporal Lopez, from Missouri, who had a severe adverse reaction to a vaccine when he was deployed, and he was not allowed the one-time benefit on the Traumatic Servicemember Group Life Insurance policy, even though he was in a coma and, in a wheelchair for a while and has ongoing problems. For the record, I want to put it in and get your reaction as to whether or not that should be a loophole in that coverage.

It seems to me that his injury has been as traumatic as any battlefield injury, and it doesn't seem fair to me that he's denied that benefit because it's an adverse reaction to a vaccine that he had to take for deployment, as opposed to an injury on the battlefield.

General SCHOOMAKER. This was a soldier?

Senator MCCASKILL. No. It was a marine.

Thanks.

Senator WEBB. Thank you, Senator McCaskill.

I have two semi-technical questions, here, I want to ask.

Then, Senator Begich, did you want another round?

Senator BEGICH. No, I'm good.

Senator WEBB. Okay.

First is—I've been trying to follow—and I think, Dr. Rice, I'd like to ask you to start on the answer—this ongoing evaluation of the disability evaluation system—the pilot program that's in place. I'm very familiar with the two different disability systems, having worked as counsel on the House Veterans Committee years ago, where traditionally DOD would be rating people based on whether they were fit for duty in a DOD environment, and then giving a percentage of disability as of the moment they left the military. VA was known as lifetime reevaluation. Whatever disability you incurred on Active Duty could be aggravated, and your VA percentage actually could go up over the rest of your life.

They're basically two totally different concepts, and the compensation amounts pretty much reflected that. Now we have been exploring ways, since the Dole-Shalala Commission, to see if we can merge the process. Could you bring us up to date on how that's working?

Dr. RICE. Senator, this issue has been a challenge. It's been a challenge since the early 1950s. It's been the subject of a number of panels and congressional hearings. The challenges that you mention are—that's exactly right, the—we have the Medical Evaluation Board, which determines whether or not somebody can continue on Active Duty, and then the VA has its own separate process.

In all candor, it—from my vantage point at the Uniformed Services University, I didn't deal with that issue on a day-to-day basis, and I'm just beginning to get up to speed. Perhaps I can ask one of my colleagues——

Senator WEBB. Okay.

Dr. RICE.—who could—General Schoomaker, I expect, is a lot more conversant with it than am I.

Senator WEBB. If there are others who would like to be in that, as well.

General SCHOOMAKER. I feel very strongly about this topic, because, of course, this surfaced with the problems that we had at Walter Reed, roughly 3 years ago this month.

We have a highly adversarial, highly bureaucratized program in which two systems are trying to intersect with one another—the DOD system that determines fitness and then begins an adjudication process of disability and I focus on disability—physical disability—for the single unfitting—most unfitting condition, and then hands it off to the VA, who adjudicates, based upon a whole-person concept, what problems that soldier, sailor, airman, marine may have. The fact remains that there are major benefits derivative from certain thresholds, like 30 percent, where you accrue, for yourself and family, TRICARE benefits. The system, in 3 years, in my view, although we've tried in every way we can to streamline the bureaucracy and to improve the handoff of the VA, continues

to be problematic. We're tweaking the edges, and I think Admiral Robinson has used language to that effect. We're nibbling at the edges of a system and a process which is inherently and intrinsically antiquated and adversarial.

I say to my soldiers, it's one of the tragedies that the very people who saved you on the battlefield, that evacuated you successfully back through two or three continents, across 8,000 miles, toward the end of your processing, becomes your enemy. The same people that you looked to, to get you recovered and rehabilitated, now you look upon as not supporting your successful transition into private life. It needs to be fundamentally changed.

We need to focus on ability. We need a system that focuses on ability, that's aspirational in its focus, much like our most successfully transitioning soldiers, soldiers who have—amputees, much as has already been discussed here, sir. Some of our most——

Senator WEBB. We also need to——

General SCHOOMAKER.—severely injured soldiers——

Senator WEBB.—to focus on properly compensating people who incur lifetime——

General SCHOOMAKER. Absolutely.

Senator WEBB.—difficulties, as a result of their military service. That's how the——

General SCHOOMAKER. Absolutely.

Senator WEBB.—the whole compensation system began. At one time in our history, if someone were to suffer an amputation on a battlefield, have to introduce a private bill in Congress in order to get relief from the government. Nobody could sue—either that or you would want to sue—you can't sue the government for your disability, so we put this system into place. The intention, I think, was to try to make people whole as—in as much as you can.

General SCHOOMAKER. To go back to what Dr. Rice said, this was a system that developed during an industrial economy, that focused on physical disability. In an information age economy, we need a far different and better system that allows the Services to adjudicate—or to decide upon unfitness, and an adjudication of disability and compensation, but also assesses ability and gives people the tools and the bridging support——

Senator WEBB. I've heard that argument. I heard it when the Dole-Shalala Commission came in, and from my perspective, it's more akin to compensation from a tort claim or an injury, rather than fitting someone to a particular profession in an industrialized economy, other than the military profession. Each Service has been very different over the years in terms of how they've evaluated people when they left.

I used an example 3 years ago when you were testifying, of two brothers, both of whom are good friends of mine in the Marine Corps, both of whom were badly wounded and returned to Active Duty. One had his patella blown off and had a really bad back injury. Went back to Vietnam and did a tour. These are the famous McKay brothers, if anyone is looking for historical documentation. Jim McKay finished his enlistment and said, "All right, I'm ready to get my disability and go on with my life." The Marine Corps said, "No, you return to duty. Your disability is zero." He went across the street to the VA, and I think he got 60 percent.

John McKay—a classmate of mine in the Naval Academy—got his eye shot out and broke a piece of the bone up here [indicating], so he couldn't even wear an artificial eye, stayed on Active Duty for 26 years, retired as a colonel, and the Marine Corps said, "You're zero disability." He had the anatomical loss of an eye, busted sinus, busted jaw where the bullet went through, and they gave him a zero. I went and testified at his appeal hearing, saying it should have—the VA immediately gave him 90 percent, probably more. But, when you say "an adversarial system," those are two pretty good examples of people who just wanted to give more and the injuries, the wounds that they suffered, even though they were able to do their job, related more to, I think, tort law—how we've formalized tort law through statute. That's really what the disability system is supposed to be.

But, Admiral, I'd like to hear from you. We're going to wrap this up fairly soon here.

Admiral ROBINSON. Just one addition, and I'm not sure it's going to be that helpful, but I think that what you and General Schoomaker are talking about is correct. I think, also, that there is—and, by the way, I'm not a lawyer, so the tort part, I'll have to ask exactly how you're working that.

VA: systematic rehabilitative care, generally. DOD: acute care, generally. What's happened is, that's intermixing now. So, how we've done business in the past is not what we're doing today. Men and women who are injured today, who would normally never be kept in the Service, because you wouldn't stay in the Service with an amputation or with all sorts of different things, are being kept in the Service now. Men and women who are amputees, as an example, who would normally have moved to the VA system, but now we have, led by Army, a huge, major, and an excellent amputation program. But, again, that's a systematic rehab type of condition.

So, you have DOD, and then you have the VA that's funded for the systematic rehab. We need to try to blend those two together. I think a great deal of what we're doing in the disability evaluation system is the two mammoth organizations that are coming to grips with: Who is going to fund this now? How is this going to get done? It has to be done, and it has to be done correctly, because the men and women who we're taking care of—I'm not thinking of 2010 and 2011, I'm thinking of 2022 and 2025—need to know how they're going to continue that amputation care, whatever care that they need to have, and how they can actually get their lives back online.

Senator WEBB. I'm really concerned that this whole process is bogged down, and we have people waiting around. We have people waiting around to get evaluated as the pilot programs move forward. I've heard a number of stories from the Wounded Warrior Program down at Camp Lejeune, for instance, with marines getting frustrated because they're waiting to have their cases adjudicated, and then getting in trouble because they're going stir-crazy down there, et cetera. So, we need to somehow come to a conclusion on this.

Senator GRAHAM. Along those lines, you have two systems that have never been melded together before, and we need to do that, and you're well on your way to doing it. Again, you have competing interests. A lot of wounded warriors want to stay in. So, their first

goal at that hearing is to convince the military, "Hey, keep me on Active Duty." Sometimes that doesn't work out, and then you have to evaluate how much disability did the person have.

The other problem we have is that, when people are discharged from DOD to the VA, we have to make that as seamless as possible, and that's what Senator Webb's talking about, having a joint board, where everybody sits at the same time and the same place to evaluate these disabilities without having redundancy, is great.

But, here's just a problem. When you're discharged to rural South Carolina with a major injury, healthcare services are going to be limited. How we connect people in rural America to these services is a challenge for the country. I know your heart's right, but these are just logistical obstacles that have to be overcome, because when you go into a military treatment facility for amputation, like Walter Reed—I know you've been out there. It's amazing what you all are doing out there to get these folks back up and prosthetics and TBI. So, you get world-class care, then you may be sent to some rural place in South Carolina, where there's just not capacity. We're trying to connect people up to the best provider possible, with the least amount of logistical problems.

Another problem that we've looked at, Mr. Chairman, is the spouse, their life changes dramatically. Their hopes and dreams basically take a back seat to this traumatic injury. Not just the spouse, but the entire family. So, I want to keep pushing to create a reimbursement system that we're honoring that spouse's service by having a reimbursement system to pay them, quite frankly, because they don't have the ability to go back to school, some amount of money that would otherwise go to some professional service to help that family, who are the primary care providers in the emotional front, particularly.

So, I look forward to working with you, Mr. Chairman, to get this process moving. People are waiting way too long. But, the sad news is, there are just a lot of people affected by this war, and we were overwhelmed a few years ago; that's what happened at Walter Reed. We just didn't have the capacity built, and we're now building it out. I want to be your partner in building it out.

As to this hearing, I'm glad we're able to conduct it. I called my leadership. It was an easy lift to allow the hearing to go forward.

My views on healthcare will be known this afternoon. You're welcome to come listen. [Laughter.]

Business as usual hasn't been done, in many ways, on both sides of the aisle, and I don't want to get into a healthcare debate, so I won't tell you my views on healthcare, but I'm glad we're able to conduct this hearing.

I hope and pray the Senate, one day, can get back to doing business as usual. We're not there yet, but maybe we will be.

So, thank you, Mr. Chairman.

Senator WEBB. I appreciate your saying that, Senator Graham. We do have people who are working on both sides of the aisle trying to solve problems, and you're one of them. I hope I'm one of them. I think Senator McCaskill is one of them.

I would like to request all of you to give me your evaluation of something before I close this hearing—not at this hearing. But, I'd like you to look at—we've talked a lot about the electronic data

management records and this sort of thing. I'm a little curious about your basic software programs that you use in your hospitals, whether you believe you have the best programs that are available. I say that from personal experience, having looked at a really fine software program at the Naval Hospital in Bethesda, which I've used for many, many years, about 6 or 7 years ago, in seeing that it was replaced by something it was less than good, according to the medical people that I was talking to. Just tell us whether you need better software systems in order to manage all your product, and we'd like to get your advice on that.

[The information referred to follows:]

Our Military Health System hospitals currently use AHLTA, the Department of Defense's (DOD) current electronic health record (EHR) capability, as part of a family of systems. AHLTA generates, maintains, stores, and provides secure online access to comprehensive patient records. The DOD EHR family of systems forms one of the largest ambulatory records systems in the world, with documentation of an average of 140,000 patient encounters each day. However, the current suite of applications and underlying infrastructure do not support the challenges of the rapid evolution of today's health care practices, the ever-increasing need to transact and share data across the continuum of care, and the timely fielding of new capabilities.

The Military Health System is executing the multi-year plan developed in the fall of 2009 to redesign the EHR supporting infrastructure and incrementally deliver key functionality. At the threshold, the system must stabilize current record capabilities so that users may efficiently perform their duties in a timely manner, regardless of location, time of day, or network issues. It is imperative that DOD address known shortfalls and key challenges with functional applications and core infrastructure, including critical user concerns with system speed, operational availability, and the user interface. This will allow DOD to meet providers' near-term needs and better prepare for the transition of applications and supporting infrastructure. Further, stabilization efforts will mitigate potential risks prior to increasing reliance on these systems for achieving expanded interoperability through the virtual lifetime electronic record.

Senator WEBB. Any other questions for the record by anyone on this subcommittee will be welcome by close of business today, which is going to be very late.

Senator McCaskill, you have anything?

Senator MCCASKILL. I don't.

Senator WEBB. Okay.

Again, I appreciate the incredible work that all of you are doing on behalf of the people who are serving, and who have served. I appreciate your coming today.

This hearing is adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR CLAIRE MCCASKILL

TRAUMATIC SERVICEMEMBER GROUP LIFE INSURANCE

1. Senator MCCASKILL. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, in September 2006 Lance Corporal Josef Lopez took a Department of Defense (DOD) administered smallpox vaccination prior to a deployment to Iraq and then suffered a severe adverse reaction resulting in temporary paralysis, coma, bladder damage, severe leg spasms, memory loss, and other conditions that require daily medication and care. At the time of his injuries from the vaccine, Lance Corporal Lopez applied for the Traumatic Servicemember Group Life Insurance (TSGLI) benefit, which was enacted by Congress in 2005 to provide a one-time benefit of up to $100,000 to servicemembers who endured a traumatic injury, whether in a combat or non-combat environment. The benefit is intended to help servicemembers and their families with immediate expenses related to the servicemember's injury and convalescence period. Due to a loophole in title 38, section 1980A(b)(3), Lance Corporal Lopez was denied the TSGLI benefit by the Department of Veterans Affairs (VA), even though by all measures his injuries from

the vaccine were traumatic enough to affect key activities of daily living, including incontinence and walking. Although his condition has improved to some degree, Lance Corporal Lopez had to be medically retired from the Marine Corps in June 2009 and now undergoes long-term care management through the VA. He cannot drive, hold a normal job, and must take extensive medication to prevent spasms in his legs. What is DOD's current policy in handling adverse reactions incurred by mandatory DOD-administered vaccines?

Dr. RICE and Admiral HUNTER. The Department's policy concerning reactions to vaccines is to follow best available medical practices to screen for potential adverse reactions and avoid unnecessary risks. Unfortunately, screening methods cannot prevent all adverse vaccine events.

The Services administer specific vaccines based upon disease risk and where the servicemember will serve. If anyone receiving a vaccine has a negative reaction, providers monitor the patient and determine the severity of the reaction. DOD medical providers are required to report and file a Vaccine Adverse Event Reporting System (VAERS) Report with the Centers for Disease Control (CDC) and Food and Drug Administration (FDA).

In addition, DOD has four vaccine health care centers to provide consultative support to providers, serve as patient advocates, support research to enhance vaccine safety, and provide long-term follow-up for patients.

General SCHOOMAKER. DOD is committed to providing our servicemembers the highest quality of health care and support. If a potential vaccine-related adverse event is suspected from a mandatory DOD-administered vaccine, the attending healthcare provider is required to file a VAERS report. VAERS is a national reporting and surveillance system to identify adverse events and promote vaccine safety, and is administered by the CDC and the FDA. Additionally, the attending healthcare provider will refer the patient to the DOD's Vaccine Healthcare Centers (VHC) network for further consultation, treatment, and follow-up. The VHC's role is to prevent, identify, and treat vaccine-related adverse events. It offers a 24-hour clinical call center and a web-based digital photo-sharing system that allows for easier diagnosis from remote sites. Following service discharge, ongoing medical care becomes the responsibility of the VA. However, the VHC will provide the healthcare providers at the VA clinical consultative follow-up care on our veterans being treated.

Admiral ROBINSON. The Military Vaccine Agency (MILVAX) is the DOD lead agent for all vaccine-related issues. If a potential vaccine-related adverse event is suspected from a mandatory DOD-administered vaccine, the attending healthcare provider will file a VAERS report. VAERS is administered by the CDC and the FDA. Additionally, the attending healthcare provider would refer the patient to the DOD's VHC network for further consultation, treatment, and follow-up based upon the clinical diagnosis.

General GREEN. TSGLI is not administered through the Air Force Surgeon General's office, but through the Air Force Office of the Deputy Chief of Staff for Manpower and Personnel (AF/A1).

If a potential vaccine-related adverse event is suspected from a mandatory DOD-administered vaccine, the attending healthcare provider will file a VAERS report in accordance with Air Force Joint Instruction 48–110, section 2–10. VAERS is administered jointly by the CDC and the FDA, with occasional assistance in the analysis by the Immunization Safety Office at the National Center for Immunization and Respiratory Diseases of the CDC. Any person—not just healthcare providers—may submit a VAERS report to the FDA.

Admiral JEFFRIES. The MILVAX is the DOD lead agent for all vaccine-related issues. If a potential vaccine-related adverse event is suspected from a mandatory DOD-administered vaccine, the attending healthcare provider will file a VAERS report. VAERS is administered by the CDC and the FDA. Additionally, the attending healthcare provider would refer the patient to the DOD's VHC network for further consultation, treatment, and follow-up based upon the clinical diagnosis.

2. Senator MCCASKILL. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, how many servicemembers have had adverse reactions to mandatory DOD-administered vaccines over the past 5 years?

Dr. RICE and Admiral HUNTER. The Department reports 3,798 servicemembers have had adverse reactions to mandatory DOD-administered vaccines over the past 5 years.

General SCHOOMAKER. DOD requires the attending healthcare provider to submit a VAERS report if a potential adverse event is suspected. Additionally, anyone can submit a VAERS report if they feel that they have had an adverse reaction to a

vaccine. From January 2005 to December 2009, DOD personnel filed 3,798 reports to VAERS.

Admiral ROBINSON. According to the MILVAX, DOD requires the attending healthcare provider to submit a VAERS report if a potential adverse event is suspected. Additionally, anyone can submit a VAERS report if they feel that they have had an adverse reaction to a vaccine. From January 2005 through December 2009, there were 3,798 reports filed by DOD personnel to VAERS.

2005	352
2006	525
2007	794
2008	1,080
2009	1,047
Total:	3,798

General GREEN. From January 2005 to December 2009, there were 3,798 reports filed by DOD personnel to VAERS. As the VAERS form does not require the specification of the Service, it is not possible to determine how many of these reports were from or about Air Force members. DOD requires the attending healthcare provider to submit a VAERS report if a potential adverse event is suspected. Additionally, anyone may submit a VAERS report if they feel that they or a family member have had an adverse reaction to a vaccine.

Admiral JEFFRIES. According to the MILVAX, DOD requires the attending healthcare provider to submit a VAERS report if a potential adverse event is suspected. Additionally, anyone can submit a VAERS report if they feel that they have had an adverse reaction to a vaccine. From January 2005 through December 2009, there were 3,798 reports filed by DOD personnel to VAERS.

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3. Senator MCCASKILL. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, how are these numbers tracked? Please provide specific numbers.

Dr. RICE and Admiral HUNTER. The number of adverse reactions to DOD-administered vaccines is tracked through the VAERS at the CDC and FDA.

General SCHOOMAKER. DOD uses the VAERS to report and track any suspected adverse events after vaccination. This system is also used by civilian vaccine manufacturers, healthcare professionals, and the public to report and track clinical events temporally associated with vaccination. From January 2005 to December 2009, there were a total of 3,798 VAERS reports filed by DOD personnel. The number of VAERS reports filed by year is as follows:

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4. Senator MCCASKILL. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, have any adverse vaccine injuries resulted in TSGLI claims? If so, how many?

Dr. RICE and Admiral HUNTER. Yes, there have been reports of adverse vaccine injuries which resulted in TSGLI claims.

The Army reported three claims for TGLSI benefits due to adverse reactions to vaccines. The Marine Corps reported three claims for TGLSI benefits due to adverse reactions to vaccines. The Navy and Air Force have reported no claims for TGLSI benefits due to adverse reactions to vaccines.

General SCHOOMAKER. The Army TSGLI program has received four TSGLI claims with losses thought to be a result of vaccine injuries. The claimed losses were primarily those of Activities of Daily Living Losses (ADL), caused by a neurological or muscular dysfunction. One claim stated that the claimant would require surgery based upon a reaction to the vaccine and his ADLs would be impacted post surgery during recovery.

Admiral ROBINSON. Navy's TSGLI database is managed by the Bureau of Naval Personnel and tracks the medical condition or event associated with the claim, but not necessarily the underlying cause. As such, the database does not explicitly track claims stemming from an adverse vaccine reaction. However, an electronic keyword search of the database was conducted, using terms such as "vaccine," "injection," and "allergic reaction." A follow-on manual search of claims in which the medical condition or event was not clearly identified in the electronic database was also conducted. These combined searches revealed that, as of 19 March 2010, no TSGLI claims filed by Navy personnel have resulted from an adverse vaccine reaction.

General GREEN. The Air Force has not received any Active Duty, Air National Guard, or Air Force Reserve TSGLI claims identifying an adverse reaction to vaccine as a traumatic injury.

Admiral JEFFRIES. The Marine Corps administration of the TSGLI plan is managed by the Manpower and Reserve Affairs (M&RA) division of Headquarters, Marine Corps and specifically the Wounded Warrior Regiment. The database maintained by the Wounded Warrior Regiment was queried and three claims related to a vaccine injury were discovered, one of which was that of Lance Corporal Lopez.

5. Senator MCCASKILL. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, how many servicemembers have been denied TSGLI claims for conditions and injuries related to adverse vaccine reactions?

Dr. RICE and Admiral HUNTER. A total of six servicemembers have been denied TSGLI claims for condition and injuries related to adverse vaccine reactions.

The Army reported three denials of TSGLI benefits claims made due to adverse vaccine reactions. The Marine Corps reported three denials of TSGLI benefits claims made due to adverse vaccine reactions. The Navy and Air Force reported no denials to TGSLI benefits claims made due to adverse reactions to vaccines.

General SCHOOMAKER. The Army TSGLI program has received four TSGLI claims with losses thought to be a result of vaccine injuries. Each claim was denied due to a lack of medical documentation establishing a direct link to the claimed losses and the administration of the vaccine. Claims were also denied as not being a result of a traumatic event per requirements of the TSGLI program.

Admiral ROBINSON. Navy's TSGLI database is managed by the Bureau of Naval Personnel and tracks the medical condition or event associated with the claim, but not necessarily the underlying cause. As such, the database does not explicitly track claims stemming from an adverse vaccine reaction. However, an electronic key word search of the database was conducted, using terms such as "vaccine," "injection," and "allergic reaction." A follow-on manual search of claims in which the medical condition or event was not clearly identified in the electronic database was also conducted. These combined searches revealed that, as of 19 March 2010, no Navy personnel have been denied a TSGLI claim for conditions or injuries related to an adverse vaccine reaction.

General GREEN. The Air Force has neither received nor denied any Active Duty, Air National Guard, or Air Force Reserve TSGLI claims identifying an adverse reaction to vaccine as a traumatic injury.

Admiral JEFFRIES. The Marine Corps administration of the TSGLI plan is managed by the M&RA division of Headquarters, Marine Corps and specifically the Wounded Warrior Regiment. The database maintained by the Wounded Warrior Regiment was queried and three claims related to a vaccine injury were discovered, one of which was that of Lance Corporal Lopez.

6. Senator MCCASKILL. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, given that TSGLI is meant to cover traumatic injuries of servicemembers, what is your interpretation of whether Lance Corporal Lopez qualifies for TSGLI given the nature of his injuries from the DOD-administered vaccine, which caused him permanent and lifelong disability?

Dr. RICE and Admiral HUNTER. DOD concluded, based on current statue and policy, that Lance Corporal Lopez does not qualify for TSGLI given the nature of his injuries from the administered vaccine.

Upon discharge a veteran would be entitled to monetary benefits and lifetime medical care for disabilities caused by lingering effects from vaccine reactions through the VA. However, DOD does not believe the TSGLI program is the appropriate vehicle for providing benefits for members who experience adverse reactions to vaccines.

TSGLI was designed by Congress to provide severely injured servicemembers, who suffer a loss as a direct result of a traumatic event, with short-term monetary assistance. The definition of a traumatic event, according to 38 CFR 9.20, is, " . . . the application of external force, violence, chemical, biological, or radiological weapons, or accidental ingestion of a contaminated substance causing damage to a living being." The TSGLI benefit is intended to lessen the economic burden on the member and the member's family which often ensues during the often long and difficult treatment and rehabilitation periods.

General SCHOOMAKER. It is tragic that Lance Corporal Lopez and other servicemembers have had adverse reactions to predeployment vaccinations. Preserving the health and safety of our servicemembers is my top concern. I would not consider this event to be a traumatic injury as defined by current law. Under the current law, inoculations are specifically excluded from TSGLI payment.

TSGLI provides for payment to servicemembers who are severely injured (on or off duty) as the result of a traumatic event and suffer a loss that qualifies for payment under TSGLI. The servicemember must suffer a qualified loss that is a direct result of a traumatic event to qualify for TSGLI payment.

Lance Corporal Lopez was given a required predeployment vaccination (smallpox). He had a severe reaction to the vaccination. As a result, he suffered temporary paralysis, was in a coma, and continues to struggle to independently perform activities of daily life. However, these injuries were not caused by a traumatic event under the VA's regulations governing TSGLI. These regulations define a traumatic event as "the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to the body." Also, specifically excluded from TSGLI pay-

ment is a loss caused by "[d]iagnostic procedures, preventive medical procedures such as inoculations . . . or any complications arising from such procedures or treatment."

Lance Corporal Lopez's loss was caused by a smallpox vaccination. Smallpox is a serious, highly contagious, and sometimes deadly infectious disease. A smallpox outbreak would significantly affect military readiness. Administering the vaccination now, before an outbreak, is the best way to protect our troops. Very rarely, the smallpox vaccine can cause serious side effects. We will continue to enhance vaccine safety through research and education. We will also continue to optimize our screening process to ensure those at increased risk will not receive the vaccination.

Admiral ROBINSON. Both the Code of Federal Regulations (CFR) (38 CFR § 9.20(e)(3)(i)(C)) and the August 5, 2009, TSGLI procedural guide specifically address this issue by stating that preventive medical procedures such as inoculations, and any complications arising from such procedures or treatment, are excluded from TSGLI payment.

The Disability Evaluation System (DES) is the Uniformed Services' program to consider servicemembers whose ability to continue their military career is called into question as a result of their health state. This system does not delineate servicemembers based upon the cause of their injury or illness, with the potential exception of self-inflicted cases, but rather the outcome and impact. The servicemember may be medically retired and compensated based on the level of disability associated with their injury or illness. Service-connected conditions and disabilities are also eligible for continuing care and potential compensation through the VA upon the servicemember's separation or retirement.

General GREEN. TSGLI is not administered through the Surgeon General's office, but through the Air Force Office of the Deputy Chief of Staff for Manpower and Personnel. However, anthrax and smallpox vaccines are not covered under the TSGLI, but would be covered under a program administered by the Department of Health and Human Services under the Public Readiness and Emergency Preparedness Act of 2005 (42 U.S.C. Secs. 247d-6d, 247d-6e). As the Air Force has not had the opportunity to review Marine Lance Corporal Lopez's medical record, we would not be able to comment further.

Admiral JEFFRIES. Both the CFR (38 CFR § 9.20(e)(3)(i)(C)) and the August 5, 2009, TSGLI procedural guide specifically address this issue by stating that preventive medical procedures such as inoculations, and any complications arising from such procedures or treatment, are excluded from TSGLI payment. Based upon this established guidance, TSGLI does not cover the injury and/or disability brought about by their adverse reaction to receipt of the small pox vaccination. Current policy focuses on the acquisition of the injury as the focus of coverage, rather than including the outcome and associated disability.

7. Senator MCCASKILL. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, do you think that Lance Corporal Lopez and people with similar injuries should receive compensation under TSGLI?

Dr. RICE and Admiral HUNTER. While I do think Lance Corporal Lopez and members with similar injuries should receive compensation, I do not think they should received TGSLI benefits resulting from adverse reactions to vaccinations, surgical trauma, or medical procedures given current policy.

While the Lance Corporal Lopez situation is unfortunate, the TSGLI program employs the same industry standards and practices regarding an insurable loss as employed across the United States with respect to anyone who make claims covered by accidental death and dismemberment insurance. DOD follows the laws and regulations that embody these standards when adjudicating TSGLI claims. Specifically, vaccinations do not meet the definition of traumatic event as contemplated in the TSGLI statutes and regulations. Servicemembers who suffer adverse reactions to vaccines (to the degree that Lance Corporal Lopez suffered) would be entitled to monetary benefits and lifetime medical care for these disabilities through the VA.

General SCHOOMAKER. Lance Corporal Lopez and other servicemembers who sustain this injury may be entitled to receive a combination of military, veterans, and Social Security health and disability benefits. However, receiving compensation under TSGLI for this injury would be inconsistent with the policy and purpose of the current law.

Military insurance programs such as TRICARE, SGLI, and TSGLI are modeled after commercial insurance policies. Specifically, TSGLI is modeled after commercial accidental death and dismemberment insurance. Like commercial insurance, TSGLI is a limited benefit that provides compensation for specific losses caused by specific events. Also, both TSGLI and commercial insurance policies specifically exclude payment for losses caused by medical treatment and procedures.

Vaccinations are preventive medical procedures provided as part of the Army's force health-protection program. Unfortunately, some servicemembers will experience side effects or adverse reactions from the smallpox vaccine. Although rare, there are some serious side effects possible from the vaccine. We try to reduce the risk of side effects by exempting servicemembers who should not receive this vaccine. Like commercial insurance, this injury is not covered by TSGLI because it is a direct result of medical treatment and not a traumatic event.

TSGLI is not the sole benefit available to servicemembers who suffer serious adverse reactions to vaccinations. TSGLI is very specific coverage that provides limited protection. The underlying policy and purpose for the TSGLI program will be significantly changed if a loss caused by a non-traumatic event qualifies for payment.

Admiral ROBINSON. Both the CFR (38 CFR § 9.20(e)(3)(i)(C)) and the August 5, 2009, TSGLI procedural guide specifically address this issue by stating that preventive medical procedures such as inoculations, and any complications arising from such procedures or treatment, are excluded from TSGLI payment.

The DES is the Uniformed Services' program to consider servicemembers whose ability to continue their military career is called into question as a result of their health state. This system does not delineate servicemembers based upon the cause of their injury or illness, with the potential exception of self-inflicted cases, but rather the outcome and impact. The servicemember may be medically retired and compensated based on the level of disability associated with their injury or illness. Service-connected conditions and disabilities are also eligible for continuing care and potential compensation through the VA upon the servicemember's separation or retirement.

General GREEN. The answer requires more than a simple yes or no reply. My understanding is that Congress modeled TSGLI after commercial accidental death and dismemberment policies with some expansion of benefits to address the unique needs of military service. Commercial accidental death and dismemberment policies specifically exclude disease and illness, including mental health conditions such as PTSD as is the case with the current TSGLI program. The TSGLI program also does not currently cover claims resulting from the diagnosis of, or medical or surgical treatment for, an illness or disease, or any complications arising from such medical or surgical treatment, or preventive medical procedures such as inoculations. Congress also expressed their intent that the basic TSGLI premium go no higher than its current level of $1 per month. Expanding TSGLI to include claims resulting from medical treatments, illnesses, or preventive inoculations would almost certainly result in higher TSGLI premiums.

Currently, our servicemembers cannot decline TSGLI coverage unless they also decline SGLI coverage. They automatically have the monthly $1 premium deducted from pay. If expanding coverage results in a TSGLI premium increase, our concern is that it could change how the program is administered. An increase in premium may require giving servicemembers an option on whether to elect TSGLI coverage. If that occurs, our junior servicemembers may decline TSGLI coverage resulting in fewer servicemembers receiving coverage and payment for future traumatic injuries. While we support a broad TSGLI program that maximizes coverage to the widest degree possible, we do not support expanding coverage to the point that it results in an increase of the current TSGLI premium and a change in the program that would allow servicemembers to opt out. Any expansion of coverage needs to consider this possibility as this program is too important to our junior servicemembers to allow that to occur.

Admiral JEFFRIES. Both the CFR (38 CFR §9.20(e)(3)(i)(C)) and the August 5, 2009, TSGLI procedural guide specifically address this issue by stating that preventive medical procedures such as inoculations, and any complications arising from such procedures or treatment, are excluded from TSGLI payment.

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QUESTIONS SUBMITTED BY SENATOR MARK BEGICH

SUICIDE PREVENTION

8. Senator BEGICH. General Schoomaker, I understand the Army has instituted a number of programs to address the increasing suicide rates among servicemembers. Can you provide an update on some of the programs?

General SCHOOMAKER. The Army has implemented several near-term projects to improve our understanding—such as the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention, and the Vice Chief of Staff's monthly suicide review meetings. The Army has also enlisted the help of the National Institute of Mental Health (NIMH) to conduct a long-term study on risk and resilience in the Army.

The Army conducts extensive reviews of every suicide death, both Active Duty and non-Active Duty, to improve our understanding of why a soldier may choose to take his/her life. The Army Suicide Prevention Task Force has created a standardized 37 line report which units use to analyze the factors surrounding each soldier's death by suicide. This report is forwarded to the Pentagon within 30 days of the soldier's death, and a general officer conducts a back brief to the Vice Chief of Staff of the Army during his monthly suicide review meeting. This back brief is done via a world-wide video teleconference so that leaders across the Army can share lessons learned and improve early recognition of at-risk soldiers.

The Army has created the Army Behavioral Health Integrated Data Environment database. This database will provide a standardized, enterprise-wide, capability to integrate information from dispersed legal, medical, and personnel databases into a comprehensive health surveillance database to support mental, behavioral, social health, and public health activities.

NIMH has undertaken the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), which is the largest study ever undertaken of suicide and mental health among military personnel. The purpose of Army STARRS is to identify, as rapidly and as scientifically as possible, modifiable risk and protective factors of suicidal behavior, to help inform the Army's ongoing efforts to prevent suicide and improve soldiers' overall psychological health and functioning.

Army actions taken in 2009 to combat the increasing suicide rate follow:

1. Produced the interactive "Beyond the Front" training video.
2. Produced the "Shoulder to Shoulder: No Soldier Stands Alone" training video.
3. Updated AR 600–63 (Army Health Promotion) and DA Pam 600–24 (Health Promotion, Risk Reduction and Suicide Prevention).
4. Published Suicide Awareness Pocket Guide for all soldiers.
5. Increased access to behavioral health and substance abuse counseling.
6. Funded NIMH grant for the Army STARRS, $50 million/5-year study—Quarterly Updates to VCSA to Accelerate Lessons Learned.
7. Initiated a tele-behavioral health screening pilot project with the 25th Infantry Division, involving 100 percent screening through face-to-face or live video counseling.
8. Approved nationally-recognized best-practice suicide intervention skills training for Army use to assist in early recognition of at-risk individuals.

Army actions for 2010 follow:

1. Developing interactive "Home Front" training video.
2. Developing sequel to "shoulder to shoulder" training video.
3. Developing an additional skill identifier for certified suicide intervention skills trainers.
4. Expanding tele-behavioral health pilot project, to become the Comprehensive Behavioral Health System of Care and implementing it into the ARFORGEN cycle so behavioral health care is targeted at critical points (predeployment, deployment, reintegration, reset, et cetera).
5. Developing program effectiveness measures.
6. Using the Suicide Specialized Augmentation Response Team/Staff Assistance Team to support commanders by assessing programs, policies, and resources, and identify gaps to improve local suicide prevention programs.

9. Senator BEGICH. General Schoomaker, in your opinion, are we doing enough?

General SCHOOMAKER. I will not be satisfied until suicide rates in the Army are reduced below the suicide rate for the civilian population. Despite our inability to halt the increase in suicide, I am very impressed with the prevention efforts of leaders across the Army. The Army has implemented many changes to programs, policies, and procedures in an effort to improve our suicide prevention programs. We have hired more behavioral health professionals, we are improving our screening

methods, and we are using technology to expand access to our behavior health providers. We are constantly looking for ways to improve and have eagerly sought the assistance of numerous outside experts.

The Army has documented behavioral health authorizations for 2,340 providers. As of the first quarter of fiscal year 2010, the Army had an on-hand behavioral health provider inventory of 3,714, this equates to a 159 percent fill rate. However, given current workload requirements and accounting for the increased demand for psychological health support for soldiers and families, we have calculated a current "needs" estimate of approximately 4,305 behavioral health providers. This represents an 86 percent fill rate when compared to the current on-hand inventory. We estimate that an additional 591 behavioral health providers are needed to meet current demand. The Army is actively engaged in the recruitment and accession of providers to meet the identified behavioral health requirements.

Stigma remains a significant issue in America and Army culture. Army leaders are concerned that soldiers appear reluctant to seek behavioral healthcare due to stigma and/or fear of negative repercussions. As a result, programs have been developed to help decrease the stigma associated with soldiers seeking behavioral healthcare while also providing an increased layer of privacy.

The Reengineering Systems of Primary Care Treatment in the military is a program designed to decrease the stigma associated with seeking behavioral health treatment by placing these services within primary care facilities. Through this program, any visit a soldier makes to his/her primary care physician for any reason is an opportunity to screen the soldier for symptoms that could indicate that he/she is struggling with symptoms associated with post-traumatic stress disorder (PTSD) or other behavioral health diagnoses. This program is also accessible via the web, where soldiers can self-refer. Services provided are confidential, unless it is determined that a soldier is at risk of harm to self or others.

The Soldier Evaluation for Life Fitness program incorporates behavioral health as a routine component of the health readiness process for all soldiers returning to their home stations following deployment. Since every soldier receives a consultation on-site, no one is stigmatized when seen by a behavioral healthcare practitioner. Through the Soldier Evaluation for Life Fitness program, soldiers first complete a computer-based self-assessment. On-site clinicians review the results of the assessments immediately, allowing them to tailor their consultations to meet each soldier's unique needs. Soldiers can then be evaluated for individual health risks that may range from PTSD and other behavioral health diagnoses to physical health conditions.

Military OneSource is a free information center and website where soldiers can seek assistance 24 hours/day, 7 days/week. Counseling is provided by phone or in person by Masters-level consultants on issues such as family support, emotional support, debt management, and legal issues for up to 12 sessions at no cost to the soldier. Military OneSource does not release information about users of the services, with the exception of issues of child abuse, elder abuse, spousal abuse, and/or risk of harm to self or others. Military OneSource can be accessed at www.militaryonesource.com or 1–800–342–9647. Soldiers may complete a free, voluntary online behavioral health self-assessment, and obtain referrals at www.MilitaryMentalHealth.org. This is an approach to assist soldiers and family members with identifying symptoms and getting assistance. It provides confidential and immediate feedback, as well as referrals to TRICARE, VA centers, and Military OneSource.

Military and family life consultants are also available to assist soldiers who are experiencing difficulty coping with daily life concerns and issues. Military and family life consultants are Licensed Clinical Social Workers, Professional Counselors, Marriage and Family Therapists, and Psychologists. They provide six free informal and confidential counseling sessions. No records are kept and flexible appointment times and locations are offered. Soldiers may access military and family life consultants through the Army Community Services by self referral, without having to provide a reason for seeking these services, or via Military OneSource, who can assist them with the identification of a consultant in the soldier's local area.

COMPREHENSIVE SOLDIER FITNESS PROGRAM

10. Senator BEGICH. General Schoomaker, the Army's Comprehensive Soldier Fitness (CSF) program is a structured, long-term assessment and development program to build the resilience and enhance the performance of every soldier, family member, and Army civilian. Can you tell me more about this program, and the role of the Army Medical Department (AMEDD) in support of the program?

General SCHOOMAKER. The Army established the CSF program to increase the resilience of soldiers and families by developing their strengths in five important domains: physical, emotional, social, spiritual, and family. The CSF program will ensure that all soldiers undergo an assessment of their total fitness. The results of the assessment will direct individualized training, intervention, or treatment programs, as needed. This program will begin at accession, and, like physical fitness, will include reassessment at appropriate intervals. The CSF office applies accepted methodology and scientific rigor to ensure that all training, interventions, and treatments have demonstrated effectiveness.

The AMEDD is a strong supporter of the CSF program. Although there is overlap with AMEDD goals, CSF is not a medical program. The AMEDD will implement CSF as will every other unit by taking the Global Assessment Tool (GAT), training Master Resilience Trainers (MRT), and implementing CSF training on our training calendar (as we would any other Warrior Task and Battle Drill). Additionally, the AMEDD supports the CSF physical dimension by providing medical/health-related data on the Soldiers Independent Operational Test to provide physical fitness metrics for the soldiers. Also, the AMEDD is instrumental in coordinating with CSF on state-of-the-art physical fitness training content and products for inclusion in the CSF online training modules, MRT training, and Warrior Task and Battle Drill training.

11. Senator BEGICH. General Schoomaker, do you believe this program is properly funded?

General SCHOOMAKER. Yes, I am not aware of any requirements for CSF that have not been funded.

FAMILY HEALTH INITIATIVE

12. Senator BEGICH. General Green, I understand the Air Force implemented the Family Health Initiative (FHI) which mirrors the American Academy of Family Physicians "Patient Centered Medical Home" concept and is built on the team-approach for effective care delivery. I also understand you have two pilot programs at Edwards Air Force Base, CA, and Ellsworth Air Force Base, SD. Can you provide an update on the status of these pilots?

General GREEN. We began implementation of the FHI at Edwards Air Force Base and Ellsworth Air Force Base in 2008. As our most mature sites, we have seen outstanding improvement in patient continuity leading to improved patient and staff satisfaction. Additionally, as we have forged greater relationships through continuity with our patients, health care outcomes have improved accordingly, especially for our most complex patients with diseases such as diabetes mellitus. We have taken the lessons learned from our initial two sites and used them to improve FHI implementation at 11 additional locations across the Air Force in 2009: Andrews, Bolling, Elmendorf, FE Warren, Hill, Lakenheath, Laughlin, Misawa, Patrick, Scott, and Sheppard Air Force Bases. The lessons learned at all 13 of these locations are being applied as we implement FHI and the Patient Centered Medical Home at 20 additional Air Force military treatment facilities (MTF) in 2010, with a goal of Air Force-wide implementation by the end of 2012.

13. Senator BEGICH. General Green, do you believe this program should be implemented across DOD and the other Services?

General GREEN. The Air Force FHI is based on a concept known as the Medical Home that originated in U.S. professional medical societies for primary care specialties. The Medical Home has become a Military Health System (MHS) strategic priority. The Army and Navy have prototype programs based on the Medical Home concept. We are exchanging information, ideas, and experiences with the Army and Navy as we move forward and adapt the processes to the missions we support. An advantage of sharing this as a MHS priority is the pursuit of common requirements supporting the Medical Home concept, reflected in the electronic health record (EHR) and personal health record requirements in DOD. We are excited about providing benchmark-quality primary care services to our patients.

CENTER OF EXCELLENCE

14. Senator BEGICH. Dr. Rice, can you give an update/status of section 1623, "Center of Excellence in Prevention, Diagnosis, Mitigation, Treatment, and Rehabilitation of Military Eye Injuries" that was in the National Defense Authorization Act for Fiscal Year 2008? In general, this section stated that the "Secretary of Defense

shall establish within DOD a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries."

Dr. RICE. The Department has completed facility design of the Vision Center of Excellence (VCE). Contract award is pending, with a projected completion by third quarter of fiscal year 2011.

The VCE is creating a staffing plan for Initial Operating Capability (IOC) and Full Operating Capability, to include functions, grades, classification, responsibilities, and mission of each subordinate division. We anticipate hiring IOC staff in the third quarter of fiscal year 2010.

SPECIALIST SHORTAGES

15. Senator BEGICH. General Green, the 3rd Medical Corps at Elmendorf Air Force Base, headed by Colonel Paul Friedrichs, runs one of the best MTFs in the Air Force. However, specialty shortages at the MTF and in Alaska continue to plague the ability to treat patients. Is the Air Force looking at how to address those shortages by bringing in more specialists?

General GREEN. I returned this week from my third visit to Alaska to learn more about how the Air Force Medical Service (AFMS) partners with our municipal, State, and Federal counterparts to improve access to care while sustaining the medical proficiency of our Air Force medics in Alaska. As part of this visit, I was able to travel with your Rural Director, Ms. Tiffany Zulkosky, to visit military medics bringing much-needed care to the residents of Kotzebue, Noorvik, and Selawik. As our military population has grown, the Air Force has added over 150 new medical authorizations at the third Medical Group to minimize the number of patients who must seek care downtown. We are actively pursuing sharing agreements with the VA and Alaska Native Medical Center to further expand the medical services we offer our patients.

The AFMS programs medical resources based on population and mission requirements. The AFMS programmed an increase of specialty doctors and key medical enablers, such as nurses, medical technicians, and administrative support from fiscal years 2008 to 2011. As part of the fiscal years 2012 to 2017 Program Objective Memorandum planning, the AFMS is carefully reviewing the mix of services offered at each of our facilities including those at Eielson and Elmendorf Air Force Bases. We see continued opportunities to support State and local medical providers' efforts to build a trauma system for Anchorage, as well as to build robust Graduate Medical Education programs, and a seamless e-health network that will help improve access for all patients.

QUESTIONS SUBMITTED BY SENATOR JOHN MCCAIN

ADARA NETWORKS CONTRACT

16. Senator MCCAIN. Dr. Rice, what is the status of the DOD Inspector General's (IG) investigation into allegations of impropriety in the award of health information technology contracts to Adara Networks, Inc.?

Dr. RICE. DOD policy does not permit comment on ongoing DOD IG investigations.

17. Senator MCCAIN. Dr. Rice, what were the findings and results of the internal investigation conducted by the Department into allegations of impropriety in the award of health information technology contracts to Adara Networks, Inc.?

Dr. RICE. The preliminary review found the program did not fully adhere to the DOD Directive 5000 series, Federal Acquisition Regulations, Defense Federal Acquisition Regulations Supplement Acquisition Principles.

There were errors in judgment and a lack of program and acquisition planning, transparency, and oversight. Software and documentation, intellectual property developed and owned by the MHS, was inappropriately provided to Adara Networks.

18. Senator MCCAIN. Dr. Rice, please identify the source and total amount of funds provided to Adara for work on the DOD EHR.

Dr. RICE. The funding source was Operation and Maintenance—fiscal year 2007 and the total aount awarded was $9,944,792.53.

19. Senator MCCAIN. Dr. Rice, please identify and describe each product delivered to the government under the Adara contract, including reports, software, and/or electronic code.

Dr. RICE. The following products were delivered to the government under the Adara contract:

- (1) Lot, Mesh Networking Technologies
- (1) Lot, Equipment, including software licenses, necessary for an eight node infrastructure. Standard support and maintenance—including 1 year of all minor releases, all maintenance patches, and support coverage is included with the software
- (8) Each, Multi Path Virtual Circuit Router
- (8) Each, Multi Path Dynamic Application Layer
- (8) Each, Multi Homed Application Layer (7) Object
- (8) Each, Multi Homed Application Layer (7) Host
- (8) Each, Multi Path Virtual Routers
- (8) Each, Multi Path Routing Software, Multi Path Routing Protocol and Daemon
- (8) Each, Multi Path QoS Router
- (8) Each, Multi Path SOA Content Based Router
- (10) Each, Secure Communication Gateways
- (1) Each, Central Management Systems

20. Senator MCCAIN. Dr. Rice, are those products being utilized in ongoing development of the EHR? If not, why not?

Dr. RICE. No, those products are not being utilized in ongoing development of the EHR.

An Analysis of Alternatives (AoA) is currently being developed, which will provide materiel solutions to the requirement to the EHR. Once that solution is chosen, an acquisition strategy will be formulated in accordance with DOD Directive 5000, the Defense Acquisition System.

21. Senator MCCAIN. Dr. Rice, according to press reports, electronic code for the MHS was provided to Adara Networks, Inc. What companies under contract to DOD are in possession of that code at this time?

Dr. RICE. Only Adara Networks, Inc., was in possession of that code.

22. Senator MCCAIN. Dr. Rice, what assurances can you give Congress that sensitive medical information is not at risk?

Dr. RICE. I am confident sensitive medical information is not at risk.

On December 7, 2009, in consultation with the TRICARE Management Activity (TMA) Privacy Office and TMA Information Assurance, the Defense Health Information Management System (DHIMS) Program Office determined that the overall risk of penetration of DOD health records, accounts, or other privileged/secured access sites or databases was low. The Computer Network Defense would prohibit unauthorized access to the production system.

23. Senator MCCAIN. Dr. Rice, has the Department imposed any sanctions with respect to future contracts on Adara Networks, Inc.?

Dr. RICE. No, the Department has not imposed any sanctions with respect to future contracts on Adara Networks, Inc.

ELECTRONIC HEALTH RECORDS

24. Senator MCCAIN. Dr. Rice, what is the schedule for development and delivery of an EHR for DOD?

Dr. RICE. Armed Forces Health Longitudinal Technology Application, the existing DOD EHR, has been deployed worldwide since 2006. A schedule of the way ahead for the EHR will be developed and released following completion of the AoA for EHR capability.

25. Senator MCCAIN. Dr. Rice, is the program fully funded in the fiscal year 2011 request and in the Future Years Defense Plan?

Dr. RICE. DOD's EHR program is fully funded in the fiscal year 2011 request and in the Future Years Defense Plan.

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

TRICARE CONTRACTS

26. Senator GRAHAM. Dr. Rice, last July, TRICARE Management Activity announced the selection of the contractors for the $55.5 billion (over 5 years) TRICARE Third Generation (T–3) Managed Care Support Services Contracts. It is our understanding that as a result of protest filed by two of the incumbents, however, that transition work with the newly selected contractors was stopped pending the Government Accountability Office (GAO) protest review and decision. Current TRICARE managed care contracts remain in place until March 31, 2011, and health care delivery continues while options are being considered. I want to ensure that TRICARE beneficiaries continue to have timely access to high quality health care during the protest period and the critical transition period to the new contracts. What is the status regarding the evaluation of GAO's recommendations?

Dr. RICE. We are concluding our evaluation of the GAO recommendations and will be announcing our approach to resolving the protest issues in the summer of 2010.

27. Senator GRAHAM. Dr. Rice, when will these contracts be awarded?

Dr. RICE. We expect to take steps to resolve the remaining issues regarding these contracts in the summer of 2010.

28. Senator GRAHAM. Dr. Rice, since the 10-month transition deadline is approaching, does DOD expect to resume transition soon or will the current contracts be further extended?

Dr. RICE. We believe transitions can be completed by April 2011, coinciding with the current contracts end date.

29. Senator GRAHAM. Dr. Rice, can you assure me that TRICARE's beneficiaries will not be harmed during this contract transition?

Dr. RICE. I assure you TRICARE beneficiaries will not be harmed during this contract transition.

The current regional health care contractors will continue to provide services to beneficiaries until March 31, 2011. Extensions to our current contracts will allow time for transition to the T–3 contracts, while ensuring beneficiaries continue to receive high-quality care and outstanding customer service.

MEDICATING THE MILITARY

30. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, do you agree with the reporting in the Army Times on March 8, 2010, that: "At least one in six servicemembers is on some form of psychiatric drug." If not, why not? What available data do you use to support your statement?

Dr. RICE and Admiral HUNTER. We do not agree with the Army Times reporting.

In an analysis completed in February 2010, data from the Pharmacy Data Transaction Service (PDTS), reported less than 3 percent of all Active Duty members are on psychiatric drugs.

The PDTS is a centralized data repository that allows us to build a common patient medication profile for all DOD beneficiaries. The data for this analysis was focused on two queries: (1) the number of unique Active Duty servicemembers who received any prescription, and (2) the number of Active Duty servicemembers that received any of the psychotropic medications as defined by the CENTCOM Pharmacy and Therapeutics Committee.

General SCHOOMAKER. I do not agree with the statistic used by the Army Times. The quote referred to data from the Mental Health Advisory Team (MHAT)-V Report from Afghanistan (2007), in which 17 percent of U.S. soldiers reported taking a medication for a mental health or sleep problem during their deployment. The MHAT–VI (2009) conducted a more systematic sampling of maneuver and support units across both the Iraq and Afghanistan theaters and separated medications for sleep and other mental health indications. Overall, in MHAT–VI, 3 to 6 percent of soldiers surveyed reported using a medication for a "mental health or stress problem," and 8 to 14 percent reported using a medication for a sleep problem. (Note: These percentages cannot be added together, because some individuals were taking both categories. In-theater data were not available for sailors, marines, or Air Force personnel.)

In a stratified random DOD-wide survey at CONUS and OCONUS installations involving Active Duty of all Services, 8.6 percent of servicemembers reported receiv-

ing a prescription for depression, anxiety, or sleep problems in the preceding 12 months (10.7 percent Army, 6.2 percent Navy, 7.9 percent Marines, 8.1 percent Air Force) (DOD Health Related Behaviors Among Active Duty Military Personnel 2009).

In January 2010, data from the PDTS which captures all prescriptions filled at MTFs, the TRICARE Mail Order Pharmacy, and civilian pharmacies (when paid for using the TRICARE benefit), indicated that 3.3 percent of Army Active Duty soldiers filled a prescription for an antidepressant in that month. Antidepressants include selective serotonin reuptake inhibitors (SSRIs), tricyclics, heterocyclics, and monoamine oxidase inhibitors (MAOIs). It should be noted, however, that this analysis does not include prescriptions filled in the deployed environment, and may not capture the full medication usage if soldiers received a prescription from outside the MHS, or a prescription prior to January that was for longer than a 1-month period.

Thus, the best data available suggest that the rate of current (1 month) use of antidepressants specifically in CONUS is approximately 3 percent and the estimate for any use of antidepressants during deployment is 3 to 6 percent. The rate is considerably higher when sleep and antianxiety medications are included in addition to antidepressants.

Admiral ROBINSON. The quoted statistic regarding one in six servicemembers on some form of psychotropic drug is apparently derived from the fifth MHAT survey done in 2007. This was a survey of deployed Army personnel and included a question about taking a medication for help with sleeping or any mental health or stress problem. The result was about 17 percent of respondents said that they had taken a medication for one of these reasons. A soldier would have answered yes to this question if they had been given a few sleep aids to help with changing 12 time zones in 2 days, which is accepted medical practice, or been on a several-month course of antidepressants. Clearly, combining these two very different answers together is not ideal.

To address this shortcoming, the MHAT 6 survey, completed in 2009, broke out the questions: (1) about taking a medication for sleep; and (2) about taking a medication for a mental health or stress problem. This resulted in a rate of 3 to 6 percent of respondents indicating they had taken a medication for mental health or stress. MHAT 6 results are consistent with other data points concerning psychotropic use by military personnel, including the Navy Behavioral Health Needs Assessment Survey (BHNAS) data from this year that indicates that about 22 percent of respondents used sleeping medication during their deployment and 3.2 percent used medication for mental health reasons. The estimate of usage for mental health reasons of the adult U.S. civilian population approximates 10 percent. The Navy BHNAS is an assessment tool utilizing similar questions to the U.S. Army's Mental Health Assessment Tool (MHAT). It provides real time, actionable, unit level psychological health surveillance and is being used to assess Navy members who are deployed as individual augmentees.

General GREEN. Thank you for the opportunity to address this concern regarding the health and well-being of our Air Force members and their use of psychotropic medications. The prevalence rate of psychotropic medication use in the Air Force on a single day, March 1, 2010, was 1 in 17, or 5.8 percent, of the Active-Duty Force. This figure is a point prevalence of one day. The number of unique Air Force servicemembers who had one or more prescriptions for any psychotropic medication, including controlled prescription pain medications, on this date was 22,003 or 5.8 percent of the Active Force. When controlled prescription pain medications are removed, the number of unique servicemembers on a psychotropic medication changes to 17,962 or 4.7 percent of the force. Psychotropic medications are used to treat many medical conditions beyond psychiatric syndromes such as the use of tricyclic antidepressants for chronic pain, and other antidepressant classes are also used to treat migraine headaches and fibromyalgia. The data was extracted from the MHS PDTS table in the M2 on March 1, 2010.

Admiral JEFFRIES. The quoted statistic regarding 1 in 6 servicemembers on some form of psychotropic drug is apparently derived from the fifth MHAT survey done in 2007. This was a survey of deployed Army personnel and included a question about taking a medication for help with sleeping or any mental health or stress problem. The result was about 17 percent of respondents said that they had taken a medication for one of these reasons. A soldier would have answered yes to this question if they had been given a few sleep aids to help with changing 12 time zones in 2 days, which is accepted medical practice, or been on a several-month course of antidepressants. Clearly, combining these two very different answers together is not ideal. To address this shortcoming, the MHAT 6 survey, completed in 2009, broke out the questions: (1) about taking a medication for sleep; and (2) about taking a medication for a mental health or stress problem. This resulted in a rate of

3 to 6 percent of respondents indicating they had taken a medication for mental health or stress. MHAT 6 results are consistent with other data points concerning psychotropic use by military personnel, including the Navy BHNAS data from this year that indicates that about 22 percent of respondents used sleeping medication during their deployment and 3.2 percent used medication for mental health reasons.

The most current data, based on actual prescriptions filled by marines, demonstrate that less than 7 percent of marines filled a prescription for an antidepressant, antianxiety medication, or stimulant during all of 2009. At any one time the percentage is obviously even smaller. Estimates for the adult civilian population of the United States are higher.

31. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, do you agree that many troops are taking more than one kind of psychiatric drug, "mixing daily cocktails," and that this behavior can lead to suicide?

Dr. RICE and Admiral HUNTER. No, we do not agree. While we are aware of a small number of troops who may be taking more than one kind of psychiatric drug to treat multiple symptoms justified by their clinical condition, this is not a common occurrence and we would not categorize it as many troops.

Suicide is caused by multiple factors. We have not seen evidence directly correlating an increase in suicides with servicemembers who are prescribed multiple psychiatric drugs justified by clinical condition under the supervision of physicians. Independent studies have found that the benefits of antidepressants outweigh the risks of suicide.

General SCHOOMAKER. The Army is concerned with the health and resilience of all servicemembers and extends great effort to reduce the risk of loss of a single servicemember to the tragedy of suicide.

In our soldier population, we use pharmacy data to provide a very precise accounting of how many soldiers are on multiple medications. We define multiple medications as two or more of any combination of sleep, psychotropic, or narcotic medications. For our Warriors in Transition, who have a variety of medical and psychiatric diagnoses, 703 (7.7 percent) Warriors are on multiple medications out of a total population of 9,095 warriors. In the overall Active Duty population, 1,075 (0.2 percent) soldiers are on multiple medications out of a population of 557,642 soldiers.

Reviewing completed suicides from 2001 to 2008, we found slightly more than one-third of the suicides had a history of psychotropic prescriptions, with 14 percent current prescriptions at time of death, and 19 percent within 3 months. We do not have the level of detail in our database to assess how many were on multiple medications.

The Army has funded a 5-year, $50 million study with the National Institute of Mental Health to help answer questions about the relationship between psychiatric medications and suicide. This is a multi-pronged and multi-site study, led by the Uniformed Services University of the Health Sciences (USUHS) and supported by Harvard University, Columbia University, and the University of Michigan.

Admiral ROBINSON. I do not agree with this statement. Sailors and marines who are taking medications have been carefully diagnosed, and when indicated, prescribed medications. Individuals placed on medications are closely monitored to ensure they are stable on the medications without side effects that would impair their ability to function or place them at risk. In addition, every sailor is screened prior to deployment via the NAVMED 1300/4 which addresses all medical requirements and is reviewed by a licensed medical provider to ensure individuals are medically suitable for deployment. Every marine is screened in a similar manner by their battalion surgeon to ensure they are suitable for deployment. Periodic surveillance of the psychological health of deployed sailors and marines is also being conducted.

General GREEN. The Air Force is concerned with the health and resilience of all servicemembers and extends great effort to reduce the risk of loss of a single servicemember to the tragedy of suicide. In reviewing Air Force suicides over the past nearly 2 years we have seen no indication of a trend toward polypharmacy, or use and/or abuse of multiple psychotropic medications, in our servicemembers lost during this time. Data pulled from M2 reflects one day point prevalence for Active Duty Air Force personnel taking more than one psychotropic medication at the same time, or polypharmacy in psychotropics, on March 1, 2010, was 6,061 or 1.6 percent of the Active Force. We have demonstrated vigilance in our management of servicemembers with chronic pain and complex medical management through guidance sent to the Chiefs of Medical Staff in an effort to ensure safe, multidisciplinary team management of servicemembers with chronic controlled pain medication use.

The Air Force Suicide Prevention Program is also engaged in a number of studies with researchers at the USUHS to examine case data on past suicides, including data collected through our Suicide Event Surveillance System, and the DOD Suicide

Event Report and Personal Health Assessment data, to look for factors that may allow us to better identify those at risk for suicide. Recent efforts in this area have allowed us to identify career fields that appear to be at greater risk for suicide, allowing leadership to target additional prevention efforts at these groups.

The Air Force has also been collecting data on new recruits entering the Air Force regarding their past behavioral history. This data collection appears to show promise in allowing us to identify, from a recruit's earliest days in the Air Force, those airmen who may be at higher risk for a variety of problems. The Air Force is now exploring ways to reach out to these airmen to improve their ability to cope with the rigors of military life and improve resiliency.

Admiral JEFFRIES. I do not agree that many marines are taking more than one kind of psychiatric medication and "mixing daily cocktails." The most current data, based on actual prescriptions filled by marines, demonstrate that less than 7 percent of marines filled a prescription for an antidepressant, antianxiety medication or stimulant during all of 2009. At any one time the percentage is obviously even smaller. Servicemembers with more serious or complicated mental health conditions are more likely to be on multiple medications and these personnel are also more likely to attempt suicide. However, this is not a cause-and-effect relationship as much as a marker of a more serious condition.

Internal Marine Corps suicide reviews have shown that regardless of duty station, deployment, or duty status, the primary stressors associated with marine suicides are problems in romantic relationships, physical health, work-related issues, such as poor performance and job dissatisfaction, and pending legal or administrative action. A fellow marine is the most likely person to notice a change in behavior that may be the first indication of an impending serious problem and the Marine Corps' strategy for dealing with the entire range of stress related issues starts with engaged leadership.

32. Senator GRAHAM. Dr. Rice, Admiral Hunter, and General Green, Brigadier General Loree Sutton, Director of the Center of Excellence for PTSD and TBI, recently testified to the House Veterans Affairs Committee that 17 percent of troops are currently on antidepressants. Is she correct?

Dr. RICE and Admiral HUNTER. Brigadier General Sutton's oral statement is correct that data from the 2007 MHAT–V Report from Afghanistan found 17 percent of U.S. Army soldiers reported taking medication for mental health or sleep problems while deployed. Those medications include, but are not limited to, antidepressants.

General GREEN. Thank you for the opportunity to address this concern regarding the health and well-being of our Air Force members and their use of antidepressant medications. Antidepressant medications are used for more than psychiatric conditions alone. Antidepressants can be used in managing pain conditions, fibromyalgia, and migraine headaches, as examples. Thus the current use of antidepressant medications in the Air Force cannot be directly construed to imply prevalence of psychiatric conditions in our members.

The Air Force has an antidepressant utilization rate of 1 in 63 or 1.6 percent of the Active Force based upon data extracted from the MHS PDTS table in the M2 on March 1, 2010. This figure is a one-day point prevalence.

33. Senator GRAHAM. Admiral Hunter, has your office conducted any kind of study to examine the utilization of prescription medicines by Active Duty members? If so, what were the results?

Admiral HUNTER. The Utilization Management Division of the Pharmaceutical Operations Directorate, within the TRICARE Management Activity, conducts routine utilization studies based on various parameters. The results of these studies show use of prescription medication in the Active Duty population is well in line with trends we see in the non-Active Duty population.

34. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, is more research needed on the effect of psychiatric drugs on performance of military duties?

Dr. RICE and Admiral HUNTER. Further research on the effects of psychiatric medications and how they relate to performance of military duties is needed for continual assessment. It is DOD policy that health care providers must recommend to commanders whether servicemembers with psychiatric disorders or who are prescribed psychotropic medication should be deployed or are fit for military duties.

General SCHOOMAKER. Yes, more research is needed to assess the effect of psychiatric drugs and all medications on the performance of military duties. This is especially true in deployed environments that may require prolonged vigilance and

sustained coordination skills to ensure safe and effective functioning of servicemembers.

Admiral ROBINSON. Psychiatric medications can and do effectively treat symptoms and permit individuals to deploy and to function without compromising performance. When individuals are placed on medications, they are closely monitored by their healthcare provider to ensure they are not experiencing side effects that may compromise their ability to perform their duties. Research on medication effects is currently underway in many sectors and clinical evidence uncovered in research is used to advise the selection of medications.

General GREEN. Yes, more research is needed to assess the effect of not only psychiatric drugs, but all medications, on the performance of military duties. This is especially true in deployed environments that may require prolonged vigilance and sustained coordination skills to ensure safe and effective functioning of servicemembers.

Admiral JEFFRIES. Psychiatric medications can and do effectively treat symptoms and permit individuals to deploy and to function without compromising performance. When individuals are placed on medications, they are closely monitored by their healthcare provider to ensure they are not experiencing side effects that may compromise their ability to perform their duties. Research on medication effects is currently underway in many sectors and clinical evidence uncovered in research is used to advise the selection of medications.

35. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, can you comment on the reasons why various medicines, such as antidepressants, are prescribed and the potential benefits for servicemembers who are receiving them?

Dr. RICE and Admiral HUNTER. Antidepressants, often referred to as psychotropic or psychotherapeutic medications, are prescribed for a variety of reasons, including depression, recurrent headaches, pain, smoking cessation, and specific mental health disorders. Antidepressants, when used with proper medical supervision, in appropriate situations, and in conjunction with other treatments, are important and effective tools for supporting the mental health needs of our Armed Forces.

These medications have changed the lives of servicemembers for the better. Each patient reacts differently to antidepressants, some require only short-term antidepressant treatment while others require long-term treatment for more resistant conditions.

General SCHOOMAKER. Antidepressants, when used with proper medical supervision, in appropriate situations, and usually in conjunction with other treatments, are an important and effective tool for supporting mental health needs, both in deployed settings and at home.

Antidepressants are now prescribed for a variety of diagnoses. They are used for a variety of depressive disorders, and anxiety disorders including PTSD. Certain antidepressants are also used for headaches, pain, and sleep.

There are many different types of antidepressants. The class known as selective serotonin re-uptake inhibitors is very safe, in general. Older agents, known as tricyclics, heterocyclics, and monoamine oxidase inhibitors have more side-effects and are used more rarely. Sometimes they are used for pain and headaches rather than depression. Finally, buproprion is also used as an anti-smoking aid.

The degree of response to medication, ranging from little relief of symptoms to complete remission, depends on a variety of factors related to the individual and the particular disorder being treated. In general, antidepressants are effective for treating symptoms of depression, anxiety, and PTSD.

Admiral ROBINSON. Medications such as antidepressants can be prescribed for a variety of reasons including depressive symptoms, anxiety, recurring headaches, pain, and smoking cessation. In addition, the use of medications can enable an otherwise nondeployable servicemember to effectively complete their mission in a deployed environment—greatly empowering the servicemember and significantly reducing the effects of mental health stigma.

Stigma can be a significant factor in personnel not receiving treatment when treatment is needed. The use of medication in a deployed setting may suggest that servicemembers who need help are increasingly comfortable seeking help, which can significantly reduce the risk associated with untreated psychiatric problems, to include suicidal behavior associated with certain mental health conditions. A potential risk of suggesting that medication use is somehow a negative indicator or a problem is that it may increase stigma, thus inhibiting some from seeking critically important mental health treatment. Mental health medications, when used with proper medical supervision, in appropriate situations, and usually in conjunction with other treatments, can be a very appropriate and helpful part of personnel treatment, both

in theater and at home and permit the servicemember to serve without the impairment that their untreated symptoms could impose.

General GREEN. The prescription and management of medication, in all cases, must be done by a responsible physician working closely with their patient and sometimes the patient's family or other mental health professionals. This is the only way to ensure that the most effective use of medication is achieved with minimum risk of side effects or complications. Psychotropic medications have made dramatic changes in the treatment of mental disorders. Psychotropic medications also may make other kinds of treatment more effective by making it possible for the person to respond better to other therapy and treatment efforts.

Like most drugs used in medicine, they correct or compensate for some malfunction in the body. Psychotherapeutic medications do not cure mental illness, but they do lessen its burden. The degree of response to medication, ranging from little relief of symptoms to complete remission, depends on a variety of factors related to the individual and the particular disorder being treated.

Admiral JEFFRIES. Medications such as antidepressants can be prescribed for a variety of reasons including depressive symptoms, anxiety, recurring headaches, pain, and smoking cessation. In addition, the use of medications can enable an otherwise nondeployable servicemember to effectively complete their mission in a deployed environment—greatly empowering the servicemember and significantly reducing the effects of mental health stigma.

Stigma can be a significant factor in personnel not receiving treatment when treatment is needed. The use of medication in a deployed setting may suggest that servicemembers who need help are increasingly comfortable seeking help, which can significantly reduce the risk associated with untreated psychiatric problems, to include suicidal behavior associated with certain mental health conditions.

A potential risk of suggesting that medication use is somehow a negative indicator or a problem is that it may increase stigma, thus inhibiting some from seeking critically important mental health treatment. Mental health medications have solid medical evidence and research to support their use and when used with proper medical supervision, in appropriate situations, and usually in conjunction with other treatments, can be a very appropriate and helpful part of an individual's treatment. Appropriate use of these medications, both in theater and at home, along with leadership support, facilitate servicemembers continuing to serve without the impairment that their untreated symptoms could impose.

VISION CENTER OF EXCELLENCE

36. Senator GRAHAM. Admiral Hunter, one of the Senate Armed Services Committee's recommendations last year was to rapidly implement the programs and research mandated by Congress for the Vision Center of Excellence. How will the 2011 request support that Center?

Admiral HUNTER. The fiscal year 2011 budget request supports requirements for staffing towards full operational capability of the Vision Center of Excellence (VCE). This full operational capability will include civilian personnel and contract support, completion of Phase One and implementation of Phase Two of the Defense and Veterans Eye Injury and Vision Registry, establishment of the VCE Regional Clinical Centers of Excellence, Vision Support Cells and Vision Deployment Support Platforms, quarterly educational conferences and research symposia, and occupation of permanent facilities.

TASK FORCE ON WOUNDED WARRIOR CARE

37. Senator GRAHAM. Dr. Rice, last year Congress directed DOD to establish a task force to continuously examine care for wounded warriors. What is the status of that task force at this time?

Dr. RICE. The task force is currently in the member nomination and establishment phase.

The membership nomination slate is complete. The Department received input from the Services, Congress, White House Liaison Office, and private sector on the nominations. Currently, the recommended slate of 14 members is being reviewed within the Department and will be completed by April 30, 2010.

The logistical support has been established by the Washington Headquarters Services for facilities, administrative support, and charter. Additionally, the initial support personnel for the task force have been identified along with a preliminary budget.

Throughout this process, we are committed to working with Congress on this vital task force to examine care for wounded warriors.

HEALTH CARE REFORM

38. Senator GRAHAM. Dr. Rice, to the best of your knowledge, are there any primary negative effects of the newly enacted health reform legislation that will negatively impact health care benefits for military personnel, retirees, and their families?

Dr. RICE. No, I do not believe the Patient Protection and Affordable Care Act will have any negative impacts on health care benefits for military personnel, retirees, and their families.

39. Senator GRAHAM. Dr. Rice, are there any secondary effects, such as cutting Medicare payments to physicians and hospitals, or expanding access to care, that could hurt military health care in the future?

Dr. RICE. There may be secondary effects to TRICARE, but we will ensure these effects will not hurt military health care in the future.

Because of this statutory connection between Medicare and TRICARE reimbursement rates, Medicare payment provisions of the Patient Protection and Affordable Care Act will affect TRICARE. We will monitor access to care and, when necessary, use available tools such as locality based waivers to increase payment levels for physicians to ensure adequate access to care for our beneficiaries.

HEALTH CARE WORKFORCE

40. Senator GRAHAM. Dr. Rice, do you agree that America and the military are facing a serious shortage of health care professionals that will only grow over time?

Dr. RICE. Yes, I agree there is a shortage of health care professionals in the military and America. The military departments have a declining inventory of some wartime critical medical specialties. There is also a growing shortage of physicians and nurses in the United States. The pool of medical school applicants is shrinking and the population traditionally applying for the Health Professions Scholarship Program (HPSP) has been declining.

41. Senator GRAHAM. Dr. Rice, how will this shortage of health care professionals affect the military, and are we adequately preparing for it now?

Dr. RICE. Currently, the military has a declining inventory of some wartime critical medical specialties which will affect the care of our servicemembers.

To prepare for and counteract these shortages, the Department relies on Multiyear Special Pay and Incentive Special Pay as critical tools for managing the medical force. Also, DOD annually convenes the Health Professions Incentives Working Group, to make recommendations on incremental adjustments to the existing financial incentives for retention underneath the Federal cap.

42. Senator GRAHAM. General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, you testified recently to the Senate Appropriations Subcommittee on Defense that you all face shortages in medical personnel. Where are your greatest shortages?

General SCHOOMAKER. The AMEDD is experiencing force-wide shortages in certain specific specialties and specialty shortages in certain locations. However, despite the persistent deployment tempo, the national shortage of many healthcare disciplines, and the compensation gap between military and civilian providers, the Army is doing well recruiting and retaining healthcare providers. Recruiting and retention authorities and bonuses are working, but we need to maintain constant vigilance.

The most difficult skill sets to recruit and retain include: fully-qualified physicians with surgical or primary care specialties, dentists (general and specialty), behavioral health professionals, and nurse anesthetists. According to the U.S. Army Recruiting Command (USAREC), one of the greatest challenges in the recruitment of healthcare professionals is simply a lack of awareness of Army Medicine. USAREC is attempting to alleviate this challenge by adopting a strategy of increased marketing of the benefits of Army Medicine.

Additionally, the AMEDD is currently short at the grade of major (O4) across all corps. This is a function of several phenomena; the most notable being the loss of officers in the grade of captain (O3) who had completed their obligation prior to implementation of current retention initiatives, thus decreasing the number of officers

available to promote to the grade of O4. While this overall grade imbalance is true, each corps also has specific specialty shortages at differing grades, signifying a potential capability gap. Recent recruiting success has increased the company grade inventory that will increase the inventory at the rank of major if these junior officers are retained, select specialty training, and earn promotion.

We are addressing resolution of specific specialty shortages through precision recruiting, training, and retention initiatives. We must continue to take full advantage of the recruiting and retention authorities and bonuses provided by Congress if we are to maintain the recent strong results. Our experience over the last decade has proven that incentives, bonuses, and special pays work.

Admiral ROBINSON.

Subspecialty	Percent Manned	Current INV	Authorized
Medical Corps			
Surgery	84	176	210
Family Medicine	84	353	418
Psychiatry	83	93	112
Preventive Medicine	69	38	55
Dental Corps			
General Dentist	86	365	424
Oral Surgeon	81	70	86
Prosthodontist	80	44	55
Endodontist	89	42	47
Medical Service Corps			
Clinical Psychologist	84	106	126
Physician assistant	75	180	241
Social Work	66	23	35
Podiatry	80	16	20
Nurse Corps			
Critical Care Nursing	73	290	396
Perioperative Nursing	81	240	295
Mental Health Nurse Practitioner	55	11	20
Family Nurse Practitioner	82	72	88

Medical Corps

- Recruiting and retaining general surgeons, preventive medicine physicians, family medicine physicians, and psychiatrists will remain a challenge over the next several years. Wartime demand, perceived inequities in pay compared with the civilian sector, and limited student pipelines are contributing factors.

Dental Corps

- Dental Corps has difficulty directly accessing and retaining oral surgeons, prosthodontists, and general dentists because of the pay gap between military and civilian compensation. A general dentist pay package offering significant compensation increases is currently routing through DOD. Additionally the DOD Health Professions Incentive Working Group will be recommending a $20,000 per year increase in incentive special pay for oral surgeons in fiscal year 2011.

Medical Service Corps

- Our greatest shortages are physician assistants, clinical psychologists, podiatrists, and social workers. Retention and recruiting has been affected due to high operational commitments.

Nurse Corps

- High operational commitments are affecting recruiting and retention in all of Navy's nurse practitioner specialties.

General GREEN. The top 10 medical fields not manned to requirements:

- Medical Corps (4):
  1. Flight Surgery (RAM) 182/213* = 85.4 percent (high value, deployable specialty)
  2. Trauma Surgery 11/19** = 57.9 percent (includes 45SXK AFS only; Health Manpower Personnel Data System {HMPDS} data included this sub-specialty within general surgery career field, hence sub-specialty not reported separately; high value, deployable specialty)

3. General Surgery 83/86** = 96.5 percent (includes 45S AFS only; HMPDS data shows 87/83* @ 104.8 percent; due to declining manning and increasing authorizations for fiscal year 2010, higher number reported under HMPDS; high value, deployable specialty—using Critical Skills Retention Bonus {CSRB} to maintain numbers)
4. Family Practice 495/551** = 89.8 percent (recent AFMS emphasis on FHI dramatically drove increased authorizations, while pipeline remains at flat rate due to demands of other specialties, rising authorizations in fiscal year 2010 over HMPDS data of 473/435 @ 108.7 percent significantly dropped percent manning for fiscal year 2010)

- Nurse Corps (2):
  1. Operating Room Nurse 219/237* = 92.4 percent (high value, deployable specialty)
  2. Flight Nurse 100/190* = 52.6 percent (high value, deployable specialty/air transport wartime demand)
- Biomedical Sciences Corps (2):
  1. Clinical Psychologists 215/255* = 84.3 percent (increasing wartime demand/limited pipeline)
  2. Pharmacists 233/253* = 92.1 percent (high value, deployable specialty)
- Enlisted Medical Corps (2):
  1. Independent Duty Medical Technician 415/625* = 66.4 percent (high value, deployable specialty)
  2. Orthopedic Technician 98/151* = 64.9 percent (high value, deployable specialty)

Admiral JEFFRIES. I did not testify at the referenced hearing. This question is most appropriately answered by the Service Surgeons General.

43. Senator GRAHAM. General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, does the budget request fully fund your requirements for scholarships, special pays, loan repayment, and accession and retention bonuses that you need to ensure the future readiness of the military medical components?

General SCHOOMAKER. The budget request does not fully fund all requirements for scholarships, special pays, loan repayment, and accession/retention bonuses across all components. For the Active component, the budget fully funds requirements for scholarship and loan repayment programs. Sweeping changes made to the DOD Health Professions Special Pay Program by Section 661 of National Defense Authorization Act for Fiscal Year 2008 expanded special pay opportunities to include psychologists, social workers, physician assistants, veterinarians, general dentists, and critical wartime specialty accessions. Army Medical Command is working closely with the Army staff to ensure special pays are supported to the maximum extent possible.

For the Army Reserve, the budget request fully funds the Health Professions Scholarship Program and the Army Reserve Health Incentives Program. While the budget request does not fully fund the Army Reserve to achieve the health professions recruiting mission, it does account for increases in mission accomplishment. As these incentives are implemented, the Army Reserve will continue to analyze the return on investment in terms of recruiting and retention and update our models appropriately to ensure the incentives programs continue to be properly funded.

For the Army National Guard, the budget request fully funds existing requirements. However, greater than 30 percent of the Army National Guard's current Medical, Dental, and Medical Specialists Corps personnel are within 1 year of their retirement eligibility date and are not eligible for incentives under current DOD regulations. The Army is reviewing proposals to ensure all available incentives are available to our critical skill personnel, regardless of the number of years' service they have within the Reserve components.

Admiral ROBINSON. The President's budget for fiscal year 2011 fully funds incentive programs for recruitment and retention of Navy healthcare professionals. We continue to closely monitor these programs to identify any need for additional resources that may be required to meet emerging growth requirements and future readiness among healthcare professionals.

General GREEN. For the current fiscal year 2010 budget and the fiscal year 2011 budget submission, the AFMS is provided sufficient money from the Line of the Air Force to cover our current projected cost of the Medical Special and Incentive Pays

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Data source: *Fiscal Year 2009 HMPDS, **9 Apr. 10 AFPC/DS data extrapolation by Lt Col Terry Mathews/SG1D

Program (special pays, accession bonuses, incentive pays, and retention bonuses). Any cuts to the fiscal year 2011 budget submission affecting Air Force Special and Incentive Pays program will have a drastic and lasting effect on accession and retention of our critical specialties. The money under the Medical Special and Incentive Pays Program covers all medical entitlements and contracted pays. Our incentive and retention pays are all contract linked and require military obligations for the fully-qualified member to receive. Our accession bonuses are currently covered for the projected increase in fully-qualified health professions officers recruiting requirements and also require a mandatory military obligation to be eligible. To avoid a possible revolving door program of accessions and separations, the AFMS will require an adjustment to the Line of the Air Force money provided to the AFMS for Medical Special and Incentive Pays Program, possibly as early as fiscal year 2014 or fiscal year 2015. As these newly accessed health professions officers complete their initial military obligations and become eligible to either separate or contract for enhanced compensation contracts under the new authorities of 37 U.S.C. 335, we must remain within 75 percent of comparable direct salary compensation to stay viable and competitive with the private sector health care employment market and retain these critical and experienced health care professionals.

HPSP/Financial Assistance Program funding for fiscal year 2010 from the Air Force Reserves and Defense Health Program are fully funded. Current projected funds will support our steady state of 1,666 participants starting in fiscal year 2011.

Admiral JEFFRIES. The President's budget for fiscal year 2011 fully funds incentive programs for recruitment and retention of Navy healthcare professionals. We continue to closely monitor these programs to identify any need for additional resources that may be required to meet emerging growth requirements and future readiness among healthcare professionals.

MENTAL HEALTH

44. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, we recently received a report from DOD which concluded that: there is an increased need for civilian mental health care providers within DOD; that the supply in the civilian labor market may not meet the demand; and we should pilot a scholarship program for civilian mental health providers in exchange for a commitment to serve in areas where there are DOD beneficiaries. Do you agree that such a program could be beneficial?

Dr. RICE and Admiral HUNTER. We agree there is an increased need for mental health providers with DOD. We are working hard to ensure the MHS remains competitive to recruit from the civilian labor market and to answer the Deputy Secretary of Defense's challenge to "grow our own" mental health professionals.

To those ends, we have proposed legislation for a scholarship program for health professionals, initially targeting mental health professionals. This legislation is entitled Health Professions Financial Assistance Program for Civilians. This program will give the Services authority to provide pay and allowances for civilians toward their education within the health professions focusing on mental health professions. This program will be given in exchange for a commitment to DOD service, ensuring additions to our inventory of critical specialties. We request congressional support for this important legislation.

General SCHOOMAKER. I have concerns about piloting a scholarship program for civilian mental health providers. Such a scholarship program may not work for all behavioral health specialties, as each specialty has unique educational requirements. Physicians who attend medical school would have to commit to a particular specialty (e.g., psychiatry) when applying to medical school. Very few people enter medical school with a clear idea of what specialty to pursue and many change their mind several times during the 4 years of medical training. Therefore, requiring a person to commit to a particular specialty prior to entering medical school is not practical. In addition, there is no guarantee that the person will match to a residency training program in that specialty 4 years later.

Similarly, a scholarship program for clinical psychologists could face significant difficulty. Clinical psychologists complete 3 to 4 years of academic coursework plus a dissertation and a 1-year internship prior to award of the doctorate; they follow this with an additional year of post-doctoral supervision prior to licensure. There are many opportunities for students to be derailed from their training plans that make a scholarship program problematic. The Army has a tight process for selecting HPSP recipients for the military, but we still find almost 20 percent of students do not meet qualification standards by the time they reach the internship. Each student who does not complete their training is a loss of about $100,000.

The Army already has an educational program for producing social workers. We are in the second year of the new Army Masters of Social Work (MSW) program. Originally only offered to servicemembers, the MSW program has expanded to include Federal service employees, and will further expand next year to include non-Federal civilians.

The Army has expended great effort and has seen strong success recruiting civilian behavioral health providers over the last 5 years. Army records indicate an increase of 861 civilian behavioral health providers from March 2006 to March 2010, or 105 percent increase for a total on-board strength of 1,680 civilian behavioral health employees. Increases among these behavioral health occupations include: (1) Psychologists (an increase from 288 to 533 or an 85 percent increase); (2) Social Workers (an increase from 369 to 854 or a 131 percent increase); (3) Psychiatrists (an increase from 89 to 131 or a 47 percent increase); and (4) Psychiatric Registered Nurses (an increase from 73 to 162 or a 122 percent increase). To achieve the 105 percent increase in civilian behavioral health providers, Army Medical Command (MEDCOM) has aggressively pursued several actions. For the past 3 fiscal years, MEDCOM centrally funded $1.5 million annually for the student loan repayment program for registered nurses, including psychiatric registered nurses. MEDCOM also set aside monies for recruitment, relocation, and retention incentives for all healthcare occupations. A little more than $11 million was granted to civilian employees in the four behavioral health occupations during the last 18 months through the end of March 2010.

Admiral ROBINSON. Navy Medicine has been generally successful hiring civilian and contract mental health providers. The Services, as well as the VA, continue to pursue a limited pool of applicants which has become more challenging especially in remote locations. Careful cost-benefit analyses in support of initiatives such as a civilian scholarship program must be conducted and the potential impact on current military scholarship programs must be assessed. We would not support competing scholarship programs. We rely on our current military scholarship programs as the primary source for commissioning military health care providers.

General GREEN. With respect to the idea of a civilian scholarship program, I feel that the establishment of such a program would compete with the recruitment of Active Duty mental health providers, which has been a significant challenge for the Air Force. This would be particularly true for our HPSP. While civilian employee mental health providers are a pivotal part of the military mental health care delivery system, we recommend continuing to emphasize the recruiting and retention of Active Duty providers who can fill certain roles only they can perform—most notably deployment.

We already have existing, vacant civilian mental health provider positions and so the issue is how to better recruit and retain civilian providers, with a particular focus on those Air Force bases located in areas underserved by civilian mental health providers. To do this, we should seek to maximize a number of initiatives already in place that could have positive effect on this situation:

1. Existing DOD Direct Hire Authority for medical occupations is a valuable recruiting tool and has made a positive impact on medical occupation accessions.
2. Multiple tools are available for civilian employees for both accession and retention purposes:
   - Recruitment bonuses for new accessions (up to 25 percent of base salary)
   - Retention allowances to sustain high caliber employees (up to 25 percent of base salary)
   - Credit for non-Federal and Uniformed Service experience for annual leave accrual for new employees
   - Student Loan Repayment for new accessions ($10,000 per year with $60,000 max payment)
3. Superior Qualification Appointments (for GS employees only) provides an advance in-hire rate up to Step-10 of assigned grade.

In addition, I would like to see incentives for those professionals willing to relocate and work on bases underserved by local civilian mental health professionals. Those areas generally provide very little in the way of a pool of candidates for positions on base.

Lastly, I encourage Congress to consider reviewing TRICARE reimbursement rates and business rules to see if there may be opportunities to encourage community civilian providers to join and expand existing TRICARE networks. Family members in certain markets frequently report challenges accessing providers willing and able to accept network referrals.

Admiral JEFFRIES. Navy Medicine has been generally successful hiring civilian and contract mental health providers that support the Marine Corps. The Services, as well as the VA, continue to pursue a limited pool of applicants which has become more challenging especially in remote locations. Careful cost-benefit analyses in support of initiatives such as a civilian scholarship program must be conducted and the potential impact on current military staffing and scholarship programs must be assessed prior to initiating such an effort. Current military scholarship programs are the primary source for commissioning military health care providers that support the Marine Corps and the development of a competing program may have undesirable consequences.

TRICARE FOR RESERVES

45. Senator GRAHAM. Admiral Hunter, I was gratified to learn that enrollment in TRICARE for Reserves has grown significantly since last year but there is still concern among the personnel chiefs of the Services that the word is not getting out to reservists. How can we improve the marketing of this program?

Admiral HUNTER. We are committed to improving the marketing of this program to reach every potential TRICARE Reserve Select (TRS) beneficiary.

TRICARE Management Activity and OASD (Reserve Affairs) are collaborating to ensure each Reserve component member has the necessary information to make an educated decision regarding the purchase of TRS.

Reserve Affairs issued a Policy Memorandum governing TRS. This requires each of the Reserve components to develop and execute a communications plan to all of their members. The Communications Plan for 2010 is designed to emphasize informing both Reserve members and family members, to enable the entire military family to make the health care decision together.

46. Senator GRAHAM. Admiral Hunter, I am not happy to hear that implementation of TRICARE for Gray Area reservists is taking so long. When will it be up and running?

Admiral HUNTER. We anticipate TRICARE for Gray Area reservists will be up and running and benefits in place no later than October 2010.

POST DEPLOYMENT HEALTH RE-ASSESSMENTS

47. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, many of you have indicated that the Post-Deployment Health Reassessment (PDHRA), is an effective program to identify health concerns that may emerge over time following deployment. In November 2009 the GAO reported that substantial numbers of records from Active and Reserve servicemembers who returned from Iraq or Afghanistan were missing from the DOD central database—in fact nearly 25 percent were missing. How can we and the Department have reasonable assurance that servicemembers are getting the care that they need when nearly one out of four of these records is missing?

Dr. RICE and Admiral HUNTER. The GAO findings led to a number of actions within DOD. I believe these actions convey reasonable assurance servicemembers are getting the care they need.

The actions initiated include:

- A memorandum sent to the Services reemphasizing the need for all eligible servicemembers to be offered the PDHRA.
- The DOD central database at the Armed Forces Health Surveillance Center (AFHSC) established a mechanism with each Service to ensure PDHRAs sent by the Services are received at the AFHSC.
- We have obtained a list of "missing" servicemembers from the GAO and are having the Services examine the reasons for why the expected PDHRAs were not present.
- A working group was formed to both monitor the Services' efforts to increase the percentage of servicemembers taking advantage of the PDHRA and to exchange successful initiatives and lessons learned across Services.

General SCHOOMAKER. The number of soldiers who complete their PDHRA is significantly higher now than when the program was initiated Army-wide in 2006. To ensure these records reach the DOD central database, we now conduct a reconciliation of records ("handshake") each month between the DOD database and the Army database. So far, this check is showing 100 percent record transfer between these two databases.

To improve compliance, we increased communication outreach to support commanders by mailing reminder postcards and emails to soldiers who are eligible for the PDHRA. Soon, we will begin to send email reminders to soldiers in all three components when they become eligible for the PDHRA and will follow up with several more email reminders as needed.

There are a variety of programs available to soldiers to self refer for care if needed such as the soldier hotline. The Reserve component uses the Yellow Ribbon Program for soldiers to complete the PDHRA and to provide many more services which includes family assistance, pre- and post-deployment services, education, and Veteran Affairs. The Reserve component audits the Regional PDHRA leadership to check compliance and also visits units to check compliance.

Increasing soldier PDHRA completion along with proper record transfers will result in more records in the DOD central database. The combination of identifying care needs from the PDHRA and our current efforts to ensure appointments are kept will provide soldiers the care they need.

Admiral ROBINSON. The GAO Report focused on servicemembers who returned from deployment between January 2007 and May 2008. Since that time, Navy has made significant progress in establishing policies and procedures to ensure timely and accurate completion of deployment health assessments. Coordinated efforts by the medical, line, and personnel communities have resulted in an effective implementation plan for meeting PDHRA program requirements. Key elements include: clear delineation of roles and responsibilities; line involvement in ensuring compliance; increased medical resources; improved information management systems and data transfer processes; and support from senior leadership. Navy currently reports a PDHRA compliance rate of 90 percent and continues to work toward a goal of ensuring that all of our returning servicemembers receive the care they need.

General GREEN. In a November 2009 audit report, the GAO identified PDHRA records were missing for 8,162 Air Force deployments, constituting 16 percent of the total number of Air Force PDHRA records expected at AFHSC. However, upon further investigation, the Air Force identified all but 3 percent of expected PDHRA records, attributing unidentified records to attrition, frequent deployments, and incorrect deployment data.

To ensure PDHRA documentation for all eligible deployments, the Air Force has implemented a number of initiatives, including: (1) establishing deployment-health requirements, including the PDHRA, as required components of in- and out-processing checklists; (2) contacting servicemembers at multiple points (90, 120, and 150 days) after return from deployment if they have not yet completed the PDHRA; (3) developing a data-verification process with AFHSC to ensure all data sent by the Air Force is received by AFHSC; and (4) developing a data-use agreement with sister Services to prevent loss of PDHRA completion data for members completing the PDHRA in sister-Service applications.

Admiral JEFFRIES. The Marine Corps is committed to the health and wellbeing of marines. The PDHRA is one tool that is used to discover marines who have concerning symptoms who for some reason may have not yet been identified. A recent audit revealed that 84 percent of marines had successfully completed their required PDHRA. While this rate offers more opportunities for improvement, it does show improving performance. One key element to improving the PDHRA rate is to ensure that leaders have the tools they need to know which marines under their command are required to complete a survey. The Marine Corps has developed a specific field in the Medical Readiness Reporting System (MRRS) on PDHRA completion that is anticipated to make tracking of marines who are required to complete a survey easier for leaders.

The PDHRA is not the only opportunity to discover marines with ongoing health concerns. The annual Periodic Health Assessment provides each marine with a personal interaction with a health care professional who can address any concerns. Marines also have open-door access to Deployment Health Clinics that are staffed with medical professionals, including mental health professionals, who can be accessed in a non-stigmatizing environment.

48. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, I believe that DOD needs to include in its quality assurance program a reliable means of determining whether or not servicemembers referred for care following a deployment, actually receive it. Do you agree?

Dr. RICE and Admiral HUNTER. Yes, we agree that a reliable means of determining whether or not servicemembers referred for care following deployment actually receive it.

To address this, the DOD Quality Assurance Program monitors, audits, and reports on the health care provided to Active Duty and Reserve components (while on Active Duty) culminating in quarterly reports to the Service Surgeons General, and an annual report to Congress.

General SCHOOMAKER. I agree that it is critically important to have a reliable means of determining whether servicemembers referred for care following a deployment actually receive care. To emphasize this importance, Army Medical Command tracks referral completion quarterly for the PDHRA on the organization's Balanced Scorecard and PDHA referral tracking is included as part of the command's Organizational Inspection Program.

The Army PDHRA Implementation Plan, dated January 23, 2006, mandates that soldiers be case-managed to ensure they are able to access needed healthcare. The Army Medical Command policy also includes guidance to the Regional Medical Commands mandating tracking of referrals for the Active component to ensure care.

Most recently, the Army developed an automated web-based tool to help track referrals from all health assessments. Enterprise-wide policy guidance will include direction on case management and reporting methods to ensure accountability. Army has released this tool for all components concurrently with the decision to change from a retrospective to a prospective tracking requirement.

The Reserve component is working to acquire funds to allow soldiers to receive travel orders to attend follow-up appointments at VA facilities as a result of the PDHRA. In addition, the Reserve Component Recovery Care Coordinators will help ensure these soldiers get to their appointments and receive the care that they need.

Admiral ROBINSON. Navy Medicine concurs that a reliable means of determining referral completion is important and a key component to ensuring that our sailors and marines receive the care they need. In addition to expanding best practices throughout the system, two Navy Medicine initiatives are underway to help address this issue. They include: (1) the development of a Referral Management Policy to ensure standardized tracking of referrals; and (2) exploration of a population health management demonstration program that is intended to coach patients through the referral process in order to facilitate the execution of referrals.

General GREEN. In accordance with DOD policy, PDHRA quality assurance must ensure referrals and follow-up visits for deployment-related medical concerns and issues are accomplished. To comply with this mandate, Air Force policy directs medical treatment facilities (MTF) to review members' medical records for pending or incomplete referrals when members separate, retire or transition to new assignments. The review also must identify any outstanding deployment-health requirements.

The Air Force will soon employ additional PDHRA quality assurance measures, and is developing a referral tracking function for the PDHRA web application. This functionality, which will be deployed Air Force-wide in August 2010, will expand the ability to ensure referral appointments occur as prescribed. Additionally, high-level oversight of PDHRA completion rates will include surveillance of PDHRA-referral completion metrics.

Admiral JEFFRIES. Navy Medicine concurs that a reliable means of determining referral completion is important and a key component to ensuring that our sailors and marines receive the care they need. In addition to expanding best practices throughout the system, two Navy Medicine initiatives are well underway that further support the Marine Corps and will help address this issue. They include: (1) the development of a Referral Management Policy to ensure standardized tracking of referrals; and (2) exploration of a population health management demonstration program that is intended to coach patients through the referral process in order to facilitate the execution of referrals.

HEALTH CARE FRAUD

49. Senator GRAHAM. Dr. Rice, I have read that Medicare has a fraud rate of as high as 10 percent—the highest rate of any Federal program. What is your estimate of the potential fraud in DOD medical care?

Dr. RICE. The National Health Care Anti-Fraud Association estimates the most generally accepted range from 3 to 7 percent. While no precise estimate can be made, TRICARE reasonably estimates fraud at the lower end of 3 percent of the Department's private sector health care expenditures. This estimate is based on the numerous pre- and post-pay controls in place.

We are continuously enhancing TRICARE's antifraud program and looking for areas of vulnerability to decrease dollar losses and increase returns to the program.

50. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, do you have sufficient resources to prevent fraud and investigate physicians, hospitals, or laboratories who attempt to commit fraud in DOD health care?

Dr. RICE and Admiral HUNTER. We have sufficient resources to prevent fraud and investigate physicians, hospitals, or laboratories who attempt to commit fraud in DOD health care at this time.

TRICARE Management Activity (TMA) has committed a host of resources to prevent, curtail, indentify, and investigate fraud, waste, and abuse. TMA continually reviews its fraud program and pursues enhanced fraud fighting tools. Recent enhancements include additional dedicated staff to combat fraud, award of the contract for pharmacy fraud detection data mining, and more rigorous requirements for Managed Care and Pharmacy Contractors.

General SCHOOMAKER. The Army Medical Command has sufficient resources to prevent fraud and investigate it if it does occur. We have a large staff of contract and fiscal law attorneys at the Command Headquarters and have increased the number of attorneys since 2008. Two of the attorneys specialize in procurement fraud prevention and advice. We do not have criminal investigators within the command, but we do have the resources of the U.S. Army Criminal Investigation Command (CID) available to us, and we receive excellent support from their agents. We provide ethics training throughout the command, particularly for those in the acquisition community, and I have directed that a video on unauthorized commitments (produced by our contract law attorneys) be shown at all ethics training this calendar year. We have a robust inspection program of our regional contracting offices, and the inspection team takes one of our contract law attorneys with them to provide additional specialized training and advice. I also place a good deal of emphasis on our command off-duty employment rules for providers, to ensure that Army providers do not engage in work arrangements that would conflict with the interests of DOD or our patients. I issued a new command regulation on this subject in 2008, and this is a topic regularly included in ethics training, particularly in ethics training for providers.

Admiral ROBINSON. This question requests information regarding DOD resources in support of the detection of health care fraud. As such, it is most appropriately answered by the Assistant Secretary of Defense (Health Affairs)/Director, TRICARE Management Activity.

General GREEN. The Air Force does have adequate resources to prevent and investigate fraud in Air Force Medical Service (AFMS) healthcare. We utilize a two-pronged approach to combating fraud in the AFMS.

In working with our TMA partners to provide appropriate off-base specialty care to our beneficiaries, the TMA identifies and investigates fraud on both the provider and patient level. Much of the provider fraud relates to billing for services that were not performed, or knowingly overbilling for work done. Many of the patient fraud incidents that are identified relate to former beneficiaries who continue to seek and obtain care within the AFMS after their eligibility for such care has expired.

The second, equally important aspect of our anti-fraud effort, is our annual statement of assurance/management internal control (SOA/MIC) program which assesses each Medical Treatment Facility (MTF) in several key fraud-susceptible areas.

The SOA/MIC program includes the following assessable units:

- Review of medical services contracts
- Review of local anti-fraud programs at MTFs
- Quality Assurance/Risk Management program review
- Custody and control of medical records
- Information security controls
- Defense Enrollment Eligibility Reporting System identification card checks and confiscation of expired identification cards.

Admiral JEFFRIES. This question requests information regarding DOD resources in support of the detection of health care fraud. As such, it is most appropriately answered by the Assistant Secretary of Defense (Health Affairs)/Director, TRICARE Management Activity.

MEDICAL SUPPORT FOR THE MARINE CORPS

51. Senator GRAHAM. Admiral Jeffries, General James T. Conway, USMC, testified last year that the military may be rethinking the so-called "golden hour" policy of evacuating wounded troops off the battlefield within 60 minutes. Can you comment on what the situation is on the battlefield today?

Admiral JEFFRIES. Currently, average medical evacuation times continue to be measurably less than 60 minutes. For operational planning purposes, the target to complete medical evacuations in less than 1 hour is unchanged.

The issue that General Conway referenced is that commanders and medical personnel working in close collaboration should not be beholden to a medical evacuation time of less than 60 minutes if operational and clinical considerations support a slightly longer time. Rather than focusing on a set timeframe from injury to arrival at an advanced treatment location, superb trauma care requires delivering high quality on-scene/first responder treatment and triage followed by expeditious and appropriate level 2 interventions or immediate transport to level 3 care. With more advanced medical capabilities moved ever closer to the areas of military engagements and with the wide use of Tactical Combat Casualty Care principles some injured servicemembers receive care in the first few minutes following an injury that may make the decision to accept a slightly longer evacuation time to a more appropriate level of care the best course of action in some situations.

52. Senator GRAHAM. Admiral Jeffries, are there sufficient resources—surgeons and mental health providers—to save lives in Afghanistan as we did in Iraq?

Admiral JEFFRIES. Absolutely yes. The Marine Corps continues to receive excellent support from Navy Medicine. The survival rates from the Afghanistan Area of Operations remain at historic highs even in the face of an aggressive and creative enemy. Psychological Health support to the operational Marine Corps forces remains Navy Medicine's top mental health imperative.

53. Senator GRAHAM. Admiral Jeffries, are there sufficient medical resources to support Marine Corps wounded warriors?

Admiral JEFFRIES. Yes, there are sufficient resources. However, it takes much more than medical expertise to fully address the needs of wounded marines. Since activation in April 2007, the Wounded Warrior Regiment has provided a wide range of nonmedical care for the injured and ill. The Marine Corps now has wounded warrior battalions at Camp Pendleton and Camp Lejeune and detachments at other installations.

The Marine Corps is investing $50 million from the 2009 Overseas Contingency Operations supplemental for the construction of resource and recovery centers at Camp Pendleton and Camp Lejeune. These recovery centers will provide spaces for counseling, physical therapy, employment support, financial management, and other training and outreach programs in support of our wounded.

With a 24-hour call center for wounded marines and their families, the Wounded Warrior Regiment has contacted 99.4 percent of all marines (7,654 out of 7,703) who were wounded since the beginning of Operations Iraqi Freedom and Enduring Freedom, in order to determine their health status. The Marine Corps also maintains a toll-free number to the medical center in Landstuhl, Germany, for families to contact their loved ones who have been wounded.

GOLDEN HOUR

54. Senator GRAHAM. General Schoomaker, could you please elaborate on your testimony regarding a "platinum 15 minutes"?

General SCHOOMAKER. The golden hour is a term coined in the 1970s for trauma patients referring to the mortality of trauma patients rising steeply 1 hour after injury without definitive surgical care. The "platinum 15 minutes" refers to medical care that may improve survival rate and extend the golden hour time frame if certain life-saving interventions are performed within 15 minutes of injury. Some of these life-extending actions include haemostatic control, definitive airway management, and correction of tension pneumothorax. Our combat casualty care training and education programs emphasize these capabilities for our combat medics and first responders.

55. Senator GRAHAM. General Schoomaker, what are you trying to convey about the doctrine for combat casualty care?

General SCHOOMAKER. Seven years into the long war against terrorism with tens of thousands of battle casualties and over 4,000 combat deaths, the Army has learned many hard lessons of combat and combat casualty care. We continue to learn new lessons as the enemy's tactics and weapons evolve and our ability to counter them and to save the lives of soldiers both before and after injury evolves. The power to actively study its own performance and that of its enemy in near real time is the hallmark of a learning organization in the 21st century. Army Medicine,

in concert with our U.S. and coalition partners, approaches the challenges of combat casualty care with the same systematic processes and analytical rigor as we do all of our core missions: we collect the data, we analyze it for lessons learned, we act on the information in one or more of the appropriate domains (Doctrine, Organization, Training, Materiel, Leadership, Personnel, and Facilities); and we verify that these actions have been done and measure their effects. With regard to the care of battle casualties, these processes have resulted in significant changes in many areas, especially the following:

The concepts and principles of Tactical Combat Casualty Care (TCCC) dramatically changed care at the point of injury, blending tactical considerations with the epidemiology of the battlefield. TCCC focuses directly on the immediate care of battle casualties in those tactical situations where the threat, the specific injuries most frequently suffered by our soldiers, and the special skills and equipment needed to save those soldiers' lives all come together and where immediate medical actions during the platinum 15-minutes make the difference between life and death. TCCC divides point of injury care into three logical phases: Care Under Fire, during which the key actions are suppressing the enemy's fire, rescuing casualties from danger, and doing only those few life-saving interventions that must be performed within minutes of the injury; Tactical Field Care, during which additional interventions directed at the main causes of preventable mortality in combat are performed; and Tactical Evacuation Care in which those life-saving interventions are maintained and additional measures taken while the casualty is moved to a forward medical facility.

The concept of Damage Control Resuscitation (DCR) is a marked change from previous methods of fluid resuscitation that concentrates on early and aggressive use of blood and blood products to correct or even prevent what is referred to as "the lethal triad:" hypothermia (low body temperature), acidosis (excessive acid in the circulation), and coagulopathy (failure of the blood clotting system). To further improve our ability to provide DCR, the development of new FDA-compliant blood products and new treatments to address trauma at the cellular or even molecular level are high priorities for our medical research and development efforts.

Damage Control Surgery (DCS) calls for the performance of targeted surgical interventions at forward surgical facilities in order to control internal bleeding and reduce internal contamination so that the casualty can then be evacuated to more robust surgical facilities for definitive surgical repair and further care.

The medical resources and processes of the entire theater (all U.S. Services and, in many instances, those of our coalition partners) are integrated and coordinated within the Joint Theater Trauma System (JTTS) to minimize mortality and morbidity and to optimize the ability to provide essential care, getting the right patient to the right place at the right time to receive the right care. The JTTS components include prevention, pre-hospital integration, education, leadership and communication, quality improvement/performance improvement, research, and information systems.

The AMEDD today captures the best knowledge and most recent experiences of combat medics, surgeons, nurses, and the whole AMEDD team in both theaters and uses that knowledge to achieve the highest battle casualty survival rates in history. However, although what we do today reflects the current best practices, we are well aware that new technologies, new data, and new tactical and strategic challenges will make some of this information obsolete. The systematic and rigorous study of battlefield medical care will make today's AMEDD soldiers and their successors learning medics in a learning organization dedicated to conserving the fighting strength and saving lives in combat.

56. Senator GRAHAM. General Schoomaker, how does it differ from the successful practices in Iraq, and what results will it achieve?

General SCHOOMAKER. The critically wounded servicemen in both Iraq and Afghanistan are being delivered to surgical facilities consistently in less than 1 hour. We have increased our resources, changed our force structure, and invested in improvements to take care of the wounded in Afghanistan. The Army implemented several initiatives to achieve this standard, the greatest being the increase in assets deployed to the theater. In March 2009 there were 15 HH–60 MEDEVAC helicopters and 3 Forward Surgical Teams (FST) deployed. Today the Army has deployed 42 HH–60 MEDEVAC helicopters and 8 FSTs. Additionally, the Army's increased assets include Role III surgical augmentation and a medical brigade command and control headquarters. Other initiatives include changing doctrine for aeromedical evacuation to 1 hour for urgent and urgent surgical missions and streamlining launch procedures. The Army's force structure changes include a May 2009 decision to aggressively grow nine additional MEDEVAC companies in the Re-

serve component (two of which will be deployed this year). Additionally, in October 2009, the Army changed the force design of each of the 37 MEDEVAC companies, increasing from 12 aircraft and 12 crews to 15 aircraft and 20 crews (13 Active component, 21 ARNG, and 3 USAR). The first of these new designed companies deployed in March 2010. All of these efforts have brought MEDEVAC response times in Afghanistan below the 1-hour standard.

DISABILITY EVALUATION SYSTEM

57. Senator GRAHAM. General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, the DES within DOD and VA is still too long, and too complicated, do you agree?

General SCHOOMAKER. Yes. The DES within DOD and VA is still too long and complicated. Current military disability law fosters a DES that is complex and adversarial. Soldiers still undergo dual adjudication by the military and VA based on the laws, legal opinions, and policies specific to each, resulting in differing outcomes between the two agencies for the same type of determination. Soldiers receive a rating for unfitting conditions by the military, and a rating from the VA for all service-connected conditions. This leads to confusion and mistrust.

DOD and VA launched a joint pilot model on November 26, 2007, as a way to improve the DES within the constraints of current law. The DES Pilot features a single medical examination based on VA disability examination templates and a single-sourced disability rating provided by VA rating officers. The Departments share the examinations and disability ratings, resulting in more consistent decisions and faster approval of disability benefits and compensation. Refinements made by the DES Pilot are an improvement, but are insufficient.

The only way to significantly improve the process is to change the law. The Army has been advocating for eliminating dual adjudication from the current DES, and moving to a system where the military determines fitness for duty and the VA determines service-connection and disability rating as part of the soldier's transition. Under this kind of system, the military compensates for loss of career due to disability based on years of service, and VA compensates for disability and loss of earnings potential.

Admiral ROBINSON. The DES Pilot provides significant improvement over the existing DES process, which is often time-consuming and complicated. The DES Pilot is a servicemember-centric initiative designed to eliminate the duplicative, time-consuming and often confusing elements of the two current disability processes of DOD and the VA. While there are instances where the time processing goals under the DES Pilot are not met, extended process delays typically result from the need to obtain additional medical information to ensure proper adjudication of the case. The majority of cases under the DES Pilot are completed within predicted time standards, and members receive considerable aid, counsel, and support along the way. Cumulative DES Pilot survey results for the period November 2007 through March 2010 indicate sailors and marines are significantly more satisfied with the DES Pilot than with non-Pilot Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processes.

Historically, the DES has been considered complicated and difficult to understand. The DES Pilot is specifically designed to streamline and simplify the existing complex process and to enhance transparency for servicemembers. Under the Pilot, the VA performs one medical exam that meets the needs of the DOD in determining fitness for continued military service and also provides the basis for the VA to rate the servicemember's disabilities if he/she has been determined to be unfit by their Service PEB. The servicemember is not directly involved in certain complexities driven by law, regulation, or administrative circumstances. Aside from counseling and support interactions, the DES Pilot typically only involves direct servicemember interaction at the following milestones:

1. VA Claim Development
2. Compensation and Pension (C&P) physical examinations
3. Review of Medical Evaluation Board Package
4. Election of Options following the Informal PEB determination
5. Formal PEB (if applicable)
6. Notification of Formal PEB determination (if applicable)
7. Appeal process (if applicable)

These steps ensure transparency and guarantee protection of due process rights. By enabling servicemembers to receive Title 10 and Title 38 disability benefits on the first day authorized by law following separation or retirement, the DES Pilot

offers a much improved process for members who are evaluated for continued service, separation, or medical retirement.

General GREEN. The DES Pilot has been successful in enabling our veterans to only have to undergo one physical exam process and receive one disability rating, greatly reducing the time involved, resources expended, and confusion incurred from the legacy system. Additionally, the DES Pilot has reduced the financial loss for the separated and retired veterans who previously would have had to wait the duration of the VA process before receiving compensation.

According to information provided by the Wounded Warrior Care and Transition Policy office in their latest analysis of case processing time in the DES Pilot:

> "The DES Pilot is "faster, more efficient, effective, and transparent. Active component servicemembers who completed the DES Pilot averaged 277 days from Pilot entry to VA benefits decision, excluding pre-separation leave. Including pre-separation leave, Active component servicemembers completed the DES Pilot in an average of 293 days. This is 1 percent faster than the goal established for Active component servicemembers and is 46 percent faster than the current DES and VA claim process. Reserve component/National Guard servicemembers who completed the DES Pilot averaged 289 days from Pilot entry to issuance of the VA Benefits Letter, which is 5 percent faster than the projected 305 day timeline (DES Pilot Weekly Report with Outlier Analysis Appendix, March 22, 2010–March 28, 2010)."

Admiral JEFFRIES. The DES Pilot process is proving to be a significant improvement in the way our wounded, ill, and injured sailors and marines navigate the DES and attain their disability benefits. While there are incidents of process delays, these are typically due to obtaining information vital to the proper adjudication of that case. Most servicemembers move through the DES Pilot within predicted time standards and receive considerable aid, counsel and support along the way. The DES Pilot is helping to make a process frequently perceived as complex easier to understand and more transparent from the perspective of the servicemember. Servicemembers receive both their title 10 and title 38 disability benefits on the first day authorized by law following separation or retirement. Based upon the cumulative DES Pilot Survey Results for the period November 2007 through 31 March 2010, sailors and marines are significantly more satisfied with DES Pilot than with non-Pilot MEB and PEB processing.

The DES still can appear overly complex to people who interface with it infrequently, but most of these complexities do not directly involve the servicemember or require them to act. The DES Pilot has several critical steps that enhance transparency and ensure due process rights are upheld. Servicemembers are provided significant counseling and support during these critical steps that include:

1. VA Claim Development
2. Compensation and Pension (C&P) physical examinations
3. Review of their Medical Evaluation Board Package
4. Election of Options following the Informal PEB determination
5. Formal PEB (if applicable)
6. Notification of Formal PEB determination (if applicable)
7. Appeal process (if applicable)

In addition, the Wounded Warrior Regiment and Battalions augments the services provided by MTF by offering additional counseling and guidance during the entire PEB process.

58. Senator GRAHAM. General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, to what extent do the medical evaluations prolong this process, and how can that part of the process be improved?

General SCHOOMAKER. Medical evaluations are an inherent component of the Disability Evaluation Process. It is imperative that soldiers are provided access to the full spectrum of medical care to determine the complete range of their medical conditions. The Army has already targeted three elements of the medical evaluations process for continued improvements: (1) Closer coordination with the VA for specialty care evaluations; (2) Monitoring of process data collected via the Veterans Tracking Application to maximize efficiencies; and (3) Targeting access to Behavior Health assets to expedite the Medical Board Process.

DOD and VA launched a joint pilot test of an improved DES on November 26, 2007, for disability cases originating at the three major MTFs in the National Capital Region. Today the DES Pilot model operates at 15 Army installations. The DES Pilot features a single medical examination based on VA disability examination templates and a single-sourced disability rating provided by VA rating officers. Survey results indicate our soldiers are more satisfied with the DES Pilot process, and re-

ceipt of VA ratings allows them to make better informed decisions reducing the number of appeals of PEB findings.

Admiral ROBINSON. The DES Pilot takes longer from start to finish; however, the process actually decreases the amount of time between the initial referral for disability evaluation and the servicemember's receipt of VA benefits determination by 28 percent. On average, the length of time from case initiation to receipt of benefits is 295 days vice over 500 days if the servicemember could not submit a claim to the VA until after disability separation or disability retirement from the military, as in the legacy process. The claim development and medical examination phases in the DES Pilot account for 55 days—10 days for claim development with the VA, and 45 days for the VA to complete the examination. This accounts for less than 20 percent of the amount of time for an average DES Pilot case.

Improved tracking of servicemembers' examination appointments reduced delays in the examination phase. Also, two Navy locations with larger volumes of DES cases—Naval Medical Center Portsmouth and Naval Hospital Camp Lejeune—actually brought VA examiners into the facility to improve access to the exams. Increased efficiencies in processing DES cases are being explored through various working groups and other activities coordinated by OSD's Wounded Warrior Care and Transition Policy office along with the Military Services and the VA. Proposed recommendations and options include using the VA Healthcare Network and their contracted exam services to perform exams at locations as close to the servicemembers as possible, and certifying military providers to perform exams.

Feedback to date from servicemembers and Wounded Warrior programs indicate overall satisfaction with the process, largely due to the fact that VA benefits are delivered at the time of completion of the process.

General GREEN. The medical evaluation process is being conducted in a timely manner. The VA is faced with the challenge of serving an ever increasing number of veterans along with the influx of new requirements under the DES Pilot program. We agree that when it comes to streamlining medical evaluations, working with the VA in the following areas of the process would be very beneficial: place more reliance on the contents of the servicemember's service treatment record; update the worksheets VA examiners use; establish improved automation for VA examiners; and establish more targeted exams, to fit the current population of servicemembers/veterans. Improving on these medical evaluation processes would be extremely helpful in making the overall process more efficient for the servicemember.

Admiral JEFFRIES. The DES Pilot takes longer from start to finish; however, the process actually decreases the amount of time between the initial referral for disability evaluation and the servicemember's receipt of VA benefits determination by 28 percent. On average, the length of time from case initiation to receipt of benefits is 295 days vice over 500 days if the servicemember could not submit a claim to the VA until after disability separation or disability retirement from the military, as in the legacy process. The claim development and medical examination phases in the DES Pilot account for 55 days—10 days for claim development with the VA, and 45 days for the VA to complete the examination. This accounts for less than 20 percent of the amount of time for an average DES Pilot case.

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TRAUMATIC BRAIN INJURY

59. Senator GRAHAM. General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, we understand that DOD is working on new, stronger guidelines for dealing with TBI in the field; what are they?

General SCHOOMAKER. A Directive Type Memorandum titled, "Policy Guidance for a Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting" is currently under review within DOD. This guideline will work in accordance with

the authority in DOD Directive 5124.02, to establish policy, assign responsibilities, and provide procedures on the medical management of mild TBI, also known as a concussion, in the deployed setting. It is intended to standardize the terminology, procedures, leadership actions, and medical management to provide maximum protection for servicemembers.

While awaiting DOD publication of the Directive Type Memorandum, the Army has begun executing a Campaign Plan for Warrior mild TBI. The Campaign Plan codifies incident driven protocols for concussion management. The mandatory events are: (1) any servicemember in a vehicle associated with a blast event, collision, or rollover; (2) any servicemember within 50 meters of a blast (inside or outside); (3) a direct blow to the head or witnessed loss of consciousness; and (4) command-directed. Leaders are required to assess all servicemembers involved in a mandatory event, including those without apparent injuries, as soon as possible using the Injury/Evaluation/Distance from Blast (I.E.D.) checklist. Exposure to a mandatory event or a 'Yes' response during screening leads to a mandated referral for medical evaluation. The evaluation component of the I.E.D. leader checklist uses the mnemonic "HEADS": Headaches, Ears ringing, Altered consciousness/loss of consciousness, Double vision/dizziness, or Something not right. After the I.E.D. assessment is complete, the results shall be recorded for each individual involved in the event and submitted as part of the significant activities report required for blast-related events or the events outlined above.

The Army has developed training programs for soldiers, leaders, and medical personnel. Training soldiers and leaders involves making them competent in recognizing signs and symptoms of mild TBI and the requirements of the Directive Type Memorandum; this is being accomplished using leadership briefings and educational videos. Training medical staff on the clinical assessment tools and algorithms is being accomplished by infusing the content into existing training programs and providing in-person and computer-based training.

Admiral ROBINSON. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury has been the lead for newer DOD In-Theater TBI evaluation guidelines. These new guidelines mandate clinical evaluations for servicemembers exposed to explosive blasts or who may have sustained a concussion and a minimum of 24 hours of rest prior to return to combat. In theater TBI treatment continues to be done using guidelines developed by the Defense and Veterans Brain Injury Center.

A Directive Type Memorandum (DTM) 09–033, "Policy Guidance for a Management of Concussion/Mild Traumatic Brian Injury in the Deployed Setting" is currently under review. It standardizes the terminology, procedures, leadership actions, and medical management to provide maximum protection of servicemembers with regards to TBI. There are four revised medical Concussion Clinical Guideline Algorithms for providers to follow:

1. Combat Medic/Corpsman Concussion (mTBI) Triage (Pre-hospital, no medical officer in the immediate area);
2. Initial Provider Management of Concussion in the Deployed Setting;
3. Comprehensive Concussion Algorithm Referral from Level I or II or Polytrauma;
4. Recurrent Concussion (3 documented in 12-month span) Evaluation Algorithm.

In addition, there is a list of mandatory events which necessitate command evaluations and reporting of exposure of all personnel involved. These events include, but are not limited to:

a. Any damage to a vehicle (e.g., blast, accident, rollover).
b. Exposure of dismounted personnel to a blast:
   (1) All within 50 meters of the blast.
   (2) All within a structure hit by an explosive device.
c. A direct blow to the head or witnessed loss of consciousness.
d. Command-directed, especially in a case with exposure to multiple blast events.

Commanders or their representatives are required to assess all servicemembers involved in a mandatory event, including those without apparent injuries, as soon as possible using a checklist. Any 'Yes' response in screening mandates a referral for medical evaluation. After the assessment is complete, the results shall be recorded for each individual involved in the event and submitted as part of the significant activities (SIGACT) report.

General GREEN. Yes. Guidelines to assure commanders and medical providers take a uniform approach to mild Traumatic Brain Injury (mTBI) in deployed settings are being finalized.

The Directive-Type Memorandum (DTM) 09–033, "Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting" is in the last stages of approval. A draft Fragmentary Order (FRAGO) "Concussion/mTBI," is a supplement to the DTM and outlines specific tracking, training, and treatment for eligible personnel. Implementation of this FRAGO is underway and will follow the approval of the DTM.

Tracking involves implementation of a dedicated database (CIDNE BECIR [Combined Information Data Network Exchange/Blast Exposure and Concussion Incident Report]). The events to be tracked include: (1) all mounted personnel in a damaged vehicle and/or personnel within 50 meters of a vehicle damaged by a blast; (2) all dismounted personnel within 50 meters of a blast; (3) all personnel who suffer a direct blow to the head or loss of consciousness; and (4) those situations where a leader suspects an individual is suffering mTBI.

Training requirements will include training both leaders and providers. Training leaders involves making leaders competent in recognizing signs and symptoms of mTBI. Providers (including corpsmen, medical technicians, and privileged medical providers) will learn to administer the MACE (military acute concussion evaluation) as well as proper management of the JTTS–CPG (joint theater trauma system clinical practice guidelines).

Guidelines involve a medical evaluation for all personnel involved in a "mandatory event." Mandatory events follow the mnemonic "IED:" (1) Injury - yes/no; (2) Evaluation - using a mnemonic for the "HEADS" symptoms—Headaches, Ears ringing, Altered consciousness/loss of consciousness, Double vision/dizziness, or Something not being right; and (3) Distance - a blast within 50 meters of the individual.

Admiral JEFFRIES. Service leadership, especially the Assistant Commandant of the Marine Corps and the Vice Chief of Staff of the Army, asked for enhanced guidelines for line commanders as well as medical personnel in the early diagnosis and treatment of TBIs that occur in the field environment. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury was given the lead for developing these guidelines. These new guidelines mandate clinical evaluations for servicemembers exposed to explosive blasts or who may have sustained a concussion and a minimum of 24 hours of rest prior to return to combat. In theater TBI treatment continues to be done using guidelines developed by the Defense and Veterans Brain Injury Center.

A draft policy in the form of a Directive Type Memorandum (DTM) "Policy Guidance for a Management of Concussion/Mild Traumatic Brian Injury in the Deployed Setting" is in final coordination. It standardizes the terminology, procedures, leadership actions, and medical management to provide maximum protection of servicemembers with regards to TBI. There are four revised medical Concussion Clinical Guideline Algorithms for providers to follow: 1. Combat Medic/Corpsman Concussion (mTBI) Triage (Pre-hospital, no medical officer in the immediate area); 2. Initial Provider Management of Concussion in the Deployed Setting; 3. Comprehensive Concussion Algorithm Referral from Level I or II or Polytrauma; 4. Recurrent Concussion (3 documented in 12-month span) Evaluation Algorithm. In addition, there is a list of mandatory events which necessitate command evaluations and reporting of exposure of all personnel involved. These events include, but are not limited to:

a. Any damage to a vehicle (e.g., blast, accident, rollover).
b. Exposure of dismounted personnel to a blast:
    (1) All within 50 meters of the blast.
    (2) All within a structure hit by an explosive device.
c. A direct blow to the head or witnessed loss of consciousness.
d. Command-directed, especially in a case with exposure to multiple blast events. Commanders or their representatives are required to assess all servicemembers involved in a mandatory event, including those without apparent injuries, as soon as possible using a checklist. Any 'Yes' response in screening mandates a referral for medical evaluation. After the assessment is complete, the results shall be recorded for each individual involved in the event and submitted as part of the significant activities report.

60. Senator GRAHAM. General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, are there sufficient treatment and rehabilitation resources available when our servicemembers return home?

General SCHOOMAKER. Yes, there are sufficient treatment and rehabilitation resources available for returning soldiers. We have implemented TBI screening for all medically evacuated patients and all soldiers during post-deployment; positive screening leads to a confirmation evaluation by a provider and documentation in the

electronic medical record. The Army TBI program has been conducting a multi-step validation of treatment facilities since 2008. Every Army medical treatment facility (MTF) is undergoing validation; 12 have achieved full validation and an additional 20 have achieved initial validation. The goal is full validation of all facilities by September 30, 2010.

Since 2008 the Army Medical Command has funded over 400 positions to treat and support patients with TBI and their families. These positions include a TBI Program Manager at each MTF and surge capability to ensure that TBI care is available at sites with limited organic TBI assets. We are emphasizing primary care and case management and using a family-centered approach. Specialty services are available, as needed. We have initiated 37 facility projects and purchased over $11 million of equipment to support the Army TBI programs.

The Army partners with Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) and Defense and Veterans Brain Injury Center (DVBIC) for care coordination, education, and clinical research for TBI. We have implemented tele-health initiatives for several aspects of TBI care. Multiple research projects are underway to further our knowledge and ability to care for TBI. In addition, current educational initiatives are geared toward a broad spectrum of audiences: soldiers, family members, commanders, leaders, providers, and medical staff.

Admiral ROBINSON. Since 2008, Navy Medicine has funded positions dedicated to treat and support TBI patients. These personnel are funded through Wounded, Ill, and Injured and TBI programs. For fiscal year 2008, 28 contract positions were hired. In fiscal year 2009, there were an additional 52 contract positions hired for a total of 80. For fiscal year 2010, we expect an increase of 2 additional contract positions. In January 2010, Navy Medicine convened a conference of medical providers to discuss standardization of TBI care across the Navy Medicine enterprise, based upon the primary care model. Not every servicemember who sustains a concussion will need to be seen by medical specialists, and initially all care is typically done by the primary care provider who then generates specialist referrals as appropriate and needed. Navy Medicine is committed to improving access to care and has dedicated resources to facilities anticipated to have increased numbers of TBI patients. Facility staffing can be flexibly augmented by temporary duty assignment of staff to support redeployment surges. Finally, telemedicine can be utilized to remind patients of appointments and to facilitate medical appointments with a provider available at a remote location interviewing patients by video teleconference.

General GREEN. Yes, there are many treatment and rehabilitation resources available when our servicemembers return home. The Air Force has case managers to take care of wounded, ill, and injured (WII) at each MTF. A WII patient is assigned a case manager and a primary care manager who coordinate care and interact/support the servicemember and family. In addition to the case manager and primary care manager, there are numerous specialists ready to take care of our servicemembers.

Other services available to our servicemembers include a Wounded and Survivor Care Division run by A1 (Manpower and Personnel). This program has four components: (a) Air Force Survivor Assistance Program; (b) Family Liaison Officer; (c) Air Force Wounded Warrior Program; and (d) Recovery Care Coordination Program.

An example of the type of care available to our servicemembers is Wilford Hall Medical Center, which partners with Brooke Army Medical Center to ensure comprehensive integrative MTF (TBI) care to medically-evacuated Wounded Warriors. The joint Air Force/Army TBI Clinic at Elmendorf AFB treats TBI/PTSD in redeployed members so that returning Operation Iraqi Freedom/Operation Enduring Freedom servicemembers may remain with their loved ones while receiving care.

Admiral JEFFRIES. Since 2008, Navy Medicine has funded positions dedicated to treat and support TBI patients. These personnel are funded through Wounded, Ill, and Injured and TBI programs. For fiscal year 2008, 28 contract positions were hired. In fiscal year 2009, there were an additional 52 contract positions hired for a total of 80. For fiscal year 2010, we expect an increase of two additional contract positions. In January 2010, Navy Medicine convened a conference of medical providers to discuss standardization of TBI care across the Navy Medicine enterprise, based upon the primary care model. Not every servicemember who sustains a concussion will need to be seen by medical specialists, and initially all care is typically done by the primary care provider who then generates specialist referrals as appropriate and needed. Navy Medicine is committed to improving access to care and has dedicated resources to facilities anticipated to have increased numbers of TBI patients. Facility staffing can be flexibly augmented by temporary duty assignment of staff to support redeployment surges. Telemedicine can be utilized to remind patients of appointments and to facilitate medical appointments with a provider available at a remote location interviewing patients by video teleconference. Importantly,

non-medical support and case management are provided to marines through the Wounded Warrior Regiment and Battalions which are critical to ensuring that marines successfully engage with available resources.

61. Senator GRAHAM. General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, what have we learned about TBI in the last 5 years that has lead to better prevention, treatment, and rehabilitation?

General SCHOOMAKER. Our knowledge of TBI continues to evolve. We have learned many things about TBI in the last 5 years, but most importantly we know early detection of injury is essential. Receiving prompt care, regardless of injury severity, is a key to returning to the highest functional level possible. Advancements in battlefield medicine have improved initial management, speed of evacuation, far forward medical and surgical assets, and survival rates of injured warriors.

Identification of mild TBI, also known as concussion, is difficult because the injury is less obvious. Identifying soldiers who have sustained an injury and experienced an alteration of mental state could lead to diagnosis of mild TBI. The Military Acute Concussion Evaluation (MACE) tool has been used for initial evaluation since 2006. The MACE contains a rapid screening tool for cognitive dysfunction, a brief neurological screening, and a review of history and symptoms. It can be given by all medical personnel and was validated by the Institute of Medicine's "Report on the Long-term Consequences of TBI" in 2008. In addition, we have established and implemented protocols (the "Mild TBI Clinical Practice Guideline in the Deployed Setting" and "Mild TBI Clinical Guidance") to help ensure our soldiers are diagnosed quickly and accurately. These guidelines standardize the systems approach to treatment by incorporating state-of-the-art science, technology, and knowledge-based outcomes.

Recognition of the importance of early detection led to the development of a DOD Directive Type Memorandum to codify incident-driven protocols for concussion management and publish revised clinical practice guidelines for the deployed setting. This accompanies our efforts to change the culture in fighter management after concussive events. Prevention and mitigation of concussion are everyone's concern beginning with command and leadership.

Significant strides are being made to improve the Personal Protective Equipment (PPE) worn by our servicemembers. Currently under development are the state-of-the-art Enhanced Combat Helmet (ECH) and a future head borne system (HBS) designed to reduce the overall effects of battle field kinetics, IED blasts, and to mitigate blunt impact.

Additionally, the Post Deployment Health Assessment and Reassessment contain TBI screening questions for all soldiers. Providers and staff at Landstuhl Regional Medical Center conduct a TBI screen for all medically evacuated soldiers. The VA also instituted a TBI Clinical Reminder. Our screening instruments are all based on the Brief TBI Screen (BTBIS), a tool validated by the Defense Health Board and the Institute of Medicine.

Research shows that repeated concussions may lead to increased long-term effects on the brain and patient function. Transcranial doppler studies demonstrate that cerebral vasospasm is more common in blast injured patients than other trauma patients, and is therefore something that should be assessed. The Army has led a multi-service/agency effort to develop and implement medical staff training in order to improve care and management of patients with TBI. The coordination of the TBI continuum of care has increased significantly through the collaboration of the Services, the Defense and Veterans Brain Injury Center, the VA Polytrauma System, and community resources. This coordination is vital to ensure that the highest level of care is provided to our injured servicemembers throughout the care continuum.

Admiral ROBINSON. Basic science and clinical advances in the last 5 years have led to improvements in the prevention, treatment, and rehabilitation of TBI. Lessons learned include:

1. A clear definition of TBI did not exist. Collaboratively, the military has developed a single, academically-rigorous, operationally-sound definition for the case ascertainment of TBI (especially mild TBI) to facilitate accurate screening, evaluation, diagnosis, treatment, coding, and education.
2. Education of patients, caregivers, providers, and leadership was needed to ensure proper identification and treatment. Formalized TBI education is now provided to deploying providers and providers at MTFs with standardized education materials available for servicemembers and their families.
3. Identification of TBI, especially mild TBI, requires standardized screening. As a result, implementation of TBI screening and documentation policy for theater, Landstuhl Regional Medical Center (initial evacuation site), CONUS/OCONUS home bases, and the VA has been instituted. TBI screening questions have been added to the Deployment Health Assessments and Navy Medi-

cine has developed tools and implemented post-deployment TBI screening. This process facilitates a formalized methodology for TBI surveillance. Additionally, servicemembers are required to have predeployment neurocognitive testing using Automated Neuropsychological Assessment Metrics (ANAM) and ANAM computers have been deployed to Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) for use after a servicemember sustains a mTBI (concussion).

4. Best practices for evaluation and treatment have been developed. In conjunction with the other Services, we have identified and adopted best practices across the continuum of care for patients with all degrees of TBI, including acute in-theater management of mild TBI and establishment of multidisciplinary TBI clinics in high volume locations.
5. Ongoing support for continued research is needed to continue to learn and evolve the care provided for wounded warriors with TBI.

General GREEN. We have learned many things about TBI in the last 5 years but most importantly that TBI can be treated, and early detection of injury is the cornerstone of treatment. Diagnosis and treatment of moderate, severe, and penetrating TBI is typically not delayed due to the obvious and visible nature of the injury. Identification of mild TBI is more difficult because it is less obvious. The keys to detection of mild TBI is identifying servicemembers who may have sustained an injury, and performing initial evaluation with a clinician confirmation when needed. The systematic tool for this process is the MACE tool. The MACE is a rapid screening tool for cognitive dysfunction, brief neurological examination, and a symptoms checklist. It can be given by all medical personnel and was validated by the Institute of Medicine Report on the long-term consequences of TBI in 2008. In addition, established protocols, the "Mild TBI Clinical Practice Guideline (CPG) in the Deployed Setting" and "Mild TBI Clinical Guidance" are in place, which help ensure our servicemembers are diagnosed quickly and accurately. This guidance standardizes the systems approach to treatment by incorporating state-of-the-art science, technology and knowledge-based outcomes.

All the Services have worked to enhance provider training that will greatly improve TBI patient management throughout DOD. The coordination of the TBI continuum of care between the DOD and the VA has increased significantly through the collaboration of the Defense and VA Brain Injury Center (DVBIC) TBI Care Coordination Network and the VA Polytrauma Federal Care Coordination System.

Significant strides are being made to improve the PPE worn by our servicemembers. Currently under development are the state-of-the-art ECH and a future HBS designed to reduce the overall effects of battle field kinetics, and improvised explosive device blasts, and to mitigate blunt impact.

Once we learned early detection was a key to TBI recovery, the DOD embarked on initiating a cultural change. The responsibility for force preservation lies with the leaders and servicemembers themselves. Operational events, such as exposure to a blast within a certain distance or the presence of vehicular damage, now mandate a medical evaluation.

Although the MACE and CPG are great clinical tools for identifying acute injuries, identifying servicemembers post-deployment and more than a week after injury require a different methodology. The DOD began screening initiatives in 2008 with the intent of finding servicemembers who may have sustained a TBI while deployed and perhaps have symptoms that require further assessment and treatment. This TBI screening occurs at several points. All servicemembers evacuated from theater for battle or non-battle injuries are screened on arrival at Landstuhl Regional Medical Center. Three other screening tools are used at various other times such as the Post-Deployment Health Assessment (PDHA), PDHRA and VA TBI Clinical Reminder. All the questions used in the screening tools are an adaptation of an instrument called the Brief TBI Screen. This tool was validated by the Defense Health Board in 2008.

The Air Force has been involved in multiple joint training efforts to ensure its medics have the most up to date information to diagnose and treat our injured servicemembers. The Air Force also added TBI training to the Expeditionary Medical Support training which is attended by all Air Force medics before deployment.

In addition, a nationwide care coordination network has been established by DVBIC for those diagnosed with TBI. A care coordinator contacts the servicemember diagnosed with TBI once they reach continental United States and again at 3, 6, 12, and 24 months following an injury. During these contacts, assessments are made to determine what resources may be needed in addition to follow up questions about substance use, relationships, readjustment after deployment and other areas shown to be important to follow up in a patient that has sustained a TBI.

The Air Force is the lead agency in formulating responses to complex medical problems involved in air transport of acute care TBI patients. At the forefront of that effort is the Air Force Critical Care Air Transport Teams. This initiative has saved countless lives. The Air Force continuously improves this capability, reviewing information from databases such as the JTTS and incorporating lessons learned.

What we have learned in the past 5 years about TBI has been key to providing the best care to our servicemembers. The future holds even more promise as research continues to provide better ways to protect, evaluate, and treat servicemembers with TBI.

Admiral JEFFRIES. Basic science and clinical advances in the last 5 years have led to improvements in the prevention, treatment, and rehabilitation of TBI. Lessons learned include:

1. A clear definition of TBI did not exist. Collaboratively, the military has developed a single, academically-rigorous, operationally-sound definition for the case ascertainment of TBI (especially mild TBI) to facilitate accurate screening, evaluation, diagnosis, treatment, coding, and education.
2. Education of patients, caregivers, providers, and leadership was needed to ensure proper identification and treatment. Formalized TBI education is now provided to deploying providers and providers at MTFs with standardized education materials available for servicemembers and their families.
3. Identification of TBI, especially mild TBI, requires standardized screening. As a result, implementation of TBI screening and documentation policy for theater, Landstuhl Regional Medical Center (initial evacuation site), CONUS/OCONUS home bases, and the VA has been instituted. TBI screening questions have been added to the Deployment Health Assessments and Navy Medicine has developed tools and implemented post-deployment TBI screening. This process facilitates a formalized methodology for TBI surveillance. Additionally, servicemembers are required to have pre-deployment neurocognitive testing using ANAM and ANAM computers have been deployed to OIF/OEF for use after a servicemember sustains a mild TBI (concussion).
4. Best practices for evaluation and treatment have been developed. In conjunction with the other Services, we have identified and adopted best practices across the continuum of care for patients with all degrees of TBI, including acute in-theater management of mild TBI and establishment of multidisciplinary TBI clinics in high volume locations.
5. Ongoing support for continued research is needed to continue to learn and evolve the care provided for wounded warriors with TBI.

TOBACCO AND HEALTH CARE COSTS IN THE MILITARY

62. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, last summer the National Institute of Medicine published a report on tobacco use in the military that concluded: there has been an upturn in consumption in the last decade; that tobacco adversely affects military performance and results in high costs; and that tobacco cessation programs have received insufficient attention in the military. Does DOD still provide tobacco products at a discount to servicemembers?

Dr. RICE and Admiral HUNTER. Yes, under current policy, tobacco products are sold at a relative discount to servicemembers at exchanges.

General SCHOOMAKER. Yes, DOD Instruction 1330.9, dated 7 Dec 2005, provides guidance to the Army and Air Force Exchange Services (AAFES) and the Defense Commissary Agency (DeCA) regarding tobacco product sales, pricing, and restrictions. This Armed Services exchange policy states that military resale outlets will not charge more than the most competitive commercial retailer, and may charge up to 5 percent less. This means that, in effect, DOD is selling tobacco products at slightly lower cost than competing retailers. For example, if the most competitive commercial retailer sold a pack of cigarettes for $5.00, AAFES could sell the same pack for $4.75. DeCA sells tobacco products at the cost from AAFES for no profit. Additionally, AAFES and DeCA do not charge State or local sales taxes (approximately 6 percent savings).

Admiral ROBINSON. Current DOD policy is that tobacco products sold in military resale outlets shall be no higher than the most competitive price in the local community and no lower than 5 percent below the most competitive commercial price in the local community.

General GREEN. Yes, Air Force commissaries and base exchanges continue to sell tobacco products at discounted prices. The military medical community is very interested in examining this issue with our commissaries and exchanges in light of the

Institute of Medicine's findings that increased tobacco prices is one of the most effective interventions for reducing tobacco consumption. The Air Force Medical Service participates in a working group to address this issue with the Defense Commissary Agency and the Army and Air Force Exchange Service.

Admiral JEFFRIES. Current DOD policy is that tobacco products sold in military resale outlets shall be no higher than the most competitive price in the local community and no lower than 5 percent below the most competitive commercial price in the local community.

63. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, do you agree that prevention could reduce overall health care costs? If so, what more should be done?

Dr. RICE and Admiral HUNTER. We agree that prevention is a route to better health and longer life, and is generally cost saving with respect to the disease being targeted for prevention.

TRICARE generally covers preventive services recommended by the U.S. Preventive Services Task Force.

General SCHOOMAKER. Yes, I agree that tobacco cessation can reduce overall healthcare costs. According to the American Journal of Health Promotion, DOD spends an estimated $564 million per year on medical care costs associated with tobacco use for TRICARE Prime Members alone. Tobacco usage is notorious for increasing the lifetime risk of acquiring serious chronic diseases and costs the DOD billions of dollars in medical care, diminished productivity, early attrition, and other adverse events. Since most tobacco-related diseases take years to develop, military personnel who use tobacco may eventually enter into the VA health system and consequently increase overall healthcare costs. In the short term, tobacco use impairs military readiness by reducing physical fitness and healing times for injuries, surgeries, lowering visual acuity, and contributing to hearing loss.

The Army must address the perception that tobacco use is an accepted practice. Equally important is the development of a strategic workgroup to address tobacco issues in the Army. Senior leadership support and role-modeling by commanders can influence a positive tobacco-free culture change. Other strategies to consider:

(1) Tobacco use prohibition at basic/AIT, military schooling, and military conferences;
(2) Use of wellness centers to help combat tobacco;
(3) Tobacco cessation throughout all medical and installation healthcare systems;
(4) Tobacco-free Army military medical treatment facilities, child development centers and schools;
(5) Incentivizing tobacco-free lifestyle, i.e. promotion points to tobacco-free soldiers;
(6) Raising awareness of tobacco cessation resources such as "UCANQUIT 2";
(7) Continue with development of 24-hour quit lines; and
(8) Standardize best practices for tobacco cessation programs and pharmacotherapy.

Admiral ROBINSON. The prevention of tobacco use in the military is one of necessity to increase mission readiness and to decrease the physical and financial burden of tobacco-related illness. Tobacco cessation interventions have been demonstrated to be one of the top preventive services to implement in terms of return on investment. Many interventions have been adopted by the Navy to decrease tobacco use with the potential to do more.

Presently, initial recruit training is done in a tobacco-free environment. Efforts are ongoing to extend this practice to advanced training schools as well. In the Fleet, the Submarine Force has just ordered that all of their submarines will be smoke free. Extending this policy to other classes of afloat units would be beneficial as well. Widespread access and provision of tobacco use screening, tobacco cessation counseling, and nicotine replacement therapy are high Navy Medicine priorities to address this most important issue.

General GREEN. Yes, there are several studies that illustrate the impact of tobacco use on health care costs, so if the Air Force can prevent military members from using tobacco, we can reduce health care costs. The Air Force currently bans tobacco use during basic training of new recruits and continues this ban for the first 36 days of technical training which is our follow-on, initial skills training. There is evidence to suggest that extending this ban would help prevent new recruits from initiating smoking or relapsing to smoking. A 2003 study found that new Air Force recruits were in favor of the tobacco-free policy during basic training and felt that it would be relatively easy for them to continue to remain tobacco-free after completing basic training if a policy were in place that prohibited the use of tobacco. Additionally,

the Department of Health and Human Services' Task Force on Community Preventive Services recommends the use of smoking bans and restrictions based on strong evidence of their effectiveness on reducing cigarette consumption and increasing smoking cessation rates.

Admiral JEFFRIES. The prevention of tobacco use in the military is one of necessity to increase mission readiness and to decrease the physical and financial burden of tobacco-related illness. Tobacco cessation interventions have been demonstrated to be one of the top preventive services to implement in terms of return on investment. Many Service and Defense Department interventions have been adopted to decrease tobacco use with the potential to do more. Widespread access and provision of tobacco use screening, tobacco cessation counseling, and nicotine replacement therapy are military medicine priorities to address this important issue.

POST-TRAUMATIC STRESS DISORDER

64. Senator GRAHAM. General Green, who is most at risk for PTSD in the Air Force?

General GREEN. The Air Force has continued to monitor the well-being of all airmen through multiple measures. Among these measures are our Post-Deployment Health Assessments (PDHA) and Post-Deployment Health Reassessments (PDHRA) administered following a deployment. For Air Force servicemembers who have deployed the prevalence of self-reported post-traumatic stress (PTS) symptoms within 6 months post deployment is around 1.5 percent for men and 2.5 percent for women over the past 2½ years. The prevalence was varied for both self-reported symptoms and provider-diagnosed PTSD rates by demographic and deployment variables. The higher PTS(D) rates (self-reported or diagnosed) were consistently observed in the demographic sub-groups of 'Female' and 'Enlisted,' and the deployment sub-groups of 'longer deployment duration' and 'positive combat exposure.' Combat exposure remains the most significant predictor of both PTS and PTSD diagnoses for those who have deployed. Air Force leadership supported plans to provide targeted, tiered resiliency training for higher-risk career groups, such as our security forces, explosive ordnance disposal, and combat convoy driver personnel, including the formation of a Deployment Transition Center (DTC) in U.S. Air Forces in Europe (USAFE). The DTC is a 2-day resiliency training and decompression stop on a deploying airman's way home. The Air Force has developed a targeted approach to assisting those at greatest risk for exposure to potentially traumatic events through the DTC. Several DTCs have already been prototyped and the initial feedback from servicemembers participating has been positive. These airmen will continue to be tracked and followed to assess program effectiveness for their reintegration. We will continue the ongoing surveillance of PTS and PTSD refining and targeting intervention approaches. In addition to the DTC, plans are underway for enhanced pre- and post-deployment resiliency training for these groups and targeted interventions for high risk groups, with enhanced small group training.

65. Senator GRAHAM. General Green, are you designing strategies in behavioral health and suicide prevention tailored to those at highest risk?

General GREEN. Yes. The Air Force is working diligently to identify those at greater risk for PTSD and suicide, and to target specific interventions to these groups. We have developed a tiered intervention approach to improve resilience of our entire force and to target and track those most at risk for additional interventions. In addition to foundational training for all airmen that serves to build strength and resilience, the Air Force addresses a variety of behavioral health risk factors through annual training, commanders' calls, exercises, and inspections. We have identified several career fields as being at greater risk for suicide and have initiated more intensive suicide prevention training for all members in those career fields, along with additional training for supervisors in the same career fields to improve their skills in intervening with at-risk airmen.

We have also identified specific career fields and mission sets that are at greater risk for exposure to trauma while deployed. For these airmen, we have developed Deployment Transition Sites that provide a critical decompression and recovery period to facilitate their smooth return to in-garrison life. These airmen will be tracked to allow us to assess the effectiveness of this program and to intervene with any of these airmen who show signs of distress.

SUBSTANCE ABUSE

66. Senator GRAHAM. General Schoomaker, please tell me more about the Confidential Alcohol Treatment and Education Pilot program. What is it intended to demonstrate and what are the early results?

General SCHOOMAKER. The Army recognizes that substance abuse has been on the increase among soldiers over the past several years. Current data indicate that roughly 50 percent of soldiers with PTSD, depression, and mild TBI (concussion) have concurrent alcohol issues. The Army also recognizes that alcohol use is a significant risk factor for accidents, domestic violence, criminal behavior, and suicide. Since the 1970s, the Army Substance Abuse Program (ASAP) has helped soldiers with addictions problems, but the program requires strict soldier accountability, notifying all commanders of soldier enrollment, and leveraging soldier treatment compliance with consequences that may adversely affect the soldier's military career. In most cases, ASAP counselors see soldiers with addiction problems only after they have gotten into trouble and been formally referred to the clinic for help. Career-minded soldiers are more likely to avoid seeking help from the ASAP clinic because of concerns about the potential risk to their careers. Based on these findings, the Army explored alternatives to benefit soldiers with substance abuse problems. The Confidential Alcohol Treatment and Education Pilot program was designed to allow soldiers to present to the ASAP clinic on a self-referral basis for alcohol problems without automatically notifying or involving their commanders, and without leveraging potential consequences that may adversely impact one's military career, as long as they have not already had a bad outcome, an alcohol-related incident, or a drug problem. The intent of the Confidential Alcohol Treatment and Education Pilot is to reach more soldiers earlier in the course of their alcohol problem, before they get into trouble or have a bad outcome or incident. The Pilot has been implemented for more than 8 months at three Army installations. Initial findings from the Confidential Alcohol Treatment and Education Pilot indicate that more soldiers are coming forward to seek substance abuse treatment for an alcohol problem. This includes more career-minded soldiers, senior enlisted soldiers, and officers, three groups that normally would avoid accessing care. Under the provisions of the Pilot, medical providers are more willing to refer to the ASAP clinic, and soldiers are more willing to go as referrals. Senior Army leadership is currently evaluating the expansion of the Confidential Alcohol Treatment and Education Program across the Army so that all soldiers may benefit from this new approach.

PATIENT AND FAMILY-CENTERED CARE

67. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, you have talked at length about patient and family-centered care. Do the families know about this?

Dr. RICE and Admiral HUNTER. Yes, patient and family-centered care was first publicized in 2006. There was an extensive media campaign that included kickoff meetings, posters, brochures, Web sites, and an intensive review of processes to better meet the needs of patients. We have continued to inform military families about these programs since their inception.

The full implementation of the Patient Centered Medical Home is still under development and will include a media campaign as well as written guidance for providers.

General SCHOOMAKER. We are making coordinated efforts to inform our beneficiaries about patient and family-centered care as part of our implementation of the Medical Home concept. Marketing and beneficiary communications are key components of Medical Home implementation. Our communication plan focuses on three interrelated goals. The first is to change culture and close the gap between what our beneficiaries value and what we deliver through the Medical Home. For example, research findings demonstrate that continuity and the ability to identify one's physician are markers of high quality care. However, our beneficiaries, like their civilian counterparts, may not understand and appreciate this concept. Accordingly, we will focus on educating our beneficiaries on the value of continuity with their identified primary care clinician as we implement the business practices that maximize continuity. The second goal is to standardize our operations to a common patient experience as beneficiaries move between medical treatment facilities. Creating a common patient experience is the basis for the Army Medical Home brand and, by making our system easier to use, will increase both staff and patient satisfaction. The third goal is to build the tools and processes required to support both day-to-day patient communications and broader campaigns and community outreach. Culture change, branding, and communication will ensure that our families

get the Medical Home message. While the overall communication effort is coordinated centrally, execution occurs at the individual MTF. This effort will accelerate as we prepare to open Community Based Primary Care Clinics and expand use of the Medical Home.

Admiral ROBINSON. Achieving optimal patient and family-centered care within Navy Medicine is one of our top strategic goals. We communicate to our Navy and Marine Corps families on many levels to ensure that their care is patient and family-centered. Our concept of care is focused around patient/family empowerment and advocacy and patient satisfaction with the health care experience.

Many Navy MTFs have healthcare consumer councils and other patient advisory groups that facilitate bidirectional feedback to Navy physicians and healthcare staff on how to improve healthcare services and access. Other MTFs host town hall meetings where patients can identify issues and topics for improvement at that activity. In addition, some MTFs also have access to information technology tools that allows patients to directly email their healthcare team, through a secure system, with questions and concerns. Finally, through our facilities' public websites, patients can access information on Navy Medicine healthcare services and educate themselves on patient and family-centered care.

Navy Medicine continuously surveys patients to assess their satisfaction with access to healthcare, coordination of healthcare services, and patient safety. This outreach ensures ongoing feedback and communication between patients and their healthcare staff to tailor healthcare delivery to patients and their family's expectations.

Finally, Navy Medicine is implementing a new model of healthcare delivery called Medical Home Port, which has proven successful in the civilian sector and at Navy Medicine's demonstration sites. The Medical Home Port model utilizes a dedicated team of medical providers and support staff designed to increase access to care, improve clinical quality, and improve patient satisfaction. Medical Home Port leverages technology and maximizes personnel to deliver services that improve continuity for beneficiaries with their provider, as well as patient outcomes.

General GREEN. Yes, as part of our implementation strategy for our FHI, Air Force Medical Service has an implementation team that works with each of our facilities when setting up their Patient Centered Medical Home. As part of this assistance, teams work with the facilities on ways to educate their wing leadership and base populace regarding the new approach to care through venues such as base newspaper articles, pamphlets, and handouts for the patients, briefings at various functions across the wing, and any other locally unique ways to communicate with our beneficiaries. Patrick Air Force Base, for example, held an open house for patients and their families. In addition to sharing education materials, each person met their own provider and their personal team, establishing a solid foundation to their medical care.

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68. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, last year in a hearing of this subcommittee, I asked family members to rate their health care system from A to F—I was surprised at the results, which were much lower than I expected. Families explained the difficulty in obtaining appointments. How will your family-centered care plans fix the access problems that family members are experiencing?

Dr. RICE and Admiral HUNTER. We are implementing several initiatives to address the access problems that some family members are experiencing.

The Patient Centered Medical Home is designed for every Prime patient to be assigned to a primary care manager by name. Each primary care manager is part of a team practice to ensure continuity of care so patients have access to advice and their provider 24 hours a day/7 days a week.

MTFs are utilizing innovative patient-centered and access-focused approaches. Several examples include open access scheduling, online appointment-making and online provider/patient communication, 24-hour nurse advice and triage phone lines, and provider/patient telephonic consults.

General SCHOOMAKER. Implementation of the Army Medical Home model is intended to improve access, increase quality of healthcare, and decrease the cost of care. The Army Medical Home model will improve access in several ways. First, the Medical Home expands the number of ways by which our beneficiaries can gain access to health care. In addition to the traditional, face-to-face encounter with a clinician, the Medical Home will offer improved telephone consultation services, secure e-mail communication between care providers and patients, group visits, and more face-to-face encounters with nurses and other members of the health care team. Second, the Medical Home uses an open access appointment-making system focused on providing same-day access for those beneficiaries who request it. Third, measures of Medical Home performance focus on access and incorporate these measures into individual performance plans so that every staff member is incentivized to focus on improving access. Finally, the Army Medical Home improves operating efficiencies that will improve the supply of both traditional and nontraditional appointments. These include increased numbers of exam rooms in new facilities, more effective administrative models that free clinicians to see patients, better information systems, updated business rules, enhanced marketing and communications, improved staff training, and standardized operating rules. Taken together, these features of the Army Medical Home will help fix the access problems that family members are experiencing.

Admiral ROBINSON. Navy Medicine is implementing a new model of healthcare delivery called Medical Home Port. This evidence-based model has proven successful in enhancing patient access to care in both the civilian sector and at pilot sites in Navy Medicine. Due to this initial success, Navy Medicine is currently expanding implementation of this model to eight additional sites by June 2010 and all primary care clinics by the end of 2011.

Medical Home Port enhances access through numerous means. The first method is through the use of open access scheduling. This scheduling model ensures that patients can book appointments based on their need and preference. Patients can be seen the same day of their requested appointment; or, if they prefer, at a later more convenient date.

Additionally, patients enrolled to the Medical Home Port will have direct access to their healthcare team 24/7 through secure messaging, telephone, pager, or other communication format. This allows the healthcare team to ensure that continuous, comprehensive and holistic care is provided to their patients. The team will address as many of the patient's healthcare needs as possible through a single appointment—from behavioral health to patient education to chronic disease management.

General GREEN. A major focus of our FHI is access to care. We require our providers to provide a minimum of 90 appointments per full week in clinic. We have subsequently seen improvement in patient satisfaction with access at locations that have implemented FHI. Additionally, as we are seeing more continuity between patients and their providers, a secondary effect has been decreased demand, improved coordination of care, and overall improvement in access.

Admiral JEFFRIES. The Marine Corps is supportive of the Patient and Family-Centered Care and Medical Home initiatives. These initiatives hold the promise of improving access and care to marines and their families.

Navy Medicine is implementing a new model of healthcare delivery called Medical Home Port. This evidence-based model has proven successful in enhancing patient access to care in both the civilian sector and at pilot sites in Navy Medicine. Due to this initial success, Navy Medicine is currently expanding implementation of this model to eight additional sites by June 2010 and all primary care clinics by the end

of 2011. This roll out plan will result in nearly all Marine Corps personnel being included in Medical Home Port by the end of 2011.

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Additionally, patients enrolled to the Medical Home Port will have direct access to their healthcare team 24/7 through secure messaging, telephone, pager, or other communication format. This allows the healthcare team to ensure that continuous, comprehensive and holistic care is provided to their patients. The team will address as many of the patient's healthcare needs as possible through a single appointment including behavioral health, patient education, and chronic disease management.

If the anticipated successes of this approach are achieved, a future next step might involve integrating the care delivered to marines in garrison by organic personnel, for example a regimental surgeon, with the care delivered to the marine's family in the Navy MTF.

GROWTH IN HEALTH CARE COSTS

69. Senator GRAHAM. Dr. Rice, your testimony indicates that health care costs are expected to grow from 6 percent to more than 10 percent of the 000 top line by fiscal year 2015. This is a change from previous statements that costs were expected to grow from 8 percent to 12 percent of the budget by fiscal year 2015. Is this an indication that we are achieving efficiencies in the system, or that we've found a different way to do the math?

Dr. RICE. The variation is neither an indication we are achieving efficiencies in the system, nor that we have found a different way to do the math. The Unified Medical Budget percentage of the DOD top line is never constant; it varies from year to year due to fluctuating cost assumptions.

MILITARY PERFORMANCE AT THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

70. Senator GRAHAM. Dr. Rice, when you are not performing the duties of the Assistant Secretary of Defense for Health Affairs, you are the President of the USUHS and have been since 2005. The University is the military's medical school and has produced hundreds of outstanding doctors since its establishment over 35 years ago, many of whom stay in uniform for long careers. Oddly, the original statute required that students remain as second lieutenants or ensigns for their entire 4-year education. At your recommendation last year, we supported a legislative provision that would allow the promotion of medical students at USUHS after 2 years—like all other commissioned officers. Our intent was to place greater emphasis on the military responsibilities of medical officers, but our friends in the House of Representatives did not support this proposal. Please comment about this idea, with the benefit of your 5 years out at USUHS. Would permitting promotion after 2 years of medical school, in response to good performance, help improve the student body?

Dr. RICE. Although I am consistently impressed with the dedication and commitment of USUHS medical students, I believe their development as future leaders could be enhanced by properly administered promotion consideration and selection. It is my view promotion ceremonies involving the Surgeons General and other Service officials at the 2-year mark would provide an important Service connection and motivator, as well as morale builder, for both officers and their families—recognizing their hard work and sacrifice. Further, providing promotion with contemporaries will assist in both recruitment—particularly in the recruitment of quality Academy and ROTC graduates and prior-service personnel—and long-term retention. I also believe such a promotion opportunity would enhance our students' understanding of being a military officer.

I am more aware now than ever successful accomplishment of the DOD mission requires military health care providers see themselves as an integral part of their Service teams. Ensuring officers attending USUHS, which is the primary accessions source for career military health care providers, are treated as part of their Service teams from their first day of service is critical to this self view.

71. Senator GRAHAM. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, do you think it could help eliminate

from the student body, students who are not motivated and who do not demonstrate the military bearing, loyalty, and leadership traits that all officers should have?

Dr. RICE and Admiral HUNTER. Yes, I believe 2-year promotion eligibility could help eliminate from the student body, students who are not motivated and who do not demonstrate the military bearing, loyalty, and leadership traits that all officers.

Promotion consideration at the 2-year point would involve a critical additional assessment of officership by the chain of command at USUHS and the Services. Medical students who fail to measure up to officership standards (military bearing, loyalty, and leadership) at this point, will be clearly identified for separation, if appropriate, or at a minimum, for continued attention (mentoring and observation).

General SCHOOMAKER. No, promotion from second lieutenant to first lieutenant while at the USUHS would not help. Processes are already in place to regularly evaluate performance and determine advancement, deceleration, or termination for students at USUHS. I doubt that any additional value would be added to the current process by the addition of a promotion opportunity.

Admiral ROBINSON. This question is specific to the USUHS. As such, it is most appropriately answered by President of USUHS.

General GREEN. Since promotions are based on merit and the demonstrated ability to perform in a higher grade, allowing medical students (both USUHS and HPSP) to advance to the next grade (O–2) following their second year of medical school would serve as a positive incentive, one that could also enhance our ability to recruit and retain strong military medical leaders for the future.

As military-medical officers, USUHS (and HPSP) students must adhere to the same standards of professional comportment as their line counterparts, so promoting those who demonstrate positive professional performance, while deferring promotion for those who fail to meet Service specific standards, would be yet another means of ensuring a truly quality force.

Admiral JEFFRIES. This question is specific to the USUHS. As such, it is most appropriately answered by President of USUHS.

REMEDIAL ACTIONS AFTER FORT HOOD

72. Senator GRAHAM. General Schoomaker, there is disciplinary action pending against Major Nidal Hasan, but we need to know what steps you have taken to ensure that the performance of young doctors in the Army Medical Corps is being accurately reported on and effective corrective measures are being implemented when individual officers fail to perform to standards. What guidance have you given to ensure that officer efficiency reports are useful tools in evaluating the performance and assignment of medical officers?

General SCHOOMAKER. I have issued guidance to my subordinate commanders reinforcing the importance of honest, forthright evaluations. Army Regulation 623–3 (Evaluation Reporting System) Appendix E provides special instructions for evaluations pertaining to Army Medical Department (AMEDD) officers. The overarching priority for Appendix E is accurately reporting on an officer's performance while ensuring effective corrective measures are in place to produce a broad-based corps of leaders who possess the necessary values, attributes, skills, and actions to perform their duties and serve the Nation. These leaders must demonstrate confidence, integrity, critical judgment, and responsibility while operating in an environment of complexity, ambiguity, and rapid change.

Furthermore, the AMEDD relies on a concerted, joint effort of subject matter experts to train, develop, and optimally assign its officers. The primary tool facilitating this process, especially to ensure that senior officers are assigned to clinical positions that maximize their utilization and experience, is the biannual Human Capital Distribution Process (HCDP). The HCDP is a business practice whereby the Army Medical Command collaboratively distributes its human capital in a manner that ensures the right mix of qualified providers are present at each AMEDD facility to ensure mission accomplishment.

Additionally, Department of the Army Pamphlet 600–4 (Army Medical Department Officer Development and Career Management) is Army guidance that promotes the assignment of senior O6 officers into positions which foster mentorship for junior officers. AMEDD leaders are directed to continually conduct developmental counseling and mentor young Medical Corps officers to help them professionally develop, accomplish organizational goals, and achieve personal ambitions, while preparing them for increased responsibilities.

73. Senator GRAHAM. General Schoomaker, what measures have you instituted to ensure that medical officers, particularly those in the training pipeline, conform to physical standards and are appropriately evaluated and counseled for shortcomings?

General SCHOOMAKER. I am aware that maintaining physical standards is an issue across the Services while students attend the Uniformed Services University. However, within the Army, I have reinforced to my subordinate commanders and leaders the need to strictly comply with Army policy and regulation regarding physical standards. Army Regulation 350–1 (Army Training and Leader Development) provides policies, procedures and responsibilities for developing, managing, and conducting Army Training and Leader Development for all Army officers. All Army officers are also covered by Army Regulation 600–9 (Army Weight Control Program) which establishes policies and procedures for the implementation of the Army Weight Control Program. Individuals who are selected to enter Graduate Medical Education (GME) must sign a training agreement acknowledging that, as a condition of employment and for continuation in GME, they must comply with the Army physical fitness, appearance, and weight standards. Those entering Active Duty internships are given a diagnostic Army Physical Fitness Test (APFT) during their orientation to assess for those who will require additional physical training. Those selected for advanced GME training must be in compliance with APFT and height and weight requirements prior to beginning training; if not, the training opportunity may be withdrawn. Trainees who are out of compliance at any time are counseled by program directors as well as company commanders on the importance of meeting the standards and the negative impact of noncompliance on their training and career progression.

74. Senator GRAHAM. General Schoomaker, what steps have you taken, or have you recommended, ensuring that personnel who demonstrate reservations or doubts about active military service are identified and dealt with?

General SCHOOMAKER. I have reinforced with my commanders, with direction to disseminate to the rest of the force, the importance of leaders engaging with their subordinates in regular, routine counseling sessions. This is a fundamental precept of military leadership. Leaders should know what is happening in their soldiers' lives and provide support and intervention as necessary. An individual who demonstrates reservations or doubts about active military service may be referred to the chaplain, a counselor, or some other appropriate authority, depending on the circumstances of the case. At all times the chain-of-command should be made aware of these cases and exercise appropriate command oversight.

QUESTIONS SUBMITTED BY SENATOR JOHN THUNE

ELECTRONIC MEDICATION MANAGEMENT ASSISTANT

75. Senator THUNE. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, I understand that the Army Surgeon General's office piloted the use of a remote medication management device known as Electronic Medication Management Assistant (EMMA) on patients at the Warrior Transition Unit at Walter Reed Army Medical Center (WRAMC). Due to the success at Walter Reed, the pilot program was expanded to Fort Carson, Fort Lewis, and Fort Bragg.

I also understand that the expanded pilots are confirming Walter Reed's results that EMMA controls the access to dangerous narcotics and controlled substances; improves outcomes by increasing prescription adherence from an estimated 65 percent to over 90 percent; and limits the abuse and misuse of medications. Furthermore, due to the results at the Warrior Transition Units, EMMA was made a TRICARE benefit.

Since the EMMA pilots are showing that this device successfully mitigates the risk of medication misuse and improves patient safety, what is being done to expedite the expansion of this device to other Warrior Transition Units and to all high risk wounded warrior patients?

Dr. RICE and Admiral HUNTER. We are not currently developing plans to expedite the expansion of EMMA device use throughout the MHS.

We have conducted a review of EMMA and in response to the review results, have cautiously restricted coverage for EMMA to cases where it is prescribed by a military physician to an Active Duty servicemember.

General SCHOOMAKER. The Army Medical Command directed an expanded pilot of EMMA after experiencing limited success at WRAMC. Once the expanded pilot has concluded and data have been analyzed, we will determine whether to continue

with EMMA and, if so, who would benefit. Although WRAMC pharmacy did not conduct outcomes studies in the WRAMC portion of the pilot, they did find success in warriors with TBI who were having difficulty remembering to take their medications. The automatic alert on EMMA has been instrumental in helping the warriors take medications at appropriate times. The WRAMC staff noted that warriors with potential prescription abuse issues were not as successful with EMMA as they often found ways to work around the automated controls. The 6-month expanded pilot will be completed in May 2010 with a planned briefing to Army leadership in July after appropriate evaluation of outcomes and satisfaction data. Since implementation at WRAMC, a total of 24 warriors have used EMMA; there are currently 18 warriors active. Each additional pilot site enrolled 10 warriors.

TRICARE reimbursement rules allow for paying for EMMA under the Supplemental Healthcare Program for Active Duty. While EMMA can be considered durable medical equipment in the TRICARE Manual Policy, it is not considered medically necessary based on a review of the supplier's literature by TMA's Medical Benefits and Reimbursement Branch. Therefore, TRICARE is not permitted to pay EMMA costs for non-Active Duty personnel.

Admiral ROBINSON. The Navy Medicine Information System Support Activity (NAVMISSA), as the execution arm for deployment and maintenance of Navy Medicine IT Systems has been providing assistance to the contractor, INRange, since October 20, 2009, to develop the necessary documentation package for the Information Assurance Certification and Accreditation (C&A) of the EMMA. NAVMISSA's responsibility as the Navy medical network security manager is to ensure that all Information Assurance C&A packages are prepared, reviewed, and validated in accordance with Joint Task Force, Global Network Operations (JTFGNO) (security arm for DOD) requirements prior to submission to the Naval Network Warfare Command (NETWARCOM) for approval. EMMA must be formally certified and accredited by NETWARCOM prior to interface with the Navy Medicine IT network. All military Services are held to the same level of security certification. INRange has not provided the level of security required both in documentation and technical certification to prepare the total package required for review and submission by NAVMISSA to NETWARCOM for approval leading to certification and accreditation. It is the intent of the Bureau of Medicine and Surgery to expeditiously field this capability as soon as the contractor, INRange, provides the predefined security deliverables.

General GREEN. This question addresses the Army's Warrior Transition Units and as such I defer to the Army Surgeon General for the response to this question for the use of EMMA in the Warrior Transition Units.

Admiral JEFFRIES. The NAVMISSA, as the execution arm for deployment and maintenance of Navy Medicine IT systems, has been providing assistance to the contractor, INRange, since October 20, 2009 to develop the necessary documentation package for the Information Assurance Certification and Accreditation (C&A) of the EMMA. NAVMISSA's responsibility as the Navy medical network security manager is to ensure that all Information Assurance C&A packages are prepared, reviewed, and validated in accordance with JTFGNO (security arm for DOD) requirements prior to submission to the NETWARCOM for approval. EMMA must be formally certified and accredited by NETWARCOM prior to interface with the Navy Medicine IT network. All military Services are held to the same level of security certification. INRange has not provided the level of security required both in documentation and technical certification to prepare the total package required for review and submission by NAVMISSA to NETWARCOM for approval leading to certification and accreditation. It is the intent of the Bureau of Medicine and Surgery to expeditiously field this capability as soon as the contractor, INRange, provides the predefined security deliverables.

76. Senator THUNE. Dr. Rice, Admiral Hunter, General Schoomaker, Admiral Robinson, General Green, and Admiral Jeffries, I also understand that the marines at Camp Lejeune have been unable to obtain the EMMA TRICARE benefit for Wounded Warriors because the NAVMISSA has refused to do so based on information systems program management issues. What is being done to provide this device to the marines and why is NAVMISSA involved in a TRICARE benefit?

Dr. RICE and Admiral HUNTER. We have conducted a review of EMMA, one of the results of that review was concerns with ensuring secure data communications from a remote device in the patient's home to protect patient privacy.

With these concerns, we have cautiously restricted coverage for EMMA to cases where it is prescribed by a military physician to an Active Duty servicemember.

General SCHOOMAKER. We respectfully defer to the Navy and the Marine Corps to address this question.

Admiral ROBINSON. The NAVMISSA, as the execution arm for deployment and maintenance of Navy Medicine IT systems has been providing assistance to the contractor, INRange, since October 20, 2009, to develop the necessary documentation package for the Information Assurance C&A of the EMMA. NAVMISSA's responsibility as the Navy medical network security manager is to ensure that all Information Assurance C&A packages are prepared, reviewed, and validated in accordance with JTFGNO (security arm for DOD) requirements prior to submission to the NETWARCOM for approval. EMMA must be formally certified and accredited by NETWARCOM prior to interface with the Navy Medicine IT network. All military Services are held to the same level of security certification. INRange has not provided the level of security required both in documentation and technical certification to prepare the total package required for review and submission by NAVMISSA to NETWARCOM for approval leading to certification and accreditation. It is the intent of the Bureau of Medicine and Surgery to expeditiously field this capability as soon as the contractor, INRange, provides the predefined security deliverables.

General GREEN. As this question relates to Navy issues, I defer the response on EMMA TRICARE benefit and NAVMISSA's involvement in a TRICARE benefit to the Navy Surgeon General for response.

Admiral JEFFRIES. The NAVMISSA, as the execution arm for deployment and maintenance of Navy Medicine IT systems has been providing assistance to the contractor, INRange, since October 20, 2009, to develop the necessary documentation package for the Information Assurance C&A of the EMMA. NAVMISSA's responsibility as the Navy medical network security manager is to ensure that all Information Assurance C&A packages are prepared, reviewed, and validated in accordance with JTFGNO (security arm for DOD) requirements prior to submission to the NETWARCOM for approval. EMMA must be formally certified and accredited by NETWARCOM prior to interface with the Navy Medicine IT network. All military Services are held to the same level of security certification. INRange has not provided the level of security required both in documentation and technical certification to prepare the total package required for review and submission by NAVMISSA to NETWARCOM for approval leading to certification and accreditation. It is the intent of the Bureau of Medicine and Surgery to expeditiously field this capability as soon as the contractor, INRange, provides the predefined security deliverables.

[Whereupon, at 12:05 p.m., the subcommittee adjourned.]

DEPARTMENT OF DEFENSE AUTHORIZATION FOR APPROPRIATIONS FOR FISCAL YEAR 2011

WEDNESDAY, APRIL 28, 2010

U.S. SENATE,
SUBCOMMITTEE PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

MILITARY COMPENSATION AND BENEFITS, INCLUDING SPECIAL AND INCENTIVE PAYS

The subcommittee met, pursuant to notice, at 10:03 a.m. in room SR–222, Russell Senate Office Building, Senator Jim Webb (chairman of the subcommittee) presiding.

Committee members present: Senators Webb, Begich, and Chambliss.

Committee staff members present: Leah C. Brewer, nominations and hearings clerk; and Jennifer L. Stoker, security clerk.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, counsel; and Gerald J. Leeling, counsel.

Minority staff members present: Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Jennifer R. Knowles and Breon N. Wells.

Committee members' assistants present: Gordon I. Peterson, assistant to Senator Webb; Lindsay Kavanaugh, assistant to Senator Begich; and Jason Lawrence and Clyde A. Taylor IV, assistants to Senator Chambliss.

OPENING STATEMENT OF SENATOR JIM WEBB, CHAIRMAN

Senator WEBB. The subcommittee will come to order.

The subcommittee meets today to receive testimony on military pay and compensation programs.

We welcome four witnesses this morning. William Carr is the Deputy Under Secretary of Defense for Military Personnel Policy; Brenda Farrell is the Director of Defense Capabilities and Management, Government Accountability Office (GAO); Dr. Carla Tighe Murray is the Congressional Budget Office (CBO) Senior Analyst for Military Compensation and Healthcare; and Dr. James R. Hosek is the Director of Forces and Resources Policy Center, RAND National Defense Research Institute. We welcome all four of the witnesses to this hearing.

I'd like to say this is the first time that I have chaired a hearing in this room, and it's rather odd, because I spent many times down where you guys are when I was in the Department of Defense (DOD). It looks a little better from this end of the table, I have to say. [Laughter.]

The cost of military personnel, including pay and compensation, noncash and deferred benefits, and healthcare continues to rise at disturbing rates. The Department's proposed base budget for fiscal year 2011 for military personnel and healthcare amounts to almost $170 billion, or more than 30 percent of the Department's total budget. By comparison, using 2010 constant dollars, the Department's total cost for military personnel and healthcare in 2001 was $109 billion. This represents an increase of more than 57 percent. The defense health program base budget, including retiree healthcare costs, has increased from $16.6 billion in 2001, using constant dollars, to $41.7 billion in 2011, which represents an increase of more than 151 percent.

Nevertheless, we face the realities posed by the ninth consecutive year of combat operations and the incredible stress this has placed on our servicemembers and their families.

In order to carry out our national obligations, the Services must continue to recruit and retain highly qualified individuals in sufficient numbers. Unlike past wars, this Nation today is fighting with an All-Volunteer Force (AVF). If the Services are to sustain the quality of the AVF, they must be able to compete with the private sector, with the right numbers of talented young men and women.

Beyond the basic requirement to compensate our servicemembers fairly for their unique conditions of service and sacrifice, a robust military compensation and benefit package is key to maintaining the military's competitive position.

As a consequence, compensation and benefits have risen significantly over the past decade. In the 2010 National Defense Authorization Act (NDAA), Congress enacted a pay raise above the annual increase in the employment cost index (ECI) for the 12th consecutive year. For 10 of those years, the pay raise was across the board for all members of the uniformed Services, including uniformed members of the National Oceanic and Atmospheric Administration, the Public Health Service, and the Coast Guard.

While the pay raises of the past decade were appropriate, and I supported them on this subcommittee over the past 3 years, DOD officials remind us that additional pay raises above the ECI have a tailing cost that is often overlooked. Because of the increased basic pay above the rate of inflation, for example, future retired pay is increased for all members of uniformed Services, well beyond DOD projections.

In addition to basic pay, the Department and the Services rely on bonuses and other special and incentive (S&I) pays to attract and retain highly qualified individuals who serve in critical occupational specialties and hard-to-fill billets. Such cash incentives, while sometimes causing sticker-shock to the media, the public, and even some Members of Congress, have the benefit of being targeted to essential people and necessary skills, when done properly.

We, in government, have a particular responsibility to have a full understanding of how such funds are being used and if they are

being used in a logical and efficient way. S&I pays are not reprogrammed from other accounts with specific congressional approval. However, unlike other DOD spending actions during a budget execution year, they can be dialed up or down, depending on circumstances and the needs of each branch of the Armed Forces. They also can be used to encourage an appropriately recognized Service, under the most arduous and demanding conditions.

The Department's management and stewardship of S&I pays is not always transparent, either to the public or to Congress. During this subcommittee's personnel posture hearing last month, I asked Under Secretary Stanley to provide a consolidated accounting and an explanation of the Department's use and management of S&I pays, and how these pays ensure that they are being used efficiently and prudently.

We are informed by DOD that S&I pays make up less than 4 percent of the proposed 2011 military personnel budget. This, in fact, represents a decline from prior years. This level of funding, more than $5.5 billion, is still significant. In its response to my inquiry, the Department has urged the greater use of S&I pays as a more efficient and, ultimately, less costly use of funds, versus an additional across-the-board pay raise above ECI that affects all members of the uniformed Services equally.

The GAO report on military compensation released this month seems to agree with this assessment, as does the 2007 CBO report on military compensation. I look forward to hearing from Ms. Farrell and Dr. Murray on their agencies' work in this area.

This raises the question of what comprises the best mix of across-the-board pay raises versus cash incentives in order to attract and retain the highest quality AVF in sufficient numbers to reduce the stress on the force while compensating servicemembers adequately and fairly for the unique conditions of their Service.

I believe this is the ultimate goal of an equitable military compensation system. In the final analysis, the relative success of recruiting and retention may be the most relevant indicator of our striking the right balance and adequately compensating our all-volunteer military.

In the end, we must make sure that our compensation systems are as efficient and responsible as fairness allows so that we can afford the end strength that we need.

I hope our witnesses today, especially Mr. Carr, can shed some light on the Department's needs and the process that it follows to ensure that S&I pays are used in a way that best serves the interests of our military and of the U.S. taxpayer.

Similarly, I look forward to working with Under Secretary Stanley to ensure that Congress has the visibility it needs in order to effectively discharge its responsibilities to oversee the military and the military compensation system.

I thank each of our witnesses for appearing to testify today. I hope you can shed some light on how we can be more efficient, at the same time being adequate and fair, in terms of compensating our servicemembers. I also hope to hear some ideas on what we can do to address the sharp growth in some of these costs. I'm looking forward to a dialogue on that during this hearing.

Senator Graham is held up in a markup in another committee. We're very pleased to have Senator Chambliss here to represent the Republican side.

Senator Chambliss, welcome.

STATEMENT OF SENATOR SAXBY CHAMBLISS

Senator CHAMBLISS. Thank you very much, Mr. Chairman, first of all, for holding this hearing, and for your leadership on this issue.

I want to join you in welcoming our witnesses and thanking them for their public service. We appreciate the great work you do. It's never easy dealing with numbers, period. But, when you're having to deal with numbers in tough times, particularly on this particular issue, where the service to the United States is reflected by the men and women who continue to serve so valiantly, it's even more difficult, I know. So, we particularly thank you for your service to our country.

In view of the sacrifices and service of the men and women of our Armed Forces, it is essential that we provide them and their families with compensation and a quality of life that reflects not only what is needed to successfully recruit and retain personnel, but also our appreciation and respect for their volunteer service.

Monitoring and adjusting the levels of military pay is a shared responsibility of Congress and the Department which we all take very seriously. Mr. Chairman, it's helpful to step back, occasionally, and assess how we are doing.

I appreciate the views expressed by our witnesses regarding military pay comparability with civilian counterparts. Since 2000, our committee has supported robust pay increases, and there is no question that this has contributed to the superb caliber and readiness of the Armed Forces. To recruit the highest caliber young people and to retain them for careers, during good economic times and bad, it is absolutely critical that incentive pay, such as bonuses and special pays, be flexible enough to respond to changing manpower needs.

The military has had to be able to compete successfully for the services of critically needed professionals, and retain leaders of proven ability for careers of service. Critically needed warfighters, such as Special Forces personnel, are high on this list. Healthcare professionals, nuclear-qualified individuals, EOD personnel, and many others come to mind, as well.

Compensation for our Reserve component personnel is another area that requires careful examination. Reservists and guardsmen provide a great return on the investment, in terms of the capability they provide; but, an operationally-oriented Reserve and Guard is very different from the Strategic Reserve of the past. I'll be interested to hear how DOD is using pay as an incentive to retain reservists for long careers, and what changes we may see in that regard.

The issue of pay and benefits is very important to our servicemembers, and one that this committee cares a great deal about. Each of your perspectives can help inform our recommendations in this area and help us, with DOD, shape a set of pay and benefit policies that serves to recruit and retain the people our Nation

needs in the military, and does so in a way that is also fiscally responsible.

I thank you for your appearance today, for your commitment to this issue, and, most of all, your commitment to our members of the military.

Thank you very much, Mr. Chairman.

Senator WEBB. Thank you very much, Senator Chambliss.

We're going to go to the witnesses. Mr. Carr will go first.

But, before we do, I would like to raise a matter. Mr. Carr, I hope you will take this back to your boss. This relates to a question that I raised about military fellows. This is a very simple question requesting data on military fellows in all elements of their involvement outside of DOD. I asked this question on February 2, 2010, to Secretary Gates. I re-asked it again on March 10 to Secretary Stanley.

I want to start off by saying, when I was a committee counsel over on the House side 30 years ago, DOD was famous for its responses. During a hearing where we were looking at the Carter discharge review program—we were trying to get a breakdown on who served during the Vietnam war, where the casualties were, et cetera—I once turned around to the DOD liaison and said, "I need a breakdown of who served: ethnically, racially, by Service, by year; and what the casualties were, by Service, by race, by ethnicity, by year." I had that information in 1 day; a very voluminous piece of information. DOD invented computer technology. It basically invented the Internet, with apologies to some other people who made contrary statements in the past. [Laughter.]

This kind of information shouldn't take 3 months. I don't want to be put in a position where I'd have to put a hold on nominations or do any of these sorts of things that we have to do in order to get cooperation. We finally, this morning, received a reply, and it's really inadequate. It's basically, I think, minimal cooperation. So, we need to do a lot better on these kinds of things.

Mr. CARR. Yes, sir.

Senator WEBB. So, just take that back to your boss, if you would.

Mr. CARR. I will do that, sir.

Senator WEBB. Welcome.

Mr. Carr, the floor is yours.

STATEMENT OF WILLIAM J. CARR, DEPUTY UNDER SECRETARY OF DEFENSE FOR MILITARY PERSONNEL POLICY

Mr. CARR. Thank you, Mr. Chairman.

Very correctly, the chair pointed out that today we fight the wars with an AVF. If we would have looked back a number of years ago and asked ourselves how a volunteer force could perform the protracted war, we would have viewed it as a risky proposition. It has not proven that. Our retention is stable. Our retention is good. Unit manning, as a consequence, is good. The skill distribution is good—far better than I would have projected years ago.

The things that have happened because of this subcommittee and because of Congress—I'll mention, simply, one, because it goes to the chairman's point on pay as being an important component, in addition to S&I pays. We took the military pay table which is rank versus years of service, and when we looked at it, we realized

noncomissioned officers (NCO) and junior officers were relatively underpaid; some pay compressions had occurred. It took a number of years to tweak the pay table and jack those up, and we did. But, we did something else. Congress moved it to a 40-year pay table, instead of 30. We had an extraordinary number of senior NCOs who were called upon repeatedly to go to the theater, because they were talented, sharp, and experienced. For that reason, they served beyond 30 years. But, retirement pay would be capped at 75 percent. That was removed, coupled with a 40-year pay table enacted by Congress. Those are the kinds of things that adapt, that show the agility and, I think, specifically, are generating the kind of readiness we have.

Today we focus on roughly 3 percent of the budget for military personnel that are, I believe, the best-leveraged dollars we invest. They allow the Nation to recognize special circumstances: the hazards of combat and special duties, such as explosive ordnance disposal, or unique private-sector opportunities, where a given segment of the force has an opportunity and a strong temptation for their families to move to a different line of work. Yet, they remain with us, in part, because of the S&I pays that we provide. Those pays are targeted. They produce a specific result on a limited population. They, therefore, tend to be some of the most efficient manpower dollars that we invest in the pursuit of readiness.

But, that account is tight, and it's growing tighter. We believe it's sized right. We believe it's prioritized correctly in this budget. But, even so, those dollars, as the chairman pointed out, are tightening, and we're moving from 2009 levels, of about 4.4 percent of the military personnel account, being allocated to these very precious, targeted, leveraged, efficient pays, to about 3 percent. There are reasons we do that. We think the risk is reasonable, based on our forecasts of how the members and families are going to react.

Now, we know that setting compensation at an appropriate level is critical to the sustainment of robust Guard and Reserve, as the chairman also correctly pointed out, as did Senator Chambliss. The 11th Quadrennial Review of Military Compensation (QRMC) has convened, and the President asked that they look specifically at this. These QRMCs are producing solid public policy options—bold, almost daring. The 10th QRMC certainly did in its reviews of options for military retirement, for example.

With the people that we've chosen to lead that, I have little doubt that this QRMC is going to produce a systematic set of outcomes that will help improve the lot of the Reserves and the way that we integrate them in today's environment.

In summary, Mr. Chairman, you have aggressively and attentively watched over those in the military. Every person in uniform owes you a debt, and the subcommittee a debt, for the things that you've done.

I thank you for the opportunity to appear before you and look forward to participating today.

[The prepared statement of Mr. Carr follows:]

PREPARED STATEMENT BY WILLIAM J. CARR

Chairman Webb, Senator Graham and distinguished members of the subcommittee, thank you for the opportunity to come before you on behalf of the men and women who so ably serve in the uniforms of our Nation's Armed Forces.

I am here today to speak to you about the state of compensation for our uniformed services. I am pleased to report that—thanks to your support—soldiers, sailors, airmen, and marines continue to express healthy satisfaction with the full pay and benefits the military services provide. This is understandable since military compensation competes very well with private sector wages.

Over the past decade, the Department and Congress together have faced a host of challenges in ensuring military compensation is adequate to recruit and sustain America's All-Volunteer Force. Together, we have reshaped military compensation to make certain that military service remains an attractive option for today's youth as they enlist, and as they progress through critical points in their careers. The success of our combined efforts is manifest by sustained success in meeting or exceeding overall recruiting and retention goals in almost every year over the past decade, across the components.

The Department is committed to carefully managing both the compensation tools and the resources provided by Congress. In the years ahead, the Department very likely will continue its focus on restrained growth of mandatory entitlements while leveraging cost-effective discretionary pays and bonuses.

Military compensation consists of five monetary components. Common to every military member serving on active duty is basic pay, the Basic Allowance for Housing, and the Basic Allowance for Subsistence. Combined with the Federal tax advantage from the housing and subsistence allowances, the aggregate of these four components is defined as Regular Military Compensation (RMC). RMC is then used to benchmark against private sector wages. Based on the Ninth Quadrennial Review of Military Compensation in 2002, the Department evaluates the comparability of military compensation by comparing RMC to the 70th percentile of comparably educated civilians in the private sector.

RMC is the foundation of military pay. It is the fundamental basis we use to recruit, retain, motivate, and separate our force. When the Department experiences broad-based recruiting and retention problems across occupations and services, it is usually because RMC lags private-sector compensation. To ensure this foundation remains sound, it must keep pace with growth in civilian wages as measured by the yearly change in the Employment Cost Index (ECI). This is why the Department supports an annual basic pay raise for 2011 of 1.4 percent—an "ECI pay raise." Should we fail to keep pace with private-sector wages, the result could be a repeat of across-the-force recruiting and retention failures witnessed as recently as the late 1990s.

In response to such failures in the late 1990s, Congress and the Department, together, swiftly improved military compensation. Between January 2002 and January 2010, military pay has risen by 42 percent, the housing allowance has gone up by 83 percent, and the subsistence allowance has grown by 40 percent. By contrast, private-sector wages and salaries rose by only 32 percent during the same period. This has been a signature accomplishment both of the administration and Congress.

The final component of military compensation—and an area of special interest in today's hearing—is represented by the Special and Incentive (S&I) pays. It is with these S&I pays that the Department draws upon, as an increment to RMC, when needed to influence human behavior toward the achievement of high levels of manning and unit performance. These S&I pays are flexible and responsive in affording DOD an ability to respond to external labor market conditions.

The Department provides guidance and exercises continuous oversight over all S&I pays, while delegating significant authority to each of the military departments and Services to implement and execute the pays. The S&I pays typically comprise less than 5 percent of the Department's personnel budgets, yet they provide critical flexibility in responding to private-sector market changes. For example, accession bonuses are used to attract America's youth into hard-to-fill specialties, while retention bonuses are used to keep them in those career fields. The Army recently identified an emerging shortage of Judge Advocate majors through fiscal year 2015. In response, the Army requested and was approved for a series of retention incentives targeting specific year groups to address and correct the projected shortfall. Additionally, S&I pays recognize wage differentials in occupations, such as dentistry, aviation, and nuclear specialties. Assignment Incentive Pay is used to fill arduous assignments around the world, and Hardship Duty Pay is used to recognize duty in a remote location.

These pays are essential and the Department maintains its careful stewardship of these resources. For example, in 2009, S&I pays totaled $6.4 billion, or 4.4 percent of the personnel account. In our recent budget submission for 2011, S&I pays were $5.6 billion, or 3.6 percent of the personnel account. This decrease does not mean S&I pays are less important; rather, it reflects the Department's recognition that the slow recovery in the economy increases the attractiveness of military serv-

ice, which in turn moderates our need to use bonuses in meeting recruiting and retention goals.

The value of the S&I pay program lies in its ability to significantly, yet cost-effectively, influence behavior. A $340 million investment in the S&I pay program, for example, would allow the Department to offer more than 11,000 members with specialized skills or training a bonus of $30,000. That's a big amount to be sure, yet nonetheless efficient when it serves to retain someone who otherwise would walk away with enormously valuable training and experience that will take years to regenerate. Special Operations Forces are a great example of that, which explains our heavy investments in that vital segment of today's military.

An alternative would be to apply that same $340 million to generate a bigger pay raise in the form of a half percent across-the-board hike. For a corporal at 4 years of service, this translates to about $11 per month before taxes. For an officer with 6 years of service, it means about $22 per month. This does not mean that overall pay raises are the wrong answer—simply that they are not the best answer when the general status of pay is healthy as it is today. With the great help of this Subcommittee, we have elevated military pay above the 70th percentile for similarly educated and experienced workers in the private sector—well into the top third of earners—and that shows up in the types of strong retention we have witnessed in recent years. For that reason, we feel strongly that, while we never can offer enough to offset sacrifices of the military and their families, we are in a generally solid position. But we are not in a solid position in certain hard to fill and hard to keep areas like Special Operations.

Furthermore, the Services continue to face challenges in recruiting and retaining certain health professionals so vital to a nation in battle. Certain skill sets are very troublesome. For example, the nature of injuries in Afghanistan and Iraq has increased demand for mental health professionals, yet physicians holding that skill are in short supply nationwide. Here, again, we must and we do turn to S&I pays to preserve our military effectiveness. In 2009, the Department implemented the special bonus and incentive pay authorities for officers in health professions as provided in the 2008 National Defense Authorization Act. These incentives have improved staffing in behavioral health, social workers and psychologists. Additionally, in 2009 the Health Professions Scholarship Program (HPSP) filled all medical and dental student positions by offering an Officer Critical Skills Accession Bonus. This will greatly assist in meeting future medical and dental recruiting goals. It will save lives.

Remaining with the health area, the Services continue to witness shortages in general dentistry and nursing specialties. To attack and control that problem, we continually monitor, adjust and expand medical special pay plans and bonus structures. For example, to attract general dentists in 2010, the Army has an accession bonus of $75,000 for a 4-year active duty service obligation. Each Service also offers loan repayment programs to recruit and retain general dentists. As for nurses, the Services offer a 3- or 4-year accession bonus, a loan repayment option, or a combination of the two to attract nurses. An advanced nursing training program is another tool the Service to recruit nurses. Currently the Department offers an incentive special pay to several nursing specialty and a nurse anesthetists incentive pay for retention contracts of 1 to 4 years. Due to a continuing shortfall for nurse anesthetists, the incentive pay next year for a 4-year retention contract will increase to $50,000.

Turning now from occupations to military components: We know that setting compensation at an appropriate level is critical to sustainment of a robust Guard and Reserve. We remain attentive to the need to treat Active and Reserve colleagues equitably. For example, while on active duty for more than 30 continuous days, Guard and Reserve members are paid the same as Active members. Congress and the Department have worked closely to ensure that reservists are not financially disadvantaged when involuntarily called to active duty. In 2006, Congress authorized the Reserve Income Replacement Program, enabling reservists to maintain the same or nearly the same monthly income. In 2009, Congress created the reservist Differential Pay Program, an additional income replacement program to cover all Federal Government employees, further strengthening the Total Force. Congress has also recognized the sacrifices of mobilized Guard and Reserve members by reducing the retirement age for qualifying service in support of contingency operations. Furthermore, the 11th Quadrennial Review of Military Compensation has been tasked by President Obama to specifically review Guard and Reserve compensation.

Let me now turn from money paid today to the many non-cash and deferred benefits. Non-cash benefits include medical, education, commissary, and Morale, Welfare, and Recreation benefits. These are critical to maintaining quality of life for members and families, directly influencing the family's impression of the military life,

and more directly, the retention decision that emerges from that impression. Deferred compensation, namely the retirement program, provides a strong retention incentive, particularly for personnel with over 10 years of service. We recognize noncash and deferred benefits are important components in the total compensation package.

In summary, Mr. Chairman and members of this subcommittee—you who have so aggressively and attentively watched over our military—I underscore the Department's request for a basic pay increase of 1.4 percent since it well maintains compensation levels competitive with the private sector. But for all the reasons just enumerated, we ask your special consideration this year in supporting our S&I pay program since that specific act will make sure the Department is able to channel resources where needed as the Nation's economy moves forward and pockets of critical—and often unexpected—shortages emerge. I thank you again for the opportunity to testify and for your continued support of our military members and their families. I look forward to your questions.

Senator WEBB. Thank you very much, Mr. Carr.

Ms. Farrell, welcome.

STATEMENT OF BRENDA S. FARRELL, DIRECTOR, DEFENSE CAPABILITIES AND MANAGEMENT, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. FARRELL. Mr. Chairman, Senator Chambliss, thank you for the opportunity to be here today to discuss our most recent report on military compensation.

The NDAA for Fiscal Year 2010 required that GAO conduct a study comparing the pay and benefits of military servicemembers with those of comparably situated private-sector employees to assess how the difference in pay and benefits affect recruiting and retention of military servicemembers. Our work focused on servicemembers' perspectives on compensation—that is, cash compensation and the value of benefits to the servicemembers—rather than the cost to the government of providing compensation.

My written statement today summarizes the findings of our report, issued earlier this month, that you mentioned in your opening statement. Now I will briefly discuss my written statement that is presented in three parts.

The first part of the written statement highlights that total military compensation for Active Duty members is broad and difficult to assess. DOD provides Active Duty servicemembers with a comprehensive package that includes cash, such as basic pay; noncash, such as healthcare; and deferred compensation, such as retirement pension.

CBO, RAND, and CNA all have assessed military compensation using varying approaches. All of their studies include some components of compensation; for example, cash compensation beyond basic pay, which includes housing and subsistence allowances, the Federal income tax advantage, and, when possible, S&I pays. However, these studies did not assess all components of compensation offered to servicemembers. Thus, the results of the studies differ based on what is being assessed, the methodology used to conduct the assessment, and the components of compensation included in the calculation. Furthermore, the valuation rates of noncash and deferred benefits proved more difficult to determine than cash compensation, because servicemembers value these benefits differently and varying assumptions have to be made to assign value.

The second part of my written statement addresses comparing private-sector compensation for civilians with those of military per-

sonnel. We found that military compensation generally compares favorably with civilian compensation in studies. But, these comparisons present limitations. While these studies and comparisons between military and civilian compensation, in general, provide policymakers with some insight into how well military compensation is keeping pace with overall civilian compensation, we believe such broad comparisons are not sufficient indicators for determining the appropriateness of military compensation levels. For example, the mix of skills, education, and experience can differ between the comparison groups, making direct comparisons of salary and earnings difficult.

The third part of my statement addresses the 10th QRMC's recommendation to include not only regular military compensation, but also select benefits, when comparing. This recommendation appears reasonable to us, because it provides a complete measure of military compensation than considering only the cash compensation. Given the large portion of servicemember compensation that is comprised of noncash and deferred benefits, the 10th QRMC emphasized that taking these additional components of compensation into account shows that servicemember compensation is generous, relative to civilian compensation; more so than the traditional comparison of regular military compensation suggests. The 10th QRMC found that when some benefits were included, military compensation compared approximately with the 80th percentile of the comparable civilian compensation. That is, 80 percent of the comparable civilian population earn less than the military population in the comparison.

In summary, I would like to emphasize that another key indicator of the appropriateness and adequacy of military compensation is DOD's ability to recruit and retain personnel. Since 1982, DOD has only missed its overall annual recruiting target three times: in 1998, 1999, and in 2005.

Certain specialties, such as medical personnel, continue to experience recruiting and retention challenges. Permanent across-the-board pay increases may not be seen as the most efficient recruiting and retention mechanism. The use of targeted bonuses may be more appropriate for meeting DOD's requirements for selected specialties where DOD faces challenges in recruiting and retaining sufficient numbers of personnel.

Mr. Chairman, that completes my opening remarks.

[The prepared statement of Ms. Farrell follows:]

PREPARED STATEMENT BY BRENDA S. FARRELL

Mr. Chairman and members of the subcommittee:

Thank you for providing me this opportunity to discuss our most recent report on military and civilian pay comparisons and the challenges associated with those types of comparisons.[1] The Department of Defense's (DOD) military compensation package, which is a myriad of pays and benefits, is an important tool for attracting and retaining the number and quality of active duty servicemembers DOD needs to fulfill its mission. Since DOD transitioned to an All-Volunteer Force in 1973, the amount of pay and benefits that servicemembers receive has progressively in-

[1] GAO, Military Personnel: Military and Civilian Pay Comparisons Present Challenges and Are One of Many Tools in Assessing Compensation, GAO–10–561R (Washington, DC: Apr. 1, 2010).

creased.[2] When it is competitive with civilian compensation, military compensation can be appropriate and adequate to attract and retain servicemembers. However, comparisons between the two involve both challenges and limitations. Specifically, as we have previously reported,[3] no data exist that would allow an exact comparison between military and civilian personnel with the same levels of work experience. Also, nonmonetary considerations complicate such comparisons, because their value cannot be quantified. For example, military service is unique in that the working conditions for active duty service carry the risk of death and injury during wartime and the potential for frequent, long deployments, unlike most civilian jobs.

In addition, there is variability among past studies in how compensation is defined (for example, either pay or pay and benefits) and what is being compared. Most studies, including those done by the Congressional Budget Office (CBO) and RAND Corporation, have compared military and civilian compensation but limit such comparisons to cash compensation—using what DOD calls regular military compensation—and do not include benefits.[4] DOD has also conducted studies comparing military and civilian compensation as part of its Quadrennial Review of Military Compensation (QRMC)—a review required by law, every 4 years, of the principles and concepts of the compensation system for members of the uniformed services.[5] The 2008 QRMC (the 10th) focused on seven compensation-related areas, including the adequacy of compensation, and it recommended, among other things, the inclusion of both cash and some benefits—such as health care—when assessing military compensation. The 10th QRMC also found that, when some benefits were included, military compensation compared approximately with the 80th percentile of comparable civilian compensation—that is, that 80 percent of the comparable civilian population earned less than the military population in the comparison. Previously, the 2004 QRMC (the 9th) found that regular military compensation met the 70th percentile of comparable civilian cash compensation.

The National Defense Authorization Act for Fiscal Year 2010 required that we conduct a study comparing the pay and benefits provided by law to members of the Armed Forces with those of comparably situated private-sector employees, to assess how the differences in pay and benefits affect recruiting and retention of members of the Armed Forces.[6] Earlier this month, we issued our report.[7] My testimony today summarizes the findings of that report. Specifically, my statement will: (1) examine total military compensation for active duty officers and enlisted personnel; (2) compare private-sector pay and benefits for civilians with those of officers and enlisted personnel of the Armed Forces; and (3) assess the 10th QRMC's recommendation to include regular military compensation and select benefits when making such comparisons.

We focused our work on active duty servicemembers' perspectives on compensation—that is, cash compensation and the value of benefits to servicemembers versus the costs to the government of providing compensation. To conduct our work, we identified and reviewed studies on compensation by such organizations as CNA Corporation (CNA), CBO, the Congressional Research Service, DOD, GAO, and RAND. We interviewed officials from DOD's Office of the Under Secretary of Defense for Personnel and Readiness, including the Deputy Under Secretary of Defense for Military Personnel Policy and officials within the Directorate of Compensation, as well as officials from CNA, CBO, the Defense Manpower Data Center, the Bureau of Labor Statistics, and the Military Officers Association of America. To assess total military compensation, we reviewed a 2008 DOD-commissioned report[8]—completed by CNA—and identified estimated values for the elements of military compensation (that is, regular military compensation, health care, retirement, and additional tax

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[2] Historically, "basic pay" has been the largest component of military compensation, and is paid to all servicemembers according to their respective rank and years of service. Congress has provided for and DOD has also implemented over the years a number of additional benefits—some of which may be deferred until after the completion of active duty service. An example is the Post-September 11 Veterans Educational Assistance Act, which expanded the education benefits available to qualified Active Duty and Reserve component members.

[3] GAO, Military Compensation: Comparisons With Civilian Compensation and Related Issues, NSIAD–86–131BR (Washington, DC: June 5, 1986) and GAO–10–561R.

[4] Regular military compensation is the sum of basic pay, allowances for housing and subsistence, and the Federal income tax advantage—which is the value a servicemember receives from not paying Federal income tax on allowances for housing and subsistence. It was initially constructed by the Gorham Commission in 1962 as a rough yardstick to be used to compare military and civilian-sector pay.

[5] 37 U.S.C. §1008.

[6] Pub. L. No. 111–84, § 606 (2009).

[7] GAO–10–561R.

[8] James E. Grefer, CNA Corporation, Comparing Military and Civilian Compensation Packages (Alexandria, VA: March 2008).

advantages). We also identified the employee benefits available to active duty servicemembers and used DOD survey data to identify the utilization rates of these benefits by servicemembers. To compare military compensation with private-sector pay and benefits of comparable civilians, we used CNA's report to identify estimated values for private-sector compensation—pay and benefits—for comparable civilians. In addition, we reviewed the methods CNA used to estimate values for several benefits—retirement, health care, and additional tax advantages.[9] Finally, to assess the 10th QRMC's recommendation to include regular military compensation and select benefits when comparing military and civilian compensation, we conducted a review of recent literature on compensation—including regular military compensation and select benefits—and interviewed DOD officials and other knowledgeable individuals in the fields of compensation and human capital management. We conducted our work in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

TOTAL MILITARY COMPENSATION FOR ACTIVE DUTY OFFICERS AND ENLISTED PERSONNEL IS BROAD AND DIFFICULT TO ASSESS

DOD provides active duty servicemembers with a comprehensive compensation package that includes a mix of cash, such as basic pay; noncash benefits, such as health care; and deferred compensation, such as retirement pension. The foundation of each servicemember's compensation is regular military compensation, which consists of basic pay, housing allowance, subsistence allowances, and Federal income tax advantage. The amount of cash compensation that a servicemember receives varies according to rank, tenure of service, and dependency status. For example, a hypothetical servicemember with 1 year of service at the rank of O–1 and no dependents would currently receive an annual regular military compensation of $54,663, whereas a hypothetical servicemember with 4 years of service at the rank of E–5 and one dependent would receive an annual regular military compensation of $52,589.[10] In addition to cash compensation, DOD offers current and retired servicemembers a wide variety of noncash benefits. These range from family health care coverage and education assistance to installation-based services, such as child care, youth, and family programs.

While many studies of active duty military compensation have attempted to assess the value of the compensation package, most did not consider all of the components of compensation offered to servicemembers. CBO, RAND, and CNA have assessed military compensation using varying approaches. All of their studies include some components of compensation—for example, cash compensation beyond basic pay, which includes housing and subsistence allowances, the Federal income tax advantage, and, when possible, special and incentive pay. However, these studies did not assess all components of compensation offered to servicemembers. Thus, the results of these studies differ based on what is being assessed, the methodology used to conduct the assessment, and the components of compensation included in the calculations.

The most recent study, a 2008 DOD-sponsored study performed by CNA, assessed military compensation using regular military compensation and some benefits (specifically, health care, the military tax advantage, and retirement benefits).[11] In particular, the results of this study state that in 2006, average enlisted servicemembers' compensation ranged from approximately $40,000 at 1 year of service to approximately $80,000 at 20 years of service.[12] Additionally, in 2006 the average officers' compensation ranged from approximately $50,000 at 1 year of service to approximately $140,000 at 20 years of service. Our analysis of CNA's 2008 study found that overall, CNA used a reasonable approach to assessing military com-

[9] For example, servicemembers do not pay Federal Insurance Contributions Act (FICA) tax and State tax on their housing and subsistence allowances.

[10] These estimates come from DOD's regular military compensation calculator, available at http://militarypay.defense.gov/mpcalcs/Calculators/RMC.aspx.

[11] CNA was commissioned by the 10th QRMC to conduct a study comparing military and civilian compensation. The results of the study were used by the QRMC. Typically, discussions of the military tax advantage focus on the savings that arise because the allowances for housing and subsistence are not subject to Federal income tax. However, CNA's study also included an estimation of the expected annual tax advantage that servicemembers receive because they do not pay State and FICA taxes on their housing and subsistence allowances and can often avoid paying any State income taxes depending on their State home of record.

[12] We did not verify the calculations underlying CNA's reported estimates of the value of these select benefits.

pensation; however, we provided comments on two issues. In general, we agree that when assessing military compensation for the purpose of comparing it with civilian compensation, it is appropriate to include regular military compensation and benefits (as many as can be reasonably valued from the servicemembers' perspective). For example, in order to value health care, CNA estimated the difference in value between military and civilian health benefits, because servicemembers receive more comprehensive health care than most civilians.[13]

As mentioned previously, we identified two areas for comment with regard to CNA's approach. First, with regard to retirement, health care, and tax advantage, CNA's methodology makes various assumptions that allow the study to calculate approximate values for these benefits. While the assumptions are reasonable, we note that other, alternative assumptions could have been made, and thus, in some cases, could have generated substantially different values.[14] Second, the CNA study omits the valuation of retiree health care, which is a significant benefit provided to servicemembers. Nevertheless, we note that CNA's study and other studies of military compensation illustrate that valuing total military compensation from a servicemember's perspective is challenging, given the variability across the large number of pays and benefits, the need to make certain assumptions to estimate the value of various benefits, and the utilization of benefits by servicemembers or their dependents, among other reasons.

MILITARY COMPENSATION GENERALLY COMPARES FAVORABLY WITH CIVILIAN COMPENSATION IN STUDIES, BUT THESE COMPARISONS PRESENT LIMITATIONS

In comparing military and civilian compensation, CNA's study as well as a 2007 CBO study,[15] found that military pay generally compares favorably with civilian pay. CNA found that in 2006, regular military compensation for enlisted personnel averaged $4,700 more annually than comparable civilian earnings. Similarly, CNA found that military officers received an average of about $11,500 more annually than comparable civilians. Further, CNA found that the inclusion of three military benefits—health care, retirement, and the additional tax advantage for military members—increased the differentials by an average of $8,660 annually for enlisted servicemembers and $13,370 annually for officers. A 2007 CBO study similarly found that military compensation compares favorably with civilian compensation. For example, CBO's report suggested that DOD's goal to make regular military compensation comparable with the 70th percentile of civilian compensation has been achieved. We note that the major difference between the two studies lies in their definitions of compensation. CNA asserted, and we agree, that the inclusion of benefits allows for comparisons of actual levels of compensation and provides some useful comparison points for determining whether servicemembers are compensated at a level that is comparable to that of their civilian peers, although the caveats that we discuss below should be considered. CBO also noted, and we agree, that including benefits can add another level of complexity to such analytical studies.

However, while these studies and comparisons between military and civilian compensation in general provide policymakers with some insight into how well military compensation is keeping pace with overall civilian compensation, we believe that such broad comparisons are not sufficient indicators for determining the appropriateness of military compensation levels. For example, the mix of skills, education, and experience can differ between the comparison groups, making direct comparisons of salary and earnings difficult. While some efforts were made by CNA to control for age (as a proxy for years of experience) and broad education levels, CNA did not control for other factors, such as field of degree or demographics (other than age), that we feel would be needed to make an adequate comparison. As another example, one approach that is sometimes taken to illustrate a difference, or "pay gap," between rates of military and civilian pay is to compare over time changes in

[13] Specifically, active duty servicemembers are automatically enrolled in TRICARE Prime and do not pay premiums or out-of-pocket expenses for their healthcare whereas many civilians do not receive any health care benefits from their employers and even those who do usually pay some out-of-pocket expenses and part of the premium. By calculating the amount that the typical civilian worker pays for premiums and out-of-pockets expenses, CNA found the difference between what civilians and servicemembers pay. In other words, the benefit servicemembers receive is avoiding the costs civilians would have to pay to receive comparable health care.

[14] For example, when applying discount rates to value retirement benefits, the rate assumed affects the value of the retirement. To illustrate, if a person is to receive $100 in 20 years, the present value of that money is $3.65 using 18 percent, $10.37 using 12 percent, or $31.18 using 6 percent.

[15] CBO, Evaluating Military Compensation (Washington, DC: June 2007).

the rates of basic pay with changes in the Employment Cost Index.[16] We do not believe that such comparisons demonstrate the existence of a pay gap or facilitate accurate comparisons between military and civilian compensation because they assume that military basic pay is the only component of compensation that should be compared to changes in civilian pay and exclude other important components of military compensation, such as the housing and subsistence allowances. We note that CBO also previously discussed three other shortcomings of making such comparisons in a 1999 report.[17] Specifically, CBO noted that such comparisons: (1) select a starting point for the comparison without a sound analytic basis; yet the results of the pay gap calculation are very sensitive to changes in that starting point; (2) do not take into account differences in the demographic composition of the civilian and military labor forces; and (3) compare military pay growth over one time period with a measure of civilian pay growth over a somewhat different period.

10TH QRMC'S RECOMMENDATION TO INCLUDE REGULAR MILITARY COMPENSATION AND SELECT BENEFITS WHEN COMPARING MILITARY AND CIVILIAN COMPENSATION APPEARS REASONABLE

The 10th QRMC's recommendation to include regular military compensation and select benefits when comparing military and civilian compensation appears reasonable to us because it provides a more complete measure of military compensation than considering only cash compensation.[18] Given the large proportion of servicemember compensation that is comprised of in-kind and deferred benefits, the 10th QRMC emphasized that taking these additional components of compensation into account shows that servicemember compensation is generous relative to civilian compensation—more so than traditional comparisons of regular military compensation suggest.[19] The 10th QRMC also recommended that in order to maintain the standard established by the 9th QRMC's 70th percentile (which includes only regular military compensation), DOD adopt the 80th percentile as its goal for military compensation when regular military compensation and the value of some benefits, such as health care, are included in the analysis. In general, when comparing military and civilian compensation, a more complete or appropriate measure of compensation should include cash and benefits. When considering either a military or a civilian job, an individual is likely to consider the overall compensation—to include pay as well as the range and value of the benefits offered between the two options. The challenge with this approach, as mentioned previously, lies in determining how to "value" the benefits, and which benefits to include in the comparison.

Prior to issuing our report earlier this month the Deputy Under Secretary of Defense for Military Personnel Policy provided us with oral comments on a draft of the report. The Deputy Under Secretary generally agreed with our findings, noting that numerous studies have attempted to estimate the value military members place on noncash and deferred benefits and that each study has found that identifying relevant assumptions, valuing these benefits, and finding appropriate benchmarks and comparisons are significant challenges. Noting the variation in the results of these studies, the Deputy Under Secretary stated that further study is necessary before DOD is willing to consider measuring and benchmarking military compensation using a measurement that incorporates benefits.

While comparisons between military and civilian compensation are important management measures, they alone do not necessarily indicate the appropriateness or adequacy of compensation. Another measure is DOD's ability to recruit and retain personnel. We have reported in the past that compensation systems are tools

[16] The Employment Cost Index is a nationally representative measure of labor cost for the civilian economy and measures changes in wages and employers' costs for employee benefits.

[17] CBO, What Does the Military "Pay Gap" Mean? (Washington, DC: June 1999).

[18] According to senior officials in the Office of the Under Secretary of Defense for Personnel and Readiness' Directorate of Compensation, the department has not yet adopted the 10th QRMC's recommendation of including benefits in comparing military and civilian compensation, thus setting the department's overall compensation goal at the 80th percentile of comparable civilian employees.

[19] According to 2005 and 2007 GAO reports, about half of active duty compensation costs consist of benefits, as compared with about 18 percent in the private sector and about 33 percent for Federal civilian employees. See GAO, Military Personnel: DOD Needs to Improve the Transparency and Reassess the Reasonableness, Appropriateness, Affordability, and Sustainability of Its Military Compensation System, GAO–05–798 (Washington, DC: July 19, 2005), and Military Personnel: DOD Needs to Establish a Strategy and Improve Transparency over Reserve and National Guard Compensation to Manage Significant Growth in Cost, GAO–07–828 (Washington, DC: June 20, 2007).

used for recruiting and retention purposes.[20] Similarly, in 2009, CBO stated that ultimately, the best barometer of the effectiveness of DOD's compensation system is how well the military attracts and retains high-quality, skilled personnel.[21] Since 1982, DOD has only missed its overall annual recruiting target three times—in 1998 during a period of very low unemployment, in 1999, and most recently in 2005. Given that: (1) the ability to recruit and retain is a key indicator of the adequacy of compensation; and (2) DOD has generally met its overall recruiting and retention goals for the past several years, it appears that regular military compensation is adequate at the 70th percentile of comparable civilian pay as well as at the 80th percentile when additional benefits are included. We note that although the services have generally met their overall recruiting goals in recent years, certain specialties, such as medical personnel, continue to experience recruiting and retention challenges. As a result, permanent, across-the-board pay increases may not be seen as the most efficient recruiting and retention mechanism. In fact, our previous work has shown that use of targeted bonuses may be more appropriate for meeting DOD's requirements for selected specialties where DOD faces challenges in recruiting and retaining sufficient numbers of personnel.[22]

CONCLUDING OBSERVATIONS

In closing, we note that comparisons between military and civilian compensation are important management tools—or measures—for the department to use to assess the adequacy and appropriateness of its compensation. However, such comparisons present both limitations and challenges. For example, data limitations and difficulties valuing nonmonetary benefits prevent exact comparisons between military and civilian personnel. Moreover, these comparisons represent points in time and are affected by other factors, such as the health of the economy. To illustrate, it is not clear the degree to which changes in the provision of civilian health care or retirement benefits affect the outcome of comparing military and civilian compensation. In addition, valuing military service is complicated. While serving in the military offers personal and professional rewards, such service also requires many sacrifices—for example, frequent moves and jobs that are arduous and sometimes dangerous. Ultimately, DOD's ability to recruit and retain personnel is an important indicator of the adequacy—or effectiveness—of its compensation.

Mr. Chairman, this concludes my prepared statement. I would be happy to respond to any questions that you or members of the subcommittee may have at this time.

Senator WEBB. Thank you very much, Ms. Farrell.

Welcome, Dr. Murray.

STATEMENT OF CARLA TIGHE MURRAY, SENIOR ANALYST, NATIONAL SECURITY DIVISION, CONGRESSIONAL BUDGET OFFICE

Dr. MURRAY. Mr. Chairman, Senator Chambliss, I appreciate the opportunity to discuss CBO's analysis of compensation for members of the Armed Forces.

I've provided a written statement for the record which gives more detail, and so, I'll simply outline my points here.

To attract and retain the military personnel it needs, DOD must offer a competitive compensation package, one that adequately rewards servicemembers for their training and skills, as well as for

[20] GAO, Military Personnel: Active Duty Benefits Reflect Changing Demographics, but Opportunities Exist to Improve, GAO–02–935 (Washington, DC: Sept. 18, 2002).

[21] CBO, Statement of Matthew S. Goldberg: Long-Term Implications of the Department of Defense's fiscal year 2010 Budget Submission (Washington, DC: Nov. 18, 2009).

[22] GAO, Military Personnel: Observations Related to Reserve Compensation, Selective Reenlistment Bonuses, and Mail Delivery to Deployed Troops, GAO–04–582T (Washington, DC: Mar. 24, 2004); Military Personnel: DOD Needs More Effective Controls to Better Assess the Progress of the Selective Reenlistment Bonus Program, GAO–04–86 (Washington, DC: Nov. 13, 2003); Military Personnel: DOD Needs More Data to Address Financial and Health Care Issues Affecting reservists, GAO–03–1004 (Washington, DC: Sept. 10, 2003); and Human Capital: Effective Use of Flexibilities Can Assist Agencies in Managing Their Workforces, GAO–03–2 (Washington, DC: Dec. 6, 2002).

the rigors of military life, particularly the prospect of wartime deployment.

The best barometer of effectiveness of DOD's compensation system may be how well the military attracts and retains high quality personnel. However, the relationship between specific changes in pay and benefits, and the amount of recruiting and retention, may not be clear. A variety of factors, including economic conditions, may affect DOD's ability to attract and retain the force it needs. Therefore, it is difficult to determine the appropriate increase in pay solely on the basis of patterns of recruiting and retention.

Another way to determine whether military compensation is competitive is to compare it with civilian compensation. This testimony will focus primarily on such comparisons, which can be useful, but not definitive, in part because of the significant differences in working conditions and benefits between military and civilian jobs.

Today, I will address three questions. The first question is: how does military cash compensation compare with civilian wages and salaries? CBO's most recent analysis for calendar year 2006 found that average cash compensation for servicemembers, including the tax-free cash allowances for housing and subsistence, was greater than that of more than 75 percent of civilians of comparable age and educational achievement. Since then, military pay raises have continued to exceed increases in civilian wages and salaries. So, that finding has not changed.

Second, is there a gap between civilian and military pay raises over the past few decades? The answer depends on how narrowly military cash pay is defined. One frequent method compares the cumulative increases in military basic pay with civilian pay raises. Applying that method would indicate that military pay rose by about 2 percent less than civilian earnings since 1982. But, this method does not encompass the full scope of military cash compensation. Using a broader measure, one which includes housing and subsistence allowances, indicates that the cumulative increase in military compensation has exceeded the cumulative increase in civilian wages and salaries by 11 percent since 1982. That comparison does not include noncash and deferred compensation, which would probably add to the cumulative difference.

Third, how would the costs of using bonuses to enhance recruiting and retention compare with the costs of adding more to basic pay? Changing the basic pay raise that would take effect on January 1, 2011, from the 1.4 percent requested by the President to 1.9 percent, for example, would increase DOD's costs by about $350 million in 2011, and by a total of about $2.4 billion through 2015. A larger pay raise would probably enhance enlistment and retention, although the effect would be small.

One alternative would be to increase cash bonuses by enough to achieve the same retention effects as a higher across-the-board pay raise. That approach would have a smaller impact on DOD's costs, because bonuses can be targeted to servicemembers who possess the occupational skills the military needs most. Unlike pay raises, bonuses do not compound from year to year or affect retirement pay and other elements of compensation.

Thank you, and I look forward to answering your questions.

[The prepared statement of Dr. Murray follows:]

PREPARED STATEMENT BY DR. CARLA TIGHE MURRAY

Mr. Chairman, Senator Graham, and members of the subcommittee, I appreciate the opportunity to discuss the Congressional Budget Office's (CBO) analysis of compensation for members of the armed forces. To attract and retain the military personnel it needs, the Department of Defense (DOD) must offer a competitive compensation package—one that adequately rewards servicemembers for their training and skills as well as for the rigors of military life, particularly the prospect of wartime deployment.

The best barometer of the effectiveness of DOD's compensation system may be how well the military attracts and retains high-quality personnel. Between 2005 and 2008, the Services periodically had trouble recruiting or retaining all of the high-quality personnel they needed.[1] To address those problems, Congress authorized increases in both cash compensation (such as pay raises and bonuses) and noncash compensation (such as expanded education benefits for veterans and their families). All of the Services met their recruiting and retention goals in 2009 and are continuing to do so in 2010. However, the relationship between specific changes in pay rates and benefits and the amount of recruiting and retention is not clear, and changes in recruiting and retention may be too gradual or too ambiguous to guide all decisions about compensation. In particular, a variety of factors—including economic conditions—may have significant effects on DOD's ability to recruit and retain personnel during a given period. Therefore, it is difficult to determine the appropriate increase in compensation solely on the basis of recent patterns of recruiting and retention.

Even when overall goals for recruiting and retention are met, shortages or surpluses may exist in specific occupations or among people with certain years of service or rank. In those cases, the military services have other tools at their disposal. For example, they can enhance their efforts to attract recruits and can fine-tune their bonus programs to retain existing personnel who possess particular occupational skills.

Another way to determine whether military compensation is competitive is to compare it with civilian compensation. This testimony will focus primarily on such comparisons—which can be useful but not definitive, in part because of the significant differences in working conditions and benefits between military and civilian jobs.

My remarks today will address three questions:

- How does military cash compensation compare with civilian wages and salaries?

CBO's most recent analysis, for calendar year 2006, found that average cash compensation for servicemembers (including tax-free cash allowances for housing and food) exceeded the median compensation for civilians of comparable age and educational achievement. Since then, military pay raises have continued to exceed the increases of civilian wages and salaries, so that finding has not changed.

- Is there a "gap" between civilian and military pay raises over the past few decades?

The answer depends on how narrowly military cash pay is defined. One common method of comparison is to calculate the cumulative difference between increases in military and civilian pay using military basic pay, a narrow measure of cash compensation that does not include, for example, tax-free allowances for housing and food. Applying that method would indicate that cumulatively, civilian pay rose by about 2 percent more than military pay between 1982 and the beginning of 2010. But that measure does not encompass the full scope of military cash compensation. Using a broader measure that includes cash allowances for housing and food indicates that the cumulative increase in military compensation has exceeded the cumulative increase in private-sector wages and salaries by 11 percent since 1982. That comparison excludes the value of noncash and deferred benefits, which would probably add to the cumulative difference, because benefits such as military health care have expanded more rapidly than corresponding benefits in the private sector.

- How would the costs of using bonuses to enhance recruiting and retention compare with the costs of adding more to basic pay?

Traditionally, servicemembers receive an across-the-board increase in basic pay each calendar year, and proposals are frequently made to boost the rate of increase. Changing the basic-pay raise that will take effect on January 1, 2011, from the 1.4

[1] Congressional Budget Office, Recruiting, Retention, and Future Levels of Military Personnel (October 2006). Data for later years come from DOD's Directorate for Accession Policy and Directorate for Officer and Enlisted Personnel Management.

percent requested by the President and DOD to 1.9 percent, for example, would increase DOD's costs by about $350 million in 2011 and by a total of about $2.4 billion through 2015, CBO estimates. A larger pay raise would probably enhance recruiting and retention, although the effect would be small. One possible alternative would be to increase cash bonuses by enough to achieve the same recruiting and retention effects as a higher across-the-board pay raise. That approach would have a smaller impact on DOD's costs because bonuses can be awarded only to the types of servicemembers the military needs most. Bonuses can also be focused on current personnel or potential enlistees who are at the point of making career decisions. Unlike pay raises, bonuses do not compound from year to year (a higher pay raise in 1 year will cause the following year's raise to be applied to a higher base), and bonuses do not affect retirement pay and other elements of compensation.

THE STRUCTURE OF MILITARY COMPENSATION

Earnings can be measured in several different ways, but most studies begin with cash compensation. For the military, the narrowest measure of cash compensation is basic pay. All members of the armed services on active duty receive basic pay, which varies according to rank and years of service. A broader measure of cash compensation—called regular military compensation (RMC)—consists of basic pay plus servicemembers' basic allowances for housing and subsistence, as well as the tax advantage that arises because those allowances are not subject to Federal income taxes. All personnel are entitled to receive RMC, and DOD has used it as a fundamental measure of military pay since at least 1962.[2]

While on active duty, servicemembers may also receive various types of special pay, incentive pay, bonuses, and allowances that are not counted in RMC. Those cash payments help compensate servicemembers for unique features of military life. They may be awarded to personnel who possess particular skills or undertake hazardous duty, including deployment and combat. Personnel may also earn bonus payments when they reenlist after completing their contracted term of service, especially if they have occupational skills that are in short supply. Because those special types of pay are earned irregularly or by a small number of specialists, they are generally excluded when comparing military and civilian compensation.

The broadest measure of military compensation includes noncash or deferred benefits, such as retirement pay, health care, and veterans' benefits. In both the armed forces and civilian jobs, such benefits can be sizable and can influence people's decisions about employment, including whether to enlist or reenlist in the military. Noncash benefits make up about half of total compensation for the average servicemember, CBO estimates—compared with about one-third for the average civilian worker. Thus, a measure of compensation that includes all noncash and deferred benefits gives a broader and clearer picture of the military's entire compensation package and provides a useful framework for analyzing servicemembers' cash compensation. However, such a comprehensive measure combines funds in different defense appropriation titles and in departments other than DOD; thus, it is more difficult to use than narrower measures of cash compensation to assess a particular department's budget.

HOW DOES MILITARY PAY COMPARE WITH CIVILIAN PAY?

The results of pay comparisons differ depending on the definition of military compensation and the segment of the civilian population used in the comparison. Most enlisted personnel join the military soon after high school, but they generally receive some college-level education while on active duty. (The share of enlisted personnel with at least 1 year of college education grew from 32 percent in 1985 to 72 percent in 2005, CBO estimates.) DOD has asserted that in order to keep experienced personnel in the force, military pay must compare favorably with the wages of college-educated civilians rather than high school graduates. Specifically, DOD's goal has been to make RMC comparable with the 70th percentile of earnings for civilians who have some college education.[3]

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[2] Department of Defense, Under Secretary of Defense for Personnel and Readiness, Report of the 9th Quadrennial Review of Military Compensation, vol. 1 (March 2002), p. 29.

[3] Ibid. Two years ago, DOD's 10th Quadrennial Review of Military Compensation developed a new measure of compensation—called military annual compensation (MAC)—that would include selected noncash elements and deferred compensation. The review's authors recommended making MAC comparable to the 80th percentile of civilian earnings (including similar noncash elements). DOD has not adopted the new measure and continues to use RMC; see, for example, the statement of Clifford L. Stanley, Under Secretary of Defense for Personnel and Readiness, before the Subcommittee on Personnel, Senate Armed Services Committee, March 10, 2010.

CBO estimated that in calendar year 2006, average basic pay for enlisted personnel closely matched the 50th percentile of estimated earnings for civilians with some college education—in other words, roughly half of those civilians had earnings that were higher than average basic pay and half had earnings that were lower.[4] CBO also estimated that average RMC (which includes cash allowances and associated tax advantages) exceeded the 75th percentile of earnings for civilians with some college education, surpassing DOD's goal. Lawmakers have continued to authorize military pay raises that exceed the average rise in civilian wages and salaries, so those measures of military compensation would probably match higher percentiles of civilian earnings today. CBO's study also concluded that servicemembers have access to a range of benefits not routinely offered in the private sector, including free or low-cost health care, housing, education assistance, and discount shopping. Other studies of cash and noncash compensation have reached similar conclusions.[5]

Comparisons of military and civilian pay have several important limitations. First, working conditions can differ markedly between military and civilian jobs. For example, military personnel are generally expected to change locations every few years—in addition to deploying for specific operations—whereas most civilians can choose to remain in the same area throughout their career. Military personnel may work longer hours or in more hazardous conditions than civilians do, even if their type of occupation is the same. At the same time, military life includes features that people may find more attractive than comparable civilian jobs. Some military personnel receive greater responsibility earlier in their career than civilians do. Job security and group solidarity can also be greater for military personnel than for civilians. Pay comparisons cannot easily incorporate those intangible job characteristics.

Second, pay comparisons may ignore the value of training and education that are provided on the job. DOD generally tries to enlist capable young people with high school diplomas or some college education and then trains them for military life and for their occupational specialty. Civilian employers, by contrast, generally hire people who have already been trained, often at their own expense (although most large employers offer work-related education assistance). In addition, civilian employers are more likely to hire people who have more experience. Adding in the value of government-provided training and education would generally make the noncash share of total military compensation even greater relative to civilian compensation.

Third, differences between military and civilian career patterns complicate pay comparisons. Because the military "promotes from within," pay may need to be higher for new recruits than for civilians of similar ages and education levels as DOD tries to compete for the best pool of applicants from which to select the best career personnel. Also, data on average civilian compensation include the pay of people who are successful in their civilian career as well as the pay of people who are not. But in the military, the "up-or-out" promotion system means that the least successful personnel have generally left military service before reaching senior levels.

IS THERE A "GAP" BETWEEN MILITARY AND CIVILIAN PAY RAISES?

Because basic pay makes up the majority of regular military compensation, one of the most common comparisons is between changes in military basic pay and changes in the employment cost index (ECI) for wages and salaries of private-sector workers. In 1981 and 1982, relatively large increases in basic pay were enacted to address shortfalls in recruiting and retention. For much of the following two decades, however, basic pay increased more slowly than the ECI did. Some observers have measured the percentage by which the cumulative increase in military basic pay since 1982 has fallen short of the cumulative increase in the ECI for private-sector wages and salaries, referring to that difference as a military "pay gap." By 1998, the gap totaled nearly 14 percent (see Figure 1).

Lawmakers enacted several measures that helped narrow the perceived gap. In November 2003, for example, they passed a provision stipulating that the increases

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[4] Congressional Budget Office, Evaluating Military Compensation (June 2007).

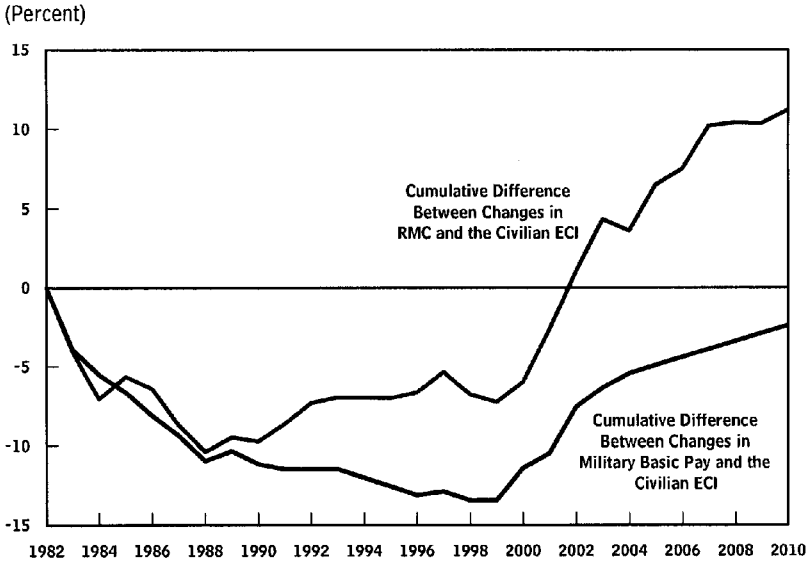
[5] See Department of Defense, Under Secretary of Defense for Personnel and Readiness, Report of the 10th Quadrennial Review of Military Compensation, vol. 1 (February 2008); James E. Grefer, Comparing Military and Civilian Compensation Packages (Alexandria, VA: CNA, March 2008); Government Accountability Office, Military Personnel: DOD Needs to Improve the Transparency and Reassess the Reasonableness, Appropriateness, Affordability, and Sustainability of Its Military Compensation System, GAO–05–798 (July 2005); Beth J. Asch, James Hosek, and Craig Martin, A Look at Cash Compensation for Active-Duty Military Personnel, MR–1492–OSD (Santa Monica, CA: RAND Corporation, 2002); and Congressional Budget Office, Military Compensation: Balancing Cash and Noncash Benefits, Issue Brief (January 16, 2004).

in basic pay for 2004, 2005, and 2006 exceed the corresponding increases in the ECI by 0.5 percentage points.[6] Each year since then, Congress has continued to set the basic-pay raise at 0.5 percentage points above the increase in the ECI.[7] As a result, the cumulative difference between increases in basic pay and the ECI since 1982 has shrunk to a little over 2 percent.

As a basis for evaluating pay, however, the gap between military and civilian raises since 1982 has some significant limitations.[8] First, the ECI is based on a survey that includes a broad sample of civilian workers; on average, those workers are older than military personnel and more likely to have college degrees. Since 1980, the pay of college-educated workers has risen faster than that of high school graduates in the civilian sector. Also, the pay of older civilian workers has generally grown faster than that of younger workers. Because the military mainly recruits young high school graduates, pay raises that were smaller than increases in the ECI would not necessarily hamper DOD's efforts to attract new personnel.

Figure 1.

Difference Between Changes in Military and Civilian Compensation Since 1982



Source: Congressional Budget Office based on data from the Department of Defense and the Department of Labor.

Notes: RMC = regular military compensation (basic pay, cash allowances for housing and subsistence, and the federal tax advantage that occurs because those allowances are not taxed); ECI = employment cost index for wages and salaries in private industry.

These comparisons exclude noncash benefits and the military's various types of special pay and bonuses.

[6] Section 602 of the National Defense Authorization Act for Fiscal Year 2004 (117 Stat. 1498, 37 U.S.C. 1009).

[7] For example, the President requested a 2.9 percent increase in basic pay for 2010, which equaled the percentage increase in the ECI. Congress authorized a 3.4 percent pay raise in section 601 of the National Defense Authorization Act for Fiscal Year 2010 (123 Stat. 2347, 37 U.S.C. 1009).

[8] CBO produced a technical analysis of those limitations in 1999, and they continue to exist today. See Congressional Budget Office, What Does the Military "Pay Gap" Mean? (June 1999).

Second, the pay-gap calculation focuses on one part of military compensation—basic pay—and ignores changes in other cash and noncash components. In 2000, besides raising basic pay, lawmakers authorized a restructuring of housing allowances that eliminated out-of-pocket expenses typically paid by servicemembers (which had averaged about 20 percent of housing costs).[9] Other changes included linking housing allowances more closely to increases in local housing prices and giving servicemembers "rate protection" from any declines in those prices.

With RMC substituted for basic pay in the comparison, the total growth in military compensation since 1982 has exceeded the growth in the ECI for private-sector wages and salaries by about 11 percent (see Figure 1). Including the value of noncash and deferred benefits would probably add to that cumulative difference.

WHAT ARE THE EFFECTS OF CHANGING BASIC PAY VERSUS AWARDING HIGHER BONUSES?

Increasing basic pay in 2011 will affect DOD's budgetary requirements in future years. Pay raises compound from 1 year to the next, because a higher raise this year will cause next year's rate of increase to be applied to a higher base. Changes in basic pay also affect other components of compensation, such as retirement pay. CBO estimates that increasing the basic-pay raise that will take effect on January 1, 2011, from 1.4 percent, as requested by DOD and the President, to 1.9 percent would boost DOD's personnel costs by about $350 million in 2011 as well as by a total of about $2 billion over the following 4 years (see Table 1).

A higher pay raise would most likely enhance recruiting and retention, but the effect would be small. The annual difference between a 1.4 percent increase and a 1.9 percent increase in basic pay for the average enlisted member is about $150. CBO estimates that roughly 1,000 people who would not choose to enlist or reenlist in 2011 if basic pay rose by 1.4 percent would do so with the higher raise.

Alternatively, the same result might be accomplished by increasing bonuses for enlistment and reenlistment or by stepping up recruiting efforts. A bonus program generally requires smaller increases in spending than a basic-pay raise does to achieve the same effect on recruiting and retention, for several reasons. Bonuses can be targeted toward those servicemembers (or potential recruits) whom the military needs most. Bonuses do not compound, as pay raises do, and they do not affect retirement pay and other elements of compensation. Bonuses also do not involve expending resources on servicemembers who do not have the option of leaving in a particular year; they can be focused on the years of service in which personnel make career decisions and can be curtailed if other factors (such as economic conditions or deployment requirements) change. In addition, larger bonuses could create more-meaningful differences in pay between occupations, which could be a cost-effective tool for improving military readiness.

However, amplifying pay differences between occupations or between people at slightly different stages of their career could run counter to the longstanding principle of military compensation that personnel with similar amounts of responsibility should receive similar pay. Also, increasing bonuses rather than adding to basic pay would reduce retirement and other benefits for servicemembers relative to what they would receive if the extra money was part of basic pay throughout their career.

[9] Those changes were enacted in section 605 of the National Defense Authorization Act for Fiscal Year 2001 (114 Stat. 1654A–147, 37 U.S.C. 403).

Table 1.

Costs to DoD of Increasing the Basic-Pay Raise from 1.4 Percent to 1.9 Percent in 2011

(By fiscal year, in millions of dollars)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total 2011–2015	Total 2011–2020
Budget Authority	367	495	502	511	524	538	554	571	588	606	2,399	5,256
Outlays	348	488	501	510	523	537	553	570	587	604	2,370	5,221

Source: Congressional Budget Office based on data from the Department of Defense (DoD).

Note: Although the numbers shown here are for fiscal years, military pay raises generally take effect on January 1 (the beginning of the second quarter of the fiscal year). These numbers apply to active-duty and reserve personnel but not to members of the Coast Guard or other branches of the uniformed services.

How much it would cost to attract and retain the same number of personnel with bonuses rather than a larger increase in basic pay would depend on how the services structured their bonus programs. In any event, the lack of compounding means that in 2012 and beyond, virtually all servicemembers would have lower overall compensation than they would receive with a larger increase in basic pay. That outcome could also affect recruiting and retention in future years. If DOD wanted to attain the same levels of recruiting and retention as it would achieve with the higher basic pay, an augmented bonus program would need to continue in future years as well.

Senator WEBB. Thank you very much, Dr. Murray.

Dr. Hosek, welcome.

STATEMENT OF JAMES R. HOSEK, DIRECTOR, FORCES AND RESOURCES POLICY CENTER, RAND NATIONAL SECURITY RESEARCH DIVISION

Dr. HOSEK. I would like to thank the committee for the opportunity to testify.

I will address my comments to the usefulness of incentive pays, such as bonuses, in influencing career decisions of servicemembers.

To summarize my main points, research consistently finds that people are responsive to enlistment and reenlistment bonuses. Bonuses expand the recruiting market, channel enlistees into hard-to-fill occupations, reduce attrition, and increase reenlistment. Because bonuses and other incentive pays can be targeted and increased or decreased in value, they can be a flexible, cost-effective element of military compensation.

The health of the AVF depends on maintaining an adequate foundation of compensation. The foundational pays of military compensation include basic pay, allowances, health benefits, educational benefits, and retirement benefits. These pays and benefits help to ensure that the Services can recruit, retain, and motivate the number and caliber of people they need to meet manpower requirements, as well as produce future leaders and shape the force. However, it is not cost-effective to pay servicemembers only

through foundational pays, but through a combination of foundational pays and incentive pays.

The relevance of this observation to policy action depends on the state of the economy. In 1999, when unemployment was low and jobs were plentiful, recruiting and retention were hampered by low military pay, and the basic pay increases enacted at that time were an effective response. Today, the economy is climbing out of a deep recession, the unemployment rate is high, and job opportunities are expected to improve only gradually during the coming year. These conditions have helped recruiting and retention, and weaken the case for a higher-than-usual increase in basic pay.

Enlistment and reenlistment bonuses have been used extensively in recent years, and they have helped to stabilize recruiting and retention. In the case of enlistment bonuses, the average Army enlistment bonus increased from about $3,000 to $12,000 from fiscal year 2004 to fiscal year 2008. In the absence of this increase, high quality enlistments would have been about 20 percent lower. If basic pay had been used instead of bonuses, the cost to the taxpayer would have been greater. Enlistment bonuses tended to decrease attrition, as well. I should add that other recruiting resources, such as the number of recruiters and advertising, have also contributed to recruiting success.

Reenlistment bonuses have been equally valuable. Our analyses show that, by 2006, the growing burden of deployment was putting downward pressure on Army and Marine Corps reenlistment. Two-thirds of the soldiers and half of the marines up for first-term reenlistment had 12 or more months of deployment in the previous 3 years. We found that this cumulative amount of deployment tended to decrease reenlistment. The expanded use and increased generosity of reenlistment bonuses, starting in 2005, helped to offset this downward pressure and keep reenlistment rates on a fairly even course.

The role of bonuses is not limited to the Active components. We are finding that enlistment bonuses are effective in increasing enlistment into the Reserve components by those who have served in an Active component and who, therefore, already have training and experience.

In closing, I want to note an area where the use of bonuses might be improved. This has to do with bonus ceilings; that is, the upper limit on the size of the bonus. Some servicemembers may be at or near the bonus ceiling because they are at a high grade or in a specialty offering a high bonus. In these cases, an increase in the bonus means that the member can sign up for a shorter term without decreasing the amount of bonus he receives. Our empirical evidence confirms this behavior. A higher bonus ceiling would remove this undesired effect. More generally, there should be flexibility to allow a higher ceiling in cases where higher bonuses are needed to sustain retention.

Thank you.

[The prepared statement of Dr. Hosek follows:]

PREPARED STATEMENT BY DR. JAMES R. HOSEK[1]

THE ROLE OF INCENTIVE PAYS IN MILITARY COMPENSATION[2]

I would like to thank the committee for the opportunity to testify. I will address my comments to the utility of incentive pays in influencing career decisions of members of the U.S. military.

The Armed Forces share a common foundation of military pay. The foundation includes basic pay, basic allowance for subsistence, basic allowance for housing (or housing in-kind), and a military health benefit for servicemembers and their families. Educational benefits could also be included, as could contributions toward retirement benefits. This foundation of pay performs several functions. It helps to ensure that the Services can recruit, retain, and motivate the number and caliber of people they need to meet manpower requirements, produce a flow of capable future leaders within the enlisted and officer ranks, and shape the force so that its experience and grade mix are appropriate to the desired force structure.

The health of the volunteer force depends on maintaining an adequate foundation of pay. This seems like an obvious statement, but at times the Nation has inadvertently tested its validity. The combination of basic pay, basic allowance for subsistence, and basic allowance for housing were set high enough at the start of the volunteer force in 1973 to enable a successful launch. Yet lower than adequate pay increases in the following years led to a recruiting and retention crisis at the end of the 70s, and Congress faced the alternatives of returning to a draft or restoring military pay to competitive levels. Congress chose to restore pay, increasing it a total of 26 percent in fiscal years 1980 and 1981. A second test occurred as the economy boomed in the late 1990s. Again military pay did not keep up with pay in the private sector and strains developed in recruiting and retention, though not as severe as in the late 1970s. Congress responded in the National Defense Authorization Act (NDAA) of 2000 with a 4.8 percent increase in basic pay, a restructuring of the pay table with higher increases for certain years of service and ranks, and a commitment to increase basic pay half a percentage point more than the Employment Cost Index in each fiscal year through 2006. The importance of this pay action was not that it had to be taken—ultimately, the volunteer concept cannot survive unless pay is kept at levels competitive with the private sector—but that the Nation had restored pay and stabilized recruiting and retention before the terrorist attack on September 11, 2001 and the ensuing military operations in Iraq and Afghanistan.

An adequate foundation of military pay is necessary for the viability of the volunteer force, but it is not cost effective to pay servicemembers only though foundational pays. Because market wages differ by skill, education, aptitude, and work conditions, it would be extremely costly to increase the foundational pays so they were competitive for the highest wage individuals. Doing so would mean that military pay was higher than needed for everyone else. This point is true in general but its relevance to policy action depends on the state of the economy. In 1999 when unemployment was low and jobs were plentiful, recruiting and retention were hampered by low military pay and the increases enacted in NDAA 2000 were appropriate. Today the economy is climbing out of a deep recession, unemployment is high, and job opportunities are expected to improve only gradually during the coming year. These conditions have helped recruiting and retention and weaken the case for a higher than usual increase in basic pay.

Incentive pays help the military compete in the labor market in a cost-effective way. Rather than increasing military pay for all, incentive pays increase military pay selectively. Incentive pays are a means of targeting higher pay to where and when it is most needed to ensure an adequate supply of manpower. Because incentive pays are targeted, they are less expensive than an across-the-board increase in military pay. Some incentive pays such as sea pay or aviation career incentive pay are highly stable additions to foundation pay. Other incentive pays such as enlistment and reenlistment bonuses can be turned on and off as needed, and this flexibility means that they offer a fast, well targeted, and temporary increase in pay.

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[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to Federal, State, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

[2] This testimony is available for free download at http://www.rand.org/pubs/testimonies/CT345/.

Similarly, deployment related pays such as hostile fire pay and the combat zone tax exclusion are viewed as a just recognition of special sacrifices and risk attached to deployment to a hostile area.

Incentive pays are paid to those people on the brink of enlisting or reenlisting who wouldn't have enlisted or reenlisted without getting these pays. But they are also paid to those who would have enlisted or reenlisted even without the bonus. For instance, all servicemembers who reenlist in a specialty covered by a bonus will receive a bonus, though some would have reenlisted without a bonus. The fact that some individuals are paid more than they need to be paid to reenlist is not unique to military incentive pays but is a common feature of labor markets. The market-clearing wage is the wage needed to hire or keep the worker on the margin and is higher than needed for workers below the margin. But all workers receive the market wage because if they didn't they could seek work in a different market, and they have no incentive to reveal that they would accept less than the market-clearing wage.

The fact that incentive pays (or market wages in general) pay some workers more than they would be willing to accept should not be seen as a flaw. Incentive pays are a way of making military pay competitive in a competitive labor market. Without them, losses at the margin would escalate and manning in specialized assignments would suffer. For example, overall manning in a military specialty such as logistics may be in good balance, but the subset of logisticians qualified to perform as recruiters or parachutists may be in very short supply. An incentive pay motivates logisticians to volunteer for specialized training and duty in these particularly challenging or risky duties, payable so long as they hold the specialized assignments.

Enlistment and reenlistment bonuses have been extensively used in recent years. This may seem puzzling in view of the major adjustments to pay in NDAA 2000 and subsequent increases in basic pay and the basic allowance for housing. But despite these pay actions, our analyses suggest that the military operations in Iraq and Afghanistan had a downward effect on Army recruiting, and the extensive deployments supporting these operations had a downward effect on Army and Marine reenlistment. However, we also find that the expanded use and higher levels of enlistment bonuses helped to counteract the downward trend on Army enlistment and the expanded use and higher levels of reenlistment bonuses greatly helped to counteract the downward pressure on reenlistment of more extensive deployments.

These analyses are described in a forthcoming RAND report, Cash Incentives and Military Enlistment, Attrition, and Reenlistment, MG–950. In the case of enlistment bonuses, we estimate that a 10 percent increase in enlistment bonuses expands the high-quality market for Army recruiting by 1.7 percent. While this may seem small, it is useful to put this result in perspective. Between the end of fiscal year 2004 and the end of fiscal year 2008, the average enlistment bonus in the Army increased from about $3,000 to about $12,000. Using our estimated model, we predict that in the absence of this increase in enlistment bonuses, high quality contracts in the Army would have been about 20 percent lower, implying that the Army would have enlisted 1,670 fewer high-quality contracts per quarter. At the same time, we estimate that the Iraq war took a negative toll on Army recruiting, after controlling for other factors that were changing at the same time, and that the increase in enlistment bonuses expanded the market and helped offset this negative effect of the Iraq war on recruiting. We also estimate that enlistment bonuses achieved this market expansion at less cost than had basic pay been increased instead. That is, if basic pay had been increased to generate the additional 1,670 recruits per quarter, the cost to the taxpayer would have been greater.

How effective are reenlistment bonuses? It is useful to think of the generosity of a bonus offer in terms of the bonus multiple, or step. The amount of the bonus for a 4-year reenlistment is equal to the product of monthly basic pay, years of reenlistment, and bonus step. Monthly basic pay depends on rank and years of service, the length of reenlistment is chosen by the servicemember, and the Service sets the bonus step. The fiscal year 2010 basic pay for a corporal (E–4) with 3 to 4 years of service is $2,094, so the bonus for a 4-year hitch at step 1 is $8,376, for example. In the study mentioned above, we estimate that a one-step increase in the bonus increased first-term reenlistment by 2.5 percentage points in the Army, or from about 40 percent to 42.5 percent. The estimates for the other services are 2.5 percentage points for the Navy, 3.6 percentage points for the Marine Corps, and 1.6 percentage points for the Air Force. Estimates at second-term reenlistment tend to be somewhat smaller: Army, 2.5 percentage points; Navy, 1 percentage point; Marine Corps, estimate not statistically different from zero; and Air Force, 1.5 percentage points. These estimates are in line with previous studies.

To put these reenlistment bonus estimates in perspective, it is useful to compare them to the effects of deployment on reenlistment. We find that soldiers and marines with 12 or more months of deployment in the 3 years before their reenlistment point had lower reenlistment rates, as compared to those with no deployment, and by 2006 two-thirds of the soldiers and half of the marines at first-term reenlistment had 12 or more months of deployment. The large portion of personnel with 12 or more months of deployment coupled with the negative effect on reenlistment for those with 12-or-more months threatened to reduce reenlistment and imperil unit manning. However, reenlistment bonus usage and amounts increased a great deal from 2004 to 2005 and remained at higher levels in the following years. For instance, in 2004 approximately 15 percent of first-term soldiers who reenlisted received a bonus, and its average step was about 1.3. In 2005 about 70 percent of first-termers who reenlisted received bonuses, and the average step was about 1.9, or roughly a 50 percent increase in bonus generosity. The percentage receiving a bonus and the average step increased a bit further in 2006 and 2007. We estimate that the expanded use and increased generosity of reenlistment bonuses was sufficient to offset the downward pressure coming from deployments, resulting in a steady overall reenlistment rate. (This is reported in How Have Deployments During the War on Terrorism Affected Reenlistment? MG–873.)

Both enlistment and reenlistment bonuses today are paid half up front at the time the new term begins and half in annual installments over the term. This approach is a sensible compromise.

Research shows that servicemembers prefer a bonus to be paid in full immediately rather than paid in installments, but by paying half of the bonus in installments the services create an ongoing incentive for the member to stay in service for the entire term. In the Cash Incentives report, we find evidence that bonuses induce members to stay in service, though the effect is rather modest. Specifically, we find that a 10 percent expansion in Army enlistment bonuses reduces first-term attrition from about 32 percent on average to about 31 percent.

Bonuses can be used to fine-tune personnel management. For instance, the Army offers higher bonuses for certain locations, and is using bonuses to match the entry date of new recruits with the availability of training seats. Another important use of bonuses is to channel recruits into hard-to-fill specialties. The effectiveness of bonuses for skill channeling was demonstrated in an enlistment bonus experiment (The Enlistment Bonus Experiment, R–3353). That study found that holding the total number of enlistments constant, an increase in bonuses targeted to hard-to-fill occupations increased enlistments in those occupations by 43 percent.

The role of bonuses is not limited to the Active components. In the Reserve components, two types of recruitment bonuses are used, enlistment bonuses and affiliation bonuses. The allowable size of these bonuses increased markedly in 2006, and in work underway at RAND we are finding that these bonuses have been effective in increasing prior service enlistment into the Reserve components. The study has not yet addressed non-prior service enlistment so we do not have estimates of bonus effects for this population.

There is an area where the use of bonuses might be improved. This has to do with bonus ceilings, i.e., the upper limit on the size of a bonus. Generally speaking, a more generous bonus creates an incentive to sign up for a longer term, but a bonus ceiling can thwart this incentive. Some servicemembers may be at or near the bonus ceiling because they are in a high pay grade or a specialty offering a high bonus step. In these cases, an increase in the bonus step means that the member can sign up for a shorter term without decreasing the amount of bonus he receives. Our empirical evidence confirms this behavior. A higher bonus ceiling would remove this undesired effect. More generally, there should be some flexibility to allow a higher ceiling in cases where higher bonuses are needed to sustain retention.

To summarize, research consistently finds that people are responsive to enlistment and reenlistment bonuses, and this finding is confirmed in our studies and those of others. Bonuses expand the recruitment market, are effective in inducing enlistees to select hard-to-fill occupations, and induce servicemembers to reenlist rather than leave for civilian opportunities. Furthermore, our analysis finds that bonuses have expanded the market and increased reenlistments in a costeffective manner, especially when compared to military pay. In other words, if Congress had instead opted to raise pay more to achieve the same increase in enlistments and reenlistments, the cost to the taxpayer would have been more. Finally, carefully targeted bonuses have been helpful in sustaining reenlistment in recent years when the burdens of deployment have threatened to decrease it.

Senator WEBB. Thank you very much.

To all the witnesses, thanks for your testimony. We have a tremendous amount of experience at the table right now, from a number of different perspectives.

As I mentioned at the outset, this is, I think, a good opportunity for all of us just to take a look at these programs. Sometimes we have to even re-explain them to the political process, because of the momentum with which they are dealt. We rarely break down and say, "All right, what is this? What is this program? How does it help?" In that spirit, I'd like to ask a number of questions, and get the panel's thoughts on them.

The first occurred to me listening to Ms. Farrell and Dr. Murray both, talking about the civilian comparability on military compensation. Let me just start by saying, when I was growing up in the military, the differential truly was the other way around. You could compare, say, an O6 with a GS15, and, in terms of benefits and long-term benefits, the civil servant clearly had a better deal. I don't think that's true today. It's probably the other way around today, when you look at the protections that are in place.

Even when my father finally made colonel—and I was long gone when that happened—I think he made $14,000. Even if you do all the multiples, it's not a whole lot of money. There weren't a lot of other incentive pays to go along with that.

I was on Active Duty when we began the volunteer Army concept. I actually was on the Secretary of the Navy's staff in 1971, when they first started talking about reconfiguring the overall pay structure. It was pretty much a bold leap forward. It was before they got into these add-ons. But, as all of you know, the premise in military compensation, until the creation of the volunteer system, was that the lower three enlisted ranks and the lower two officer pay levels were paid very little, the idea being that that was the citizen soldier, as a consequence of a country that had conscription. Then, the money, such as it was, went into the career force, to try to protect and properly compensate the career force. So, when they started the volunteer concept, the first step that they made was to dramatically increase the pay scale at the bottom, to incentivize people to come in on a voluntary basis.

Then all these other programs that are now in place, fell in incrementally over the years. We saw a lot of it when I was in the Reagan administration, in the Pentagon, where it really started focusing in on different areas.

This is still a work in progress, in terms of how we field the best military in the world, and how we take care of our people.

The question that came to my mind when I was listening was, when we're talking about comparability with the private sector—for instance, when the comment was made if you include other benefits, there's about an 80th percentile for the typical military person—I would like to hear from all of you—first of all, which benefits are we including when we do that? Which benefits are we not? For instance, even on the medical side, do we factor in such things as not having to have malpractice insurance or to pay for an office? Do we count that as compensation when we're looking at comparing what the costs would be on the outside? What are we doing

on these different areas? What are we putting in and what are we leaving out when we hit these kinds of numbers?

Ms. Farrell, you might want to start on that.

Ms. FARRELL. Sure, Senator.

As I noted, the studies differ in what they include. That's the reason you get different results; although at this time, the reports that we looked at from my colleagues here all came up with similar results showing that the military pay was very favorable. The 10th QRMC included select benefits: it was healthcare, retirement, and the tax advantage. We're talking about a very broad base approach. When you referred to malpractice insurance, maybe you're thinking more of a scenario that's comparing one occupation for a physician with a physician in the private sector. These studies are very broadbased, and that's the reason we say that they have limitations, because the populations can differ, for example, in terms of age and education—usually your private-sector population is older than what you have in the military workforce, and usually your private-sector population is already further ahead in education. Many of our young people join the military with the plans to go on and get that education. So, you have different populations, in terms of demographics that you're reviewing, that places some limitations on the methodology.

But, with that said, we feel that the studies that reviewed, with CNA being the backup for the data, with the 10th QRMC that included the three select benefits, took a very reasonable approach. There could be—there were a couple comments that we made on the CNA study, regarding assumptions about healthcare and retirement, and some other organization could come up with different assumptions. We still think it's reasonable.

One of the assumptions made, for example, about retirement involves the discount rate. If someone's going to retire in 20 years and receive $100, to make if very simple, what is the discount rate that would be the present value today? The discount rate that CNA used could be a little bit on the high side, compared to if a different rate was used. So, there's differences in the assumptions that are used for these noncash benefits, such as the healthcare—trying to place the value on it—as well as the retirement.

Does that help?

Senator WEBB. That helps.

Mr. CARR. I should make a point, I think.

Senator WEBB. Mr. Carr.

Mr. CARR. Military pay, if it's simple and it's understood—for example, paystub—we, for years, used regular military compensation, which is roughly synonymous with paystub. It considers my basic pay, my allowances, and—housing allowances, for example—because allowances are not taxable, the tax advantage—an enormous amount of time explaining that to the soldier, sailor, or marine, so that they can gain some cross-comparison. Whether it's true that—and I'll stipulate that we're 70 percent against that paystub measurement—or 80 percent, if we included esoteric things that aren't reflected in the paystub. It simply is a means of communicating a baseline. Either one is producing the same effect—80 percent, if you use the esoteric; 70 percent, if you're not. But, the importance is consistency in use.

So, if we are 70 percent today, and we've used that measurement for years and hope to use it into the future, then we are communicating about a point at which core retention patterns look okay to us. What was the pay level then? We'd say, "The regular military compensation"—because we have to account for the tax break—"is at this level, and yes, retention was good, and unemployment was that." We can communicate in much simpler, cogent terms that I think the troops would subscribe to, first, because we've talked to them in those terms for so long, and, second, because it has to do with the paystub. They get that.

Senator WEBB. The question, though, is whether we have the right information to truly compare, because there are a number of concerns. We hear from the Military Officers Association, et cetera, saying that the pay differential for the same type of job in the military is less. We need an accurate number. If it's less, it's less. If you're factoring all of the different pieces in together, and it's good, we should say, "It's good."

So, the question, again, becomes, what are we putting into this when we make the formula?

Ms. Farrell, when I was talking about medical insurance, it was just one of the things that popped into my mind while you were giving your presentation, in that you can't sue a military doctor—Federal Tort Claims Act. There are a lot of doctors in civilian practice who spend tens, if not hundreds, of thousands of dollars in medical malpractice insurance in order to cover the possibility of a lawsuit. We, arguably, should factor that in when we look at compensation for medical folks.

Just one of many questions that I would have in terms of how sophisticated are we in—should people be concerned about these pay levels as they are right now? Maybe they should, maybe they shouldn't. But, are we using the right formula?

Ms. FARRELL. Again, we think by going with the 10th QRMC's recommendation to include select benefits, that's an advantage to DOD, to show how good their package really is and that it could be used even as a recruiting or retention tool. We have reported in the past through our surveys with servicemembers—they lacked an understanding of how their pay compared to counterparts in the private sector. There are a lot of misperceptions out there.

Granted, DOD has its hands full, because this is such a large workforce. They bring in about 180,000 every year. They're maintaining 1.2 million servicemembers; it's a vast array of occupations. But, when you're doing a broadbased comparison of how the military compares to the private sector, we firmly believe that the total package should be included. The regular military compensation that Mr. Carr mentioned, we're not saying, "Don't look at that." Keep that measurement of how the cash does compare with the civilian, but also go with the recommendation to look at select benefits, to the extent possible, because it will give a fuller picture. It will help DOD to monitor what is going on so that they can keep pace and be competitive with the private sector. It's a good recruiting tool, as we said.

Senator WEBB. Dr. Hosek, what do you think about that?

Dr. HOSEK. Various things. The first thing to observe, I think, is that the basic elements—what, in the past, have been referred to

as "regular military compensation" for officers or enlisted personnel—still constitutes the vast majority of their current compensation, even when one considers benefits and allowances. That is, it's on the order of 90 percent. What that means to me is that it's really important to make sure that, whatever we do, we keep track of that and watch it carefully.

The second thing is that probably the most salient benefit to military families on Active Duty or Reserve today would be the health benefit. That comes not only because the military has pledged to care for military servicemembers and their families, and follow through with this health benefit—it's a fairly comprehensive benefit—but also because the cost of similar services in the private sector have risen dramatically—at times, upwards of a 40 to 50 percent a year increase in cost. Today, I believe, in the private sector, the cost of a relatively good healthcare benefit for a family of four is around $13,000; whereas at the beginning of the decade, it was probably half that. So, the value of the military benefit can be thought of in terms of what it would cost a military family to obtain comparable healthcare outside.

I want to, certainly, recognize the fine work that's been done by CBO, GAO, and, in this area, but, let me with that comment, add that a few years ago before these studies we did a study at RAND, trying to place a value on the military healthcare benefit, by which we made use of information on private-sector claims data for providers, and skill sets, and the age and ethnic distribution similar to that in the military. To make the story short, we, too, came up with a number such that, when you put it in the full context, enlisted personnel had a benefit, including basic pays, allowances, tax—the nontaxability of the allowance—and the healthcare benefit, placing their compensation at around the 80th percentile. For officers, I believe it was at around the 90th percentile.

I'll end there, with only an additional final comment, that, as you stressed at the beginning, as important as it is to look at the specific elements of pay and be clear about what we're including and how we're doing it, we always want to be able to relate those elements of pay to our recruiting and retention outcomes.

Thank you.

Senator WEBB. Also, if I may, on an issue like healthcare, that's a moral contract. It's a moral contract that goes beyond benefits, and it goes to the life of an individual who spends a career in the military. I can't tell you how many people in my lifetime who are career military who point that out while they're on Active Duty and after they retire.

Mr. Carr, how do you develop, for lack of a better term, the internal discipline on a lot of these special pays, when there's really no business model here? We're doing this if this were a business, you would say, "This is the amount of money we have coming in. Unless we take out a loan, we can't get more money. This is where we're going to put this money, in order to make a productive business work." When we're doing DOD, we're not doing that. We look at what we need in order to keep the country secure; we make decisions. When it goes to a lot of these S&I pays—I'm going to ask some questions in a minute about some of them—what are the factors that you put in that could bring a discipline to the process?

Mr. CARR. Sir, if we asked any of the Services, "What are you trying to hit with your retention incentives?", the answer is going to be, "A grade and experience mix, such that I produce seasoned noncommissioned and petty officers." I say, "Okay. Define that, mathematically." The answer would be, "I'd like to have 50 percent of my enlisted force with fewer than 7 years of service, and 50 percent with more than that." They draw, physically, as I'm sure the chairman has seen, a profile that says how many people they want to have in year of service 1, 2, 3, 4, 5. Do it for pilots. Do it for—you name the skill or the service aggregate.

So, the question becomes, "For my inventory, how much does that inventory deviate from that ideal line? Where does it deviate? How do I prop it up?" There is a mathematical solution to that. It's imperfect, because human behavior cannot be perfectly predicted. But, we would know, for the given investment, what it seeks to accomplish. By drawing another picture—we know who's out there in the force—whether or not that gap is being closed.

So, the empirical knowledge in this area is applied against that rigidly defined goal in a disciplined way, with a best estimate of what the cause and effect is on the money we're going to spend. If we guess wrong, we adjust, because it is, after all, a forecast. But, take that through any skill, and it pretty much proceeds the same way.

There's a lot of pays, of course, that do not depend on retention—such as recognizing the hazardous exposure of service, and so forth. So, there's many others that do that. But, I think the chairman's question was, "When we're trying to decide where to put a retention dollar and why we're going to put it on that occupation, for that zone, which is expressed as a range of years of service," the answer is, "Because we're trying to close the gap between two explicit lines."

Senator WEBB. Can you give us an understanding of continuation pay and how it fits into that formula that you just expressed? You have aviator career incentive pay (ACIP), nuclear officer continuation pay, judge advocate continuation pay, engineering and scientific career continuation pay, acquisition corps continuation pay, surface warfare officer continuation pay; just if you could explain for us the program and how it affects what you just said.

Mr. CARR. I'll knock out surface warfare officer and aviator continuation pay pretty much the same way. The question is, "what's your force profile?" In the late 1980s, we overhauled aviation pays. I chaired the study that produced the legislation that revised ACIP and then reinvented aviator continuation pay (ACP). But, in every case, in every weapons system that we were trying to satisfy—and the Navy was the most disciplined in this—there was a reason that they wanted to move this year-of-service cohort, this experience group, to a higher level. It had to do with department-head requirements. So, they would say, my department heads on ship—the squadrons that are embarked—are weapon-system-specific. I, therefore, need X number of department heads who grew up in Prowlers. How many do I have in the pipeline? If my number is too short, then I pay ACP in whatever measure is required to close that gap. The Air Force is similar. It has greater fungibility across weapon systems. Whether it's a surface warfare officer or an avi-

ator, simply, in those cases, count your department heads who are going to pop up at their certain years of service. How many people are in the pipeline, in that occupational discipline? Am I going to fill them, or am I going to be short? If I'm short, then I'm going to cause some people to change their behavior so that I can fill them all.

So, again, it's empirically derived against a very specific, tight target.

Senator WEBB. But, the continuation pay goes to everyone who is qualified, under those occupational specialties? Would it not?

Mr. CARR. An aviator is going to come in, as the chairman knows, having completed their major weapon system training. Then, with that is, say, a 9-year Active Duty service obligation. So, you're taking the person at that point—up until then, there's been no retention choice; the contract said, "You must remain"—and we're focusing on that group of people, to stimulate their behavior to carry them from the end of the contract, which we all agreed to, incident to entering the training, and vault them out for another 6 years. It is system-specific, but it's not to all, because we're targeting the retention-sensitive years, so it is almost exclusively dedicated to those who are approaching their first quit option.

Senator WEBB. But, in that group, it's all.

Mr. CARR. Yes, sir.

Senator WEBB. The same with how you do the judge advocate? As a lawyer here, I'm treading on sensitive ground.

Mr. CARR. No, you're right, sir. If we were talking about an aviator, about pilots—is that they hold that rank of O4 for a reason, and they're promising. So, I'm ambivalent as to which ones I get, so long as I get so many. I could, however, set quality standards for department head and say, "Only those that had these assignments may be considered in the pool I'm trying to vault up." As a general proposition, yes, sir, you're right. For a given experience cohort, take all comers within that, considering them to be of homogeneous quality.

Senator WEBB. Same with the Judge Advocate General Corps (JAG)?

Mr. CARR. Same with JAG.

Senator WEBB. We have a problem recruiting JAGs?

Mr. CARR. The JAGs demonstrated to us, convincingly, that there was a shortage in retaining JAGs against the force profile. Let me set it up this way.

If Congress should enact a law that says, "Pay money for this circumstance," typically, it says, under regulations established by the Secretary of Defense, "We, in turn, will issue a directive that says, 'If you think you meet these conditions, come see us and we'll discuss it and have a second review.'" If you present evidence that you do have a shortage against authorized lawyer billets, and you're not keeping them, then, yes, we would be in, I'll call that "readiness"—and say, "We must keep that number of lawyers," and therefore, we would pay them in order to fill a specific set of billets that would have otherwise demonstrably go unfilled.

Senator WEBB. But, there is no continuation pay for infantry.

Mr. CARR. There is not a continuation pay for infantry officers, and the Army did use an incentive to retain captains. There can

be. I think the chairman's point may be, I suspect we're in a tight supply on infantry captains, if the selection to major is running as high as it is. Shouldn't we try and boost up the number of persons entering the zone for major?

The Army, a few years ago, for example, said yes and offered a continuation bonus to combat arms in order to address that very specific shortage. The new battlefield required new organization, begat smaller organizations, which, necessarily, creates, proportionately, a richer grade structure, and, boom, we had a lot of major requirements that we didn't have before and some lean captain cohorts that we had to pay some incentives to in order to generate the requisite number.

Senator WEBB. As a former infantry rifle platoon and company commander, I think the question needed to be asked.

That's one of the questions that, actually, was being asked a lot, back in the 1980s, when you were going to this targeted pay, as Dr. Hosek may remember, having been on so many of these boards—these quadrennial reports. In fact, I don't know, was it General Vessey, someone back there, who said, "How much do you pay a point man in the infantry when things really get bad? What kind of a bonus should they get?" So the perception, from the inside out, from people who've done a lot of the hard work, seeing some of these continuation pays is that I think that's still there, as a matter of fairness, inside the military.

Mr. CARR. Point taken, sir.

Senator WEBB. Dr. Hosek, you have sat on three quadrennial reviews?

Dr. HOSEK. Yes.

Senator WEBB. When was the first?

Dr. HOSEK. I think it was 1992.

Senator WEBB. 1992? What would be your observations on this particular area, the specialty pays, as they've evolved from that period? Are we on the right track? Is there something else we need to be looking at?

Dr. HOSEK. I think, even going back to the 1970s and 1980s, and certainly since, there's been a recognition of how important special and incentive pays can be, for various reasons. I think the evolution, as you mentioned earlier, of the increase in these pays is notable. It's really a reflection of the fact that the pays have turned out to be a useful, flexible, and, I think, on the whole, cost-effective mechanism allowing the Services to tailor their compensation to secure the people needed for particular occupational areas and leadership positions, both enlisted and officer.

I'm not dismayed in any way, I think, with the way things have evolved, in terms of the increase in the numbers of these pays. As I mentioned, I think that the foundational pays, that I noted in my testimony, still remain of vital importance to the health of the force. The suggestion on that has since been enacted under the 10th QRMC, to consolidate into, I believe, seven categories the proliferating number of special pays that had become confusing, is a good move, if only to do a better job of communicating what these pays are to our servicemembers, Active and Reserve. So, I look forward to that.

Basically, I think these pays are quite good. I think that we do have to—the S&I pays are of different types and serve different purposes. For example, the ACIP that you mentioned and, for that matter, the pays for JAGs and so forth, I view as fairly permanent compensating differentials that reflect private market conditions for those skills. Same for physicians. It's important that the military be able to get physicians, lawyers, et cetera, in order to satisfy its requirements. In fact, I think I would emphasize, even more than that. To me, we have to go back and ask, "What would an enlisted person or an officer think if they didn't have the full cadre of individuals needed to provide military capability, if we didn't have officers or enlisted?" Even though they, individually, might not be the beneficiary of certain select—certain S&I pays, I think, somehow, that they're also willing to recognize and accept the importance of pay differentiation in order to ensure that we have a full complement of individuals for the purpose of military capability. I think that's really the role of these things.

I've thought about this a fair amount, because, as you noted, the infantry point guy—if he comes under fire or is in really dangerous conditions, you wonder if we are paying that person enough at that time? What do we do to recognize that? We don't have spot bonuses to award that sort of thing, and I'm not sure we want them.

Senator WEBB. That's sort of where the civilian comparative model breaks down, because maybe that—well, actually, there are some areas where that skill is marketable on the outside, but there's not a lot of people on the outside who aren't doing it who would step in to do it. It's sort of an inverse model, in a way.

Dr. HOSEK. The bottom line is, we want to set pay so that, on net, when people come to making their decisions to stay or leave, and, for that matter, to really exert effort and take risks on behalf of their country, they're there, and they know that the country is providing the compensation, family support, healthcare, retirement benefits, and educational benefits that they want. The real test of that in our military over time, though not necessarily at a particular instant, is whether we have gotten, and can keep, the caliber of people we need.

The market is a real taskmaster in that regard. Even in draft years, in the 1960s, and leading up to the advent of the AVF in 1973, we had, primarily, an AVF. What we also had was a partially drafted force. As you pointed out, absolutely correctly, the onset of the AVF involved serious exercise in trying to raise the entry-level pay to competitive levels.

People have always served on a voluntary basis, for the most part. Certainly, all servicemembers do so today. That means, when they're thinking about entering or thinking about leaving the military, they're scouting around to consider their outside opportunities. That's the test; that's the source of feedback that tells us something about whether we're paying people the right amount.

Thank you.

Senator WEBB. I couldn't agree with you more, and you raise an interesting point that people tend to forget. It has two different components to it, when you mention that, during the Vietnam era, most people were volunteers. Two-thirds of the people who served during the Vietnam era were volunteers, and 73 percent of those

who were killed in action were volunteers. There's an application in that thought pattern today, in the sense that, even though we are a volunteer military, we're not an all-career military.

It's something that I had a number of challenges putting on the table when I first came to the Senate, becoming a member of this committee, the tendency of a lot of people coming over from the Pentagon would simply talk about retention, rather than assisting the large number of people, the majority of the people who enlist, actually, who leave on or before the end of their first enlistment. It took us about a year to get the numbers, but the numbers we had before this economic meltdown were that 75 percent of the people who enlist in the Army, and 70 percent of those who enlist in the Marine Corps, leave the military on or before the end of their first enlistment. That's actually very healthy for the military. It's very healthy for the country. It preserves the citizen-soldier concept. It's one of the reasons I pushed so hard to get this GI Bill through, because the transition period is something that we haven't always looked at.

It also goes to the notion that, aside from these S&I pays, we really want to make sure that people who aren't eligible for these S&I pays are adequately compensated while they are in the military, and properly cared for the rest of their lives.

I thank you very much for your comment on that.

Dr. Murray, you've been silent. Would you have any thoughts on what we've been talking about?

Dr. MURRAY. I would just say that when you ask CBO for the cost of military personnel, including cash and noncash benefits is important. Sometimes it depends on the question being asked, and the context in which it's being framed. When you start to include noncash benefits, of course, they do cut across different departments, involving the Department of Veterans Affairs, et cetera.

Also, the valuation aspect is very important in analyzing the role that compensation plays in peoples' decisions to join or stay in the military. So, when I offer cash compensation, the value is easily understood. I give you a dollar, you spend that dollar on goods and services, and the cost to the government is the value that's been received by the servicemember.

I think for all researchers deciding the valuation of something that is less easily tangible—counted—things like noncash benefits, and the role that those different aspects play is much more dependent on how the analysis is done and what you choose to include, and so on and so forth.

Senator WEBB. I believe it was your written testimony that had the chart on the percentage of military medicine that was being provided to retirees. Was that yours? I believe it was your testimony, your pie chart.

It had, I think it was 52 percent of medical care actually was going to—of the different programs—were going to retirees at this point—and their families, obviously.

Dr. MURRAY. That was not in my written testimony.

Senator WEBB. Not in yours?

Was it in yours, Ms. Farrell?

Ms. FARRELL. We didn't have a chart, but, in terms of retirement figures, we had 15 percent of the enlisted would go on and be eligi-

ble for retirement. Around 47 percent of officers would go on and be eligible for retirement.

Senator WEBB. I'll find the chart and get back to you. [Laughter.]

Ms. FARRELL. We'll get you a chart, if you want a chart. [Laughter.]

Senator WEBB. No, actually, it was in one of the pieces of the testimony that I read. I found it really interesting, that a majority of the healthcare was going to dependents, retirees, et cetera.

Dr. MURRAY. That is correct, yes.

Senator WEBB. Senator Begich has arrived.

Senator BEGICH. Thank you, sir.

Senator WEBB. Welcome, sir.

Senator BEGICH. Thank you very much, Mr. Chairman.

If I can, I just have just a couple quick questions. Is that okay?

First, just a general question on compensation. If this was talked about, I apologize to repeat it. But, because of where the economy is today—unemployment—and if I remember the information I was reading here, the pay gap between military and civilian pay is about 2½ or so percent. Has there—have you had—I'm trying to think how to word this—for the increases or the pay that we're trying to make sure that we're competitive with, has that pay changed in the private sector because the economy has flattened, and therefore, their pay has come down? Or is there a real gap that we don't really realize yet, because as soon as the economy recovers then there'll be a bigger gap? Do you follow what I'm saying?

Mr. CARR. I do, Senator.

Senator BEGICH. Okay.

Mr. CARR. The private sector wages have gone flat, for reasons you understand. Our objective is to parallel that. By law, we set a relationship between those two events by saying that the annual military pay raise would equal the change in the private sector in what's called the "employment cost index"—how much does it cost me to pay all these people in these chairs?

Senator BEGICH. Sure.

Mr. CARR. I, each year, sample the same chairs, and I see what the change is. So, the military parallels it. Hence, the pay raise for this year, proposed in the President's budget, is probably on the order of half that is programmed for future years in the Defense budget, if all were to hold together.

So, the economy is flat.

Senator BEGICH. Right.

Mr. CARR. We're, therefore, flat because we are, by law, tracking against that, but we're holding our own.

Senator BEGICH. Do you think—my assumption is—and, again, we saw some good market indicators yesterday and the day before housing starts are up and housing loans are up. The consumer confidence, which to me is the ultimate measuring stick—all this other stuff—I know people say unemployment's important to measure, but if the confidence of the consumer is not up, the economy will not fully recover. That number has moved, the first time; and the number that it's at now is equal to where it was in September or so of 2008, which is good. That's a good signal.

So, as the private sector recovers and the job rates or the pay rates will start moving up, will we fall into—because the way our

system works here, it's not the fastest system, to say the least—will we be able to track that as fast as the private sector will be moving? Because I believe the private sector will move much faster than we could ever move. So, the question is, can we get there?

Mr. CARR. I have to say that, in order to do it, yes, that's our duty. That's our objective in forecasting the funds. If we get it out of line before we would hemorrhage experience that we couldn't replace, then we would probably turn to reprogramming, because if we have gotten it wrong and we thought the economy was going to do this, but it heated up much faster, then our resources allocated to retention incentives won't be sufficient, because, again, it happened faster than, better than we thought. In that case, then we have to look at the defense budget in the execution year and find what we're going to do to prevent the hemorrhage.

Senator BEGICH. Okay. You feel confident enough that, if that moment happens—it's nice to have a nice slide, rather—and a glide up, rather than a spike; but, if it's a spike potential, do you feel the system that you work within can deal with this in a rapid pace, versus us coming along and saying, "Why the heck haven't you done it?" Do you think—we might still do that——

Mr. CARR. I believe that——

Senator BEGICH.—the way we operate here. [Laughter.]

Mr. CARR.—we can. The great insurance policy that Congress has—security blanket that you've placed over retention is the construction of our pay table. For military pay, from 1999, it's gone up 57 percent, compared to 42 percent in the private sector. That's insurance, and I think that's stabilized our retention.

Senator BEGICH. Gave you the flexibility?

Mr. CARR. Say again, sir?

Senator BEGICH. Gives you the flexibility to sort of——

Mr. CARR. It gives us a baseline stability, so that we don't have to chase the tweaks, and we're not trying everything.

Senator BEGICH. Gotcha.

Mr. CARR. So, that baseline stability keeps things settled so that where we do have to chase will be relatively few in number and we can do that better.

Senator BEGICH. Let me ask you one last question. This is on base housing and allocations. When you do your studies—and I'll just be very parochial here—in Alaska—and when you've done your studies, the most recent one, you based part of the study, obviously, on vacancies. The timetable you did it was in the summer in Alaska, which has very low vacancies. What's left is—to be very frank with you, as someone who's been in the real estate business for almost 25 years now, it's low quality. So, it's not a real market condition.

On top of that, through the winter here, our utility rates have gone significantly up, for a variety of reasons. We have a problem with gas supply in South Central. By 2015, we anticipate a shortage of gas which is a predominant utility for heating which also generates our electricity. So, that has spiked. There was a slight decrease, but overall, it's spiked in the winter, and probably will stay that way, as well as—other utility costs have gone up.

You don't have to answer this right here, because it's very Alaskan perspective—I'm just trying to understand how we ensure that

these soldiers aren't pulling money out of their pocket to survive in their housing when—because the formula we used was just the wrong timing. In other words, for us, summer was probably not the best time to do it. Then the winter set in some heavy rate increases.

Mr. CARR. Whenever an artificiality is introduced that serves to the disadvantage, then we have to look to what change we're going to do to make that good.

Senator BEGICH. Would you be willing to look at this for us?

Mr. CARR. I will.

Senator BEGICH. It might be other States having the same problem, but for us, just because the way our energy costs are there, the higher cost, but also the transient and summertime business, we do really fill our apartments up. Then what's left, really, is a very low quality. I'm sure I'm going to hear from my friends in the rental business that will say, "Our property isn't low quality." But, I'm just telling you, after 25 years in the business, I know.

Mr. CARR. Sir, I'd be eager to do that.

[The information referred to follows:]

The Department contracts Runzheimer, International, an industry leader in cost-of-living data collection and analysis, to collect housing cost data used in the setting of Basic Allowance for Housing (BAH) rates. Runzheimer obtains rental cost data from properties selected by the local Military Housing Offices (MHOs), as well as properties found in local newspapers, apartment guides, and from local real estate professionals.

The MHOs are directed to provide housing to be priced which is both adequate and in safe and secure areas. Unacceptable, low quality housing is not included for BAH rate-setting purposes. Rental data are collected for a variety of housing types, from April through August. Pricing during this period ensures that rents are collected and documented during the high demand seasons, when rents are highest.

Runzheimer collects utility cost data from the American Community Survey over a 12-month period. Since the expenses are collected throughout the year, highs and lows in seasonal energy costs are captured. Housing cost data in the form of rent, utilities, and renter's insurance are collected in each military housing area for the 50 States and the District of Columbia.

However, if members rent above their median and/or above their housing profile, they will have out-of-pocket expenses as BAH is not intended to cover every member's total housing costs.

Senator BEGICH. Okay. That'd be great.

Mr. Chairman, I'll leave it at that.

I really wanted to ask him one question, but I know they can't answer it, and that is—because I deal with personnel—it's been bugging me ever since I heard it—and that is the personnel pay system, which I won't bother you with, because I know it's out of your realm. But, how we spent half a billion dollars and got minimal utilization out of it. But that's another question for another day, unless you want to dive into that. I don't want to torture you with that issue. But, I think we have to figure out how, when we pay our personnel in the military, that the complaint levels go down. I know there was a great attempt by DOD to solve this problem. But, a huge amount of expenditure was laid out with minimal utilization. I know there'll be efforts to try to utilize all that information. But, it's half a billion-plus in expenditure.

Someone who's been a former mayor, it can't be that complicated. We had police and fire. I'll tell you, that's complicated pay scales. For everything they do, from breathing to walking onto the soil of a crime scene, there's different pay levels you have to incorporate

within that 2-week pay period. We were able to do it, and every local government does it. Why the military couldn't figure this out is beyond me. But, you don't have to answer. It's just a rant I just went on, and I apologize.

Thank you, Mr. Chairman.

Senator WEBB. Well, sir, I'd be happy to have a further discussion with you about that. If you like, we can put together a question that could be sent over to Mr. Carr.

Senator BEGICH. That'd be great.

Senator WEBB. Perhaps we could clarify where your concern is here.

Senator BEGICH. I will do that. We'll work on it and give it to you, Mr. Chairman.

I want to make sure when we spend that kind of money to revamp the personnel pay system, that we do it. I just got frustrated when I heard at a big committee meeting that it just was scrapped. It's hard to explain to taxpayers when you scrap a half-a-billion-dollar program.

Senator WEBB. Let's run down where the direction of the question would go, and I'll submit it.

Senator BEGICH. Thank you, Mr. Chairman.

Thank you all for being here. Thank you for letting me come in late here to give you my two bits.

Thank you, sir.

Senator WEBB. Thank you, Senator Begich.

Mr. Carr, I want to ask you a question that is not directly related to the hearing today, but you're a target of opportunity here, obviously, because it's within your jurisdiction and it is within the jurisdiction of the committee. I'm trying to get a better overall picture of how DOD has evolved over the years. This is a small area, but it's something I want to get a clear understanding of.

When I was on Active Duty, there were 3 million people on Active Duty. When I was in the Pentagon, I think there were 2.14 million. Today, there's about 1.4 million, with, obviously, the greatly expanded participation of the Guard and Reserve, which I was responsible as Assistant Secretary, for 3 years, at one point.

I would appreciate it if you could get me a—on that timeline—so, let's say, 1970, 1986, and today—how many generals and admirals, by Service and by rank, there were, and are, in the United States military. I would think the number—from what I'm looking at, the number is well more than it was when I was in the Pentagon in the 1980s. I would like to better educate myself as to what these responsibilities are—where these people are now being used in flag billets, with the smaller number of people on Active Duty, and also flag levels in the Guard and Reserve, in a separate category. I would hope that would be pretty easy to put together.

Mr. CARR. It is, sir.

[The information referred to follows:]

I would like to submit for the record the requested General and Flag Officer (GFO) ratios for the Active component and the Reserve components. Please note that between 1970 and 2000, Active component end strength was reduced at a greater rate than the pace of GFOs (55 percent versus 34 percent). Between 2000 and 2010, Active component end strength grew at a slower rate than the number of GFOs (3 percent versus 8 percent). This increase in GFOs was largely due to recent reforms (2009 and 2010 National Defense Authorization Acts) passed by Con-

gress to address joint warfighting requirements. Only a handful of in-service authorizations were created during this period and the majority were specific to the acquisition community.

The best methodology for confirming fidelity of the proper number of GFO has been the subject of numerous debates. Since World War II, there have been 10 documented special studies or reviews of GFO requirements. Each used a distinct methodology and ALL recommended increases beyond the statutory authority. The use of ratios does not offer sufficient fidelity in explaining changes in mission requirements of the institution. As a rudimentary example, the deployment of five Army brigades (led by a colonel) instead of eight brigades may well require the same number of general officers in the parent headquarters. This in turn produces a corresponding shift in GFO requirements.

In 2006, the Department evaluated a number of different ratios to include: total Active Duty, officer only, senior leader (SES and GFO), capital assets, and joint participation. Each was ultimately considered inferior in determining the appropriate number of GFO authorizations. This information is detailed in a report to Congress titled, "General and Flag Officer Strategic Review," which was the impetus for the statutory changes that led to the current structure and number of GFOs. On the opposite end of the spectrum is a methodology that involves a position-by-position review. The last external study of this type was completed in 2003, when the Department undertook a review of all general and flag officer billets. This study validated 1,039 Active Duty and 591 Reserve GFO requirements, which significantly exceeded the statutory limit at the time of 889 Active Duty and 422 Reserve GFO authorizations.

A similar position-by-position internal review was conducted in 2008, to inform the previously mentioned legislative reforms. This review was documented in the previously referenced report to Congress, "General and Flag Officer Strategic Review." This report specifically addressed GFO requirements and the methodologies used to identify the appropriate number of GFOs authorized. The resulting legislation institutionalized joint GFO positions for the first time in the history of the Department, and resulted in joint restricted GFO authorizations. The in-service GFO authorizations were reduced by more than 25 percent to compensate for these authorizations. A nominal increase did occur which elevated the number of joint GFO positions filled from 231 to 294, allowing the Department to meet joint warfighting demands. This, in turn, greatly reduces the need for use of the available emergency authorities.

Senator WEBB. Anecdotally, when I was doing a lot of work in NATO for Secretary Weinberger, when I was ASD, I came across the number—the British Army, in the 1980s, had 145,000 people on Active Duty. My recollection is, I think they had 321 generals. I came back to Al Gray, who was the Commandant, and I said, "We have 200,000 people in the Marine Corps, and we have 67 generals. What's going on?" Al Gray made a very famous comment. He said, "Well, they have more bands." [Laughter.]

Mr. CARR. That's not bad.

Senator WEBB. He may not want to have that comment recycled today. But, let's just—I'd just like to get an idea of what we're doing on the GFOs.

Mr. CARR. We'll follow up with you, sir.

Senator WEBB. I appreciate all of your coming in to be with us today. I think it's really helped. This information will get recycled to other Members of Congress sent out for it to increase the understanding of these programs.

I think there should be no doubt in anybody's mind that we are very committed to making sure that our military people are well compensated. We know how hard they work. We know what they're doing. We appreciate it. We will make sure that we retain the quality and the expertise of our military, to keep them the finest military in the world.

Thank you very much.

We are adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR JIM WEBB

EDUCATION OF THE VALUE OF THE TOTAL MILITARY COMPENSATION PACKAGE

1. Senator WEBB. Mr. Carr, in its report, the Government Accountability Office (GAO) discussed the importance of understanding the value of the servicemembers' total compensation package and how this understanding can be used as a recruiting and retention tool. GAO has recommended in the past that the Department of Defense (DOD) develop a comprehensive communication and education plan to inform servicemembers, recruits, and their families of the value of their pays and benefits. Meanwhile, in the 2010 National Defense Authorization Act (NDAA), Congress required DOD to establish a comprehensive Web site that would allow servicemembers and their families to learn the value of their benefits, including survivor and retirement benefits. What steps has DOD taken to provide comprehensive education on the value of pay and benefits to servicemembers and their families, including the value of such benefits as health care, commissary and exchange benefits, and child care benefits?

Mr. CARR. DOD and the Military Services have substantive efforts underway, and continue to seek new and responsive mechanisms to educate their servicemembers and families on their earned benefits. Efforts include a variety of communication formats including: handbooks and guides such as the Wounded Warrior Pay and Entitlements Handbook, the Guard and Reserve Family Member Benefits Guide, the Mobilization Information and Resources Guide, and annual statements of military compensation. Furthermore, DOD and the Military Services continue providing numerous educational classes and facilitating online resources to help raise awareness of these benefits so that servicemembers can take full advantage of them. The portal, MilitaryOneSource.com, is a comprehensive Web site that provides servicemembers a wealth of information about many topics, including pay and benefits. This Web site is also linked to each of the Service Web sites that provide additional information. For example, My Army Benefits (http://myarmybenefits.us.army.mil), one of many resources offered by the Military Services about benefits, educates soldiers and their families about the wide variety of educational pay and compensation and other benefits available to them, even allowing them to calculate their pay while on deployment. The Navy's Pay and Compensation Calculator at the Stay Navy Web site (https://staynavytools.bol.navy.mil/PCC/?B3=Launch+Calculator) allows sailors to input their current pay and benefits to see how these compare to those in the civilian world, showing what a comparable salary would be outside the military to be able to enjoy the same benefits, services, and standard of living.

USE OF EMPLOYMENT COST INDEX AS BENCHMARK INDEX FOR MILITARY BASIC PAY

2. Senator WEBB. Dr. Murray and Ms. Farrell, in Dr. Murray's prepared statement, she stated that using the Employment Cost Index (ECI) as the benchmark index for annual military pay raises had its limitations, since it measured a population that tended to be older and college-educated, a population whose pay has increased more rapidly over the past decade than younger high school graduates. Is the ECI an appropriate index to use to adjust military basic pay rates annually? If not, is there a benchmark that is more appropriate?

Dr. MURRAY. Despite its limitations, the ECI provides lawmakers with a reasonable benchmark of the growth in civilian wages and salaries upon which to evaluate the basic pay raise in a particular year. Because of its limitations, however, the decision about the basic pay raise can be better informed by supplementing that benchmark with data regarding recent recruiting and retention trends, changes in noncash benefits, and assessments of how the housing and subsistence allowances may change.

Ms. FARRELL. In our April 1, 2010 report,[2] we noted that using the ECI for the purpose of determining the amount of the annual basic pay raise for servicemember has both strengths and weaknesses, but is generally reasonable to use to adjust such pay annually. It should also be noted that basic pay is just one component of the total military compensation package. In addition to basic pay, servicemembers

[2] GAO, Military Personnel: Military and Civilian Pay Comparisons Present Challenges and Are One of Many Tools in Assessing Compensation, GAO–10–661R (Washington, DC: Apr. 1, 2010).

also receive allowances, tax advantages, as well as deferred and in-kind compensation.

The ECI is a measure of changes in wages and employer costs for employee benefits. Created in the mid-1970s, the ECI is published quarterly by the Bureau of Labor Statistics and is part of the bureau's National Compensation Survey program, which provides measures of occupational wages, employment cost trends, and benefit incidence and detailed plan provisions. Organizations use the ECI to inform their decisionmaking in a variety of ways—including adjusting their wage rates to keep pace with what their competitors pay or to adjust wage rates in collective bargaining agreements. In addition, the Federal Government uses the ECI to inform its decisionmaking. For example, Congress included a provision in the NDAA for Fiscal Year 2004 tying the annual basic pay raise for military personnel to the ECI.[3] The law contains a provision allowing the President to propose alternative pay adjustments to Congress, in certain circumstances, if the President deems the standard increase required by the law to be inappropriate.

As noted, our recent work[4] has found that using the ECI to adjust military basic pay annually has both strengths and weaknesses. For example, its strengths include the following: the ECI is a nationally representative measure of labor costs for the civilian economy; it is also produced in a consistent fashion,[5] using a transparent methodology; and it provides separate data series for different occupational groups, industries, and geographic areas. With regard to its weaknesses, the ECI is not tailored to the specific segments of the civilian economy most relevant to the DOD—for example, those occupations and industries that the Military Services primarily compete with for workers. Also, because the ECI is constructed from data collected from surveys of employers, it does not provide data about the demographics of the civilian workforce—such as workers' education and experience, both of which are important factors that are often taken into account when setting employee pay. Nevertheless, we, as well as the Congressional Budget Office (CBO),[6] have previously reported[7] on the challenges of creating more tailored indexes. Further, none of the experts with whom we consulted, nor any reports published by other organizations that we reviewed during the course of our review, suggested that any other existing indexes or data series would provide more useful data than those provided by the ECI.

QUESTIONS SUBMITTED BY SENATOR ROLAND W. BURRIS

THRIFT SAVINGS PLAN

3. Senator BURRIS. Mr. Carr and Dr. Hosek, one benefit that the military offers is the Thrift Savings Plan (TSP). However, the military does not match contributions to the TSP, even though they are authorized to. What is the reason for this and are there plans to implement this benefit in the future?

Mr. CARR. The Department currently has no plans to provide military members with matching TSP contributions. There are two reasons for this. First, unlike the circumstance for Federal employees under the Federal Employee Retirement System (FERS), TSP for military members represents an added vehicle for long-term savings, it is not a fundamental component of their retirement plan. Thus, matching contributions do not fulfill the same purpose as they do for civilians. Second, independent studies by RAND and the Center for Naval Analyses (CNA) indicate that matching contributions are not effective recruiting and retention tools and have a sizable estimated annual cost—$840 million to $2.8 billion.

For a military member, the government provides a defined benefit retirement plan that is more generous than FERS and is fully funded by the government. Unlike

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[3] Pub. L. No. 108–136, §602 (2003), codified at 37 U.S.C. §1009. Specifically, the law requires that all eligible servicemembers' monthly basic pay be increased annually by the annual percentage increase in the ECI, except for in fiscal years 2004, 2005, and 2006 when the law required that servicemembers' basic pay increase be equal to the annual percentage increase in the ECI, plus an additional one-half percentage point.

[4] GAO–10–561R.

[5] We do note, however, that adjustments to the methodology have been made from time to time. For example, in 2006 the Bureau of Labor Statistics changed the way the ECI classified industries and occupations to reflect new industry and occupational classification systems and rebased the index, among other changes.

[6] Congressional Budget Office, Evaluating Military Compensation (Washington, DC: June 2007),

[7] GAO–10–561R; GAO, Poverty Measurement: Adjusting for Geographic Cost-of-Living Difference, GAO/GGD–95–64 (Washington, DC: March 9, 1995); and GAO, Developing a Consumer Price Index for the Elderly, GAO/T–GGD–87–22 (Washington, DC: June 29, 1987).

the civilian employee under FERS, the military member does not contribute to the defined benefit plan and receives monthly retired pay immediately upon retirement, but at an earlier age with many prime working years ahead.

Dr. HOSEK. I do not know the reason the military does not match contributions to the TSP and do not know of plans, if any, regarding the implementation of TSP in the future. The NDAA 2000 extended TSP to the military and provided for service matching of individual contributions. Individual contributions can be 1 to 100 percent of basic pay, and 1 to 100 percent of any special or incentive pay provided that contributions are also made from basic pay. Total contributions must be no more than a stated maximum, e.g., $15,500 in 2007. According to the Defense Finance and Accounting Service (http://www.dfas.mil/militarypay/thriftsavingsplantsp/contributionbasics.html), NDAA 2000 also allowed uniformed Services to designate critical specialties for matching contributions—although no Services have chosen to do so. The law stated that servicemembers in these specialties must agree to serve on Active Duty for 6 years as a condition of eligibility for matching. If eligible, the member may receive a Service match dollar-for-dollar on the first 3 percent of basic pay contributed and 50 cents per dollar of contribution on the next 2 percent of pay, per period. The military TSP is an offshoot of the TSP for Federal civilian workers established in 1986. According to the Social Security Administration (SSA) (http://www.ssa.gov/policy/docs/ssb/v63n1/v63n1p34.pdf), employees under the FERS may contribute up to 10 percent of their earnings, with Federal Government matching up to 5 percent. Also, the Federal Government makes a 1 percent contribution to TSP regardless of whether the employee contributes. Civil Service Retirement System (CSRS) participants may contribute up to 5 percent of their earnings and do not receive any matching. SSA reports the following participation rates in the 1990s in TSP by income: $10,000 to $19,999, 57 percent; $20,000 to $29,999, 78 percent; $30,000 to $39,999, 90 percent; $40,000 to $49,999, 90 percent; and $50,000 or more, 96 percent. (These participation rates exclude the automatic 1 percent contribution made by the Federal Government for employees under FERS.)

Drawing together some of the above information, I speculate that the willingness of Services to match contributions is limited by the cost and resources required to administer the matching program for a target population of eligible servicemembers that is likely to be small. Small, because the members must be in a critical specialty and must agree to an Active Duty service obligation of 6 years. These eligibility requirements may also be relevant to speculation about the recruiting and retention effects of matching. From the perspective of a servicemember or a would-be recruit, both the chance of being in a specialty designated as critical and the willingness to sign up for 6 years might be low.

Obligations of 3 or 4 years are common, but 6-year obligations are much less common. Enlistment and reenlistment might not increase much in response to the Federal match. The value of the Federal match will depend on how much the individual contributes, and it is likely that lower income, younger servicemembers would choose not to participate in TSP—and hence put a zero value on possible Service match contributions—or would participate but contribute a small amount. To put this in perspective, a one-step increase in a reenlistment bonus is worth roughly $4,000 to a soldier at first-term reenlistment and, we estimate, would increase the reenlistment rate in the specialty offering the bonus by 2 to 3 percentage points. Suppose the soldier is willing to contribute 3 percent of basic pay plus bonus to TSP, for a contribution of about $1,000. The match on this would be $1,000 for a total contribution of $2,000, and this would produce an effect on reenlistment of perhaps 1 to 1.5 percentage points. The effect could be smaller because once the money is contributed there is a penalty for withdrawing it early (withdrawals are not tax sheltered), so the money is not as liquid as, say, money in a savings account. The individual might alternatively consider contributing to a Roth IRA, which does not entail a service obligation but has no matching.

From a longer perspective, the expansion of TSP matching to all servicemembers rather than only those in designated specialties would be a way, if desired, to alter the nature of the military retirement system. It is currently a cliff-vested system with vesting at 20 years. Most enlistment members, about 85 percent, do not qualify for military retirement benefits and leave the military with no vested pension contributions apart from the Social Security contributions made on their behalf by DOD. About half of military officers do qualify for military retirement benefits. The cliff-vesting system creates a strong incentive to remain in the military after completing 10 or so years of service, and immediate eligibility to receive retirement benefits upon vesting creates an incentive to leave military service. As is well known, these incentives cause high retention in the 10 to 20 year of service range and a noticeable drop in retention around the 20-year point. Depending on how it was done, expanding TSP to make participation and matching universal could induce

more servicemembers to stay in service longer on average than they do today and would provide all who complete some minimum number of years of service with vested TSP retirement benefits. However, this increase in mid-career retention might result in too many heading for 20 years under the current military retirement benefit system, and to control this increase there would probably have to be changes in the regular military retirement system to decrease its generosity or greater use of separation pay. Issues like these were considered by the 10th QRMC.

4. Senator BURRIS. Mr. Carr and Dr. Hosek, in your opinion, would matching TSP contributions be an effective recruiting or retention tool?

Mr. CARR. The Department is not convinced providing matching TSP contributions would be an effective recruiting or retention tool.

RAND analyzed a recent Army pilot program offering new, non-prior service enlistees matching TSP contributions as an incentive to enlist for longer terms or into critical military occupational specialties (MOS).

In the study, there was little evidence that the availability of TSP matching contributions increased the likelihood that a soldier would select an MOS eligible for the TSP matching contribution program as compared to an MOS not eligible for the program. There was some evidence that suggested the availability of TSP matching contributions may have resulted in longer-term enlistments, however, a number of other factors, such as larger enlistment bonuses easily could have accounted for this increase. Overall, the Army pilot program achieved minimal success, and the cost to provide matching contributions as an incentive did not achieve the desired results.

The Center for Naval Analyses (CNA) also studied the impact on retention of providing matching TSP contributions, using discount rate analysis. The study identified that providing these matching TSP contributions would appeal most to members seeking short-term savings. A member who receives a poor performance report would be likely to save the maximum amount necessary to receive a full matching contribution in anticipation of leaving the military. The TSP matching contributions are an incentive to those more likely to leave the military rather than stay.

Dr. HOSEK. I would expect the effect of matching TSP contributions on recruiting and retention to be small if matching were limited to critical specialties and required a 6-year obligation. The effects could be much larger if TSP—with matching were universally available to servicemembers. Universal TSP with matching and with a required service obligation of 6 years—the current obligation—or perhaps longer, say 8 or 10 years, could be expected to increase the average number of years of service. The effect on recruiting might be small because many potential recruits would not be sure they wanted to be in the military long enough to vest their TSP match.

POST-DEPLOYMENT AND MOBILIZATION RESPITE ALLOWANCE

5. Senator BURRIS. Mr. Carr, the Army has a detailed plan for payment to all National Guard soldiers who are eligible for compensation under the Post Deployment and Mobilization Respite Allowance (PDMRA). The Army Deputy Chief of Staff, G–1, is responsible for this action and already has the Army National Guard's preliminary list of 6,865 eligible individuals. There is a projection of up to 15,000 Reserve component personnel who may be eligible. The Army anticipates that the majority of claims will be paid by March 19, 2010. The Secretary of the Army has directed the immediate flow of certified portions of the eligible list to the Defense Finance Accounting System (DFAS) as soon as they are ready. How many of the projected 15,000 Reserve component personnel have yet to receive their PDMRA?

Mr. CARR. As of May 18, 2010, the Army has paid 7,655 soldiers a total of $30,717,800 for 153,092 PDMRA days. If the projected estimate of 15,000 is accurate, there are approximately 7,345 soldiers still eligible to be paid.

RESERVE AFFAIRS

6. Senator BURRIS. Mr. Carr, in 2001, the Office of the DOD Office of Reserve Affairs, in a report for the 2001 Quadrennial Defense Review (QDR), outlined a new approach to military service as a continuum between full-time duty and service for only a few days a year. The report suggested "a new availability and service paradigm—referred to here as a continuum of service—that provides individual servicemembers greater flexibility in becoming involved in and supporting the Department's mission. In turn, DOD would have greater flexibility in accessing the va-

riety of skills required to meet its evolving requirements." How many Reserve component personnel are affected by this policy and what are the projected costs?

Mr. CARR. The continuum of service concept applies to all military servicemembers in the Active component (1.4 million) and the Reserve components (851,000 Selected Reservists and 218,000 Individual Ready Reservists).

A comprehensive cost analysis of this policy has not been completed. However, the real issue is access to servicemembers and reducing the barriers that impede the seamless movement of Total Force members between Active and Reserve components. The continuum of service capitalizes on the operational experience of the Active, Guard, and Reserve components and enhances a return on our training and education investment. It creates a system of Reserve component service that continues to effectively use each individual's abilities throughout their career. Making the best use of our military talent pool, particularly in an era of increasingly constrained resources, translates to a more capable force at a lower cost.

7. Senator BURRIS. Mr. Carr, how does DOD plan to implement the continuum of service policy?

Mr. CARR. The Joint Service Continuum of Service Working Group was established to identify and eliminate barriers to fielding capabilities by providing seamless transition between Total Force components (Active component, Reserve component, and civilians) to fill the Nation's requirements. Coordinated actions between Services result in retention of experienced and trained individuals and eliminate barriers that prevent transition between differing service commitments and between military and civilian service.

The Working Group is addressing the reform of military personnel records information management, to include a review of the types of information (such as waivers and law enforcement infractions) that should be maintained throughout servicemembers' careers. It is also addressing the life-cycle management of medical records. The Working Group continues to work with the Services on improving the seamless transition between the Active and Reserve components.

8. Senator BURRIS. Mr. Carr, how does policy support the plan to operationalize the Reserve component?

Mr. CARR. The current policy, DOD Directive 1200.17, establishes the overarching set of principles and policies to promote and support the management of the Reserve components (RC) as an operational force. It outlines the major stakeholders' responsibilities and defines terms of reference necessary to accomplish those responsibilities. This policy also defines the duration and frequency for orders to Active Duty and implements the train-mobilize-deploy model that ensures our servicemembers are mission-ready yet able to balance the needs of their families, civilian careers, and periodic military service.

The 2010 QDR also included several themes that support an Operational Reserve force. It stressed that RC forces will be required to serve in an operational capacity through predictable deployments in order to prevail in today's wars and also to fulfill requirements for which they are well-suited in the future. In the QDR, the Department committed to meeting expectations of National Guard and Reserve men and women to periodically serve on Active Duty, be judiciously used, given meaningful work to do and provided the right training and equipment to complete the mission. It also recognized that using the RC in this way will lower overall personnel and operating costs and contribute to the sustainability of the Active and Reserve components. Lastly, the QDR acknowledged the untapped capability and capacity of the RC and called for a comprehensive review of the future role of the RC, to include an examination of the balance between Active and Reserve Forces. We anticipate the findings from this review will generate recommendations for further law, policy, and doctrinal adjustments.

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

SUFFICIENCY OF PAY RAISE AND THE PAY TABLE

9. Senator GRAHAM. Mr. Carr, Ms. Farrell, Dr. Murray, and Dr. Hosek, the proposed pay raise for fiscal year 2011 is 1.4 percent, but this matches last year's rise in the ECI. Increasing this percentage would cost an additional $350 million in fiscal year 2011, and much more over time, as you have all noted in your testimony. Please explain what the impact on the DOD budget would be if Congress directed an increase in the pay raise by 1 percent, or half a percent without offsets.

Mr. CARR. Increasing the military pay raise by an additional 1 percent would cost approximately $680 million for the fiscal year 2011 base budget and increase fiscal year 2011 Overseas Contingency Operation costs by another $60 million. If funding was provided without offsets, there would be no impact on DOD's fiscal year 2011 budget. However, there would be significant impact on the Defense budget in fiscal year 2012 and every year thereafter as the pay raise increase continues to compound and crowd out funding for other critical DOD programs within a fiscally constrained environment.

For example, because the pay raise occurs on January 1st each year, the $680 million in fiscal year 2011 represents the cost for only 9 months. Therefore in fiscal year 2012, the full 12-month impact of the 1 percent increase is over $900 million.

Ms. FARRELL. Any increase in basic pay—whether it is equivalent to the ECI or some percentage above the ECI—results in additional near-term and long-term costs to compensate servicemembers. The NDAA for Fiscal Year 2004[8] included a provision tying the annual basic pay raise to the annual percentage increase in the ECI and, for fiscal years 2004, 2005, and 2006, the law required that servicemembers' basic pay increase be equal to the annual percentage increase in the ECI plus an additional one-half percentage point. That law also contains a provision allowing the President to propose alternative pay adjustments to Congress, in certain circumstances, if the President deems the standard increase required by the law to be inappropriate. For fiscal year 2011, the President and DOD have requested a 1.4 percent increase, which is equivalent to the percentage increase in the ECI.

In recent years, the additional one-half percentage point has been added in order to reduce a perceived gap between military and private-sector pay. However, as our recent work comparing military and civilian compensation asserts, we do not believe that comparing changes in the ECI with changes in the rates of basic pay shows there is a difference, or pay gap, between the two, or that such comparisons facilitates the assessment of how military pay rates compare with what civilian employers provide. In our view, and as officials at CBO noted,[9] such a comparison does not reveal a pay gap because, among other reasons, it assumes that basic pay is the only component of military compensation that should be compared with changes in civilian pay. While basic pay represents the largest portion of military compensation, servicemembers may also receive allowances for housing and subsistence. By excluding these allowances, comparing changes in the ECI with changes in the rates of basic pay simply illustrates how a portion of military compensation—basic pay—has changed over time.

Dr. MURRAY. CBO estimates that increasing the pay raise to 1.9 percent, rather than the 1.4 percent requested by the President, would cost an additional $350 million in fiscal year 2011, assuming the pay raise took effect in January 1, 2011. In fiscal year 2012, DOD personnel costs would rise by $490 million, and by a total of about $2.4 billion between 2011–2015, CBO estimates. Increasing basic pay by 2.4 percent would double the effect: it would raise DOD personnel costs (relative to a 1.4 percent pay raise) by about $700 million in fiscal year 2011 and by a total of about $4.7 billion between 2011–2015.

Dr. HOSEK. I defer to the others as they have developed models for such projections.

10. Senator GRAHAM. Mr. Carr, Ms. Farrell, Dr. Murray, and Dr. Hosek, is there a better metric than the ECI to gauge what an annual pay raise should be?

Mr. CARR. The Department believes the ECI provided by the Bureau of Labor Statistics is the appropriate metric to gauge the annual adjustment to basic pay. This index measures the change in the cost of labor in the United States, free from the influence of employment shifts among occupations and industries. It is national in scope and, like the military, covers a full spectrum of occupations. While some variations exist in comparing the military population with the population surveyed for the ECI, the ECI provides a broad, reliable, and statistically sound measure upon which to base the annual pay raise.

The 11th Quadrennial Review of Military Compensation intends to review the adequacy of military basic pay and to compare pay to the portion of the civilian population with similar characteristics. Currently, the Department uses the ECI for measuring wage growth in the private sector. It is possible the 11th QRMC could

[8] Pub. L No 108–136, §602 (2003), codified at 37 U.S.C. §1009.

[9] Congressional Budget Office, Statement of Carla Tighe Murray: Evaluating Military Compensation, CBO (Washington, DC, Apr. 28, 2010); CBO, Evaluating Military Compensation (Washington, DC, June 2007); and CBO, What Does the Military "Pay Gap" Mean? (Washington, DC, June 1999).

identify a more tailored metric to gauge military pay raise. The 11th QRMC's recommendations are expected in May 2011.

Ms. FARRELL. As we have reported[10] and as noted above, using the ECI for the purpose of determining the amount of the annual basic pay raise for servicemembers has both strengths and weaknesses but is generally reasonable to use to adjust such pay annually. It should also be noted that basic pay is just one component of the total military compensation package. In addition to basic pay, servicemembers also receive allowances, tax advantages, as well as deferred and in-kind compensation.

The ECI is a nationally representative measure of labor costs for the civilian economy and is used by businesses and other organizations to, among other things, adjust wage rates to keep pace with competitors. In our view, using the ECI to determine the amount of the annual basic pay raise has both strengths and weaknesses, but it is generally reasonable to use it to adjust basic pay annually. As mentioned earlier, the strengths include the following: the ECI is a nationally representative measure of labor costs for the civilian economy; it is produced in a consistent fashion,[11] using a transparent methodology; and it provides separate data series for different occupational groups, industries, and geographic areas. However, the ECI is not tailored to the specific segments of the civilian economy most relevant to DOD—for example, those occupations and industries that the Military Services primarily compete with for workers. Also, because the ECI is constructed from data collected from surveys of employers, it does not provide data about the demographics of the civilian workforce—such as workers' education and experience, both of which are important factors that are often taken into account when setting employee pay. Nevertheless, we, as well as CBO,[12] have previously reported[13] on the challenges of creating more tailored indexes. Further, none of the experts whom we consulted nor any reports published by other organizations that we reviewed during the course of our review suggested that any other existing indexes or data series would provide more useful data than those provided by the ECI.

Dr. MURRAY. While the ECI does have some limitations, as discussed in the CBO testimony, it is a reasonable benchmark of the increase of civilian wages and salaries to use in evaluating the annual basic pay raise. Because it is only a benchmark, however, the decision of where to set the basic pay raise can also be informed by trends in recruiting and retention, recent changes in noncash benefits, and expected changes in housing and subsistence allowances.

Dr. HOSEK. The ECI is an objective, well-documented, frequently updated measure of employment cost growth in the U.S. economy. It is designed to be representative of nationwide employment. In earlier research (A Civilian Wage Index for Defense Manpower), my colleagues and I critiqued the ECI because it was not designed to be representative of the military population. This is important because wage trends for workers with age, education, race/ethnicity, gender, and occupations characteristics of enlisted and officer personnel are not the same as those of the general working population. The research proposed an index approach similar in character to that of the ECI but designed to be representative of the Active Duty military. The research found that over the 1982–1991 period military basic pay grew 11.8 percent slower than the ECI but only 4.7 percent slower than our civilian wage index representative of the military. This is evidence that civilian wage trends do vary by worker age, education, et cetera, which implies that relying on a broad-gauge measure such as the ECI might give an inaccurate picture of whether military pay was keeping up with civilian pay. Further, the ECI is not always the best index to use in defining the military pay gap. A measure of military/civilian pay based on the ECI did a worse job of tracking recruiting and retention than one based on our representative index.

No approach will be perfect. My sense in brief is: (a) continue to rely on the ECI, but (b) require that recruit quality and retention measures be reported and considered in tandem, and (c) conduct periodic—even annual—assessments of military pay using micro data to control for the factors mentioned above. The ECI is a convenient starting point for a discussion of annual pay raises but not the ending point. The fact that it is provided by the Bureau of Labor Statistics, an impeccable source that

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[10] GAO–10–561R.

[11] There are adjustments in the methodology from time to time. For example, in 2006 the Bureau of Labor Statistics changed the way the ECI classified industries and occupations to reflect new industry and occupational classification systems and rebased the index, among other changes.

[12] Congressional Budget Office, Statement of Carla Tighe Murray: Evaluating Military Compensation (Washington, DC, Apr. 28, 2010) and Evaluating Military Compensation (Washington, DC, June 2007).

[13] GAO–10–561R, GAO/GGD–95–64, and GAO/T–GGD–87–22.

is independent of interest groups, is a genuine plus. However, discussions of military pay raises should include consideration of recruiting and retention as well as comparisons of military pay with the civilian wage distribution for workers with comparable characteristics to those of military members. CBO currently does such comparisons.

11. Senator GRAHAM. Mr. Carr, Ms. Farrell, Dr. Murray, and Dr. Hosek, several years ago, the Department proposed targeted changes to the pay in certain grades with certain longevity, which was designed to relieve pay compression, and provide greater incentives for promotion. Does the current pay table need adjustment?

Mr. CARR. The Department believes the changes to the pay table over the past several years have achieved the objectives of relieving pay compression and providing greater compensation incentives for promotion. The current pay table does not need further adjustment in this regard.

The 9th Quadrennial Review of Military Compensation (QRMC) evaluated military compensation and determined pay should be benchmarked against the 70th percentile of comparably educated civilians. In certain places within the basic pay table, basic pay fell below the 70th percentile. As a result, the 9th QRMC recommended and the Department implemented specific changes in the basic pay table to move those grades and years-of-service up to the 70th percentile. The 9th QRMC recommendations also were designed to relieve pay compression and provide greater incentives for promotion.

Since the review in 2006, we have reevaluated the basic pay table every 2 years and concluded military pay across-the-board continues to exceed the 70th percentile.

Ms. FARRELL. While we have not previously assessed whether the current pay table needs adjustment, we have for over 3 decades reported[14] that the current military compensation package has been the result of piecemeal changes and adjustments over time and lacks overall guiding principles. Specifically, in 1979, we evaluated DOD's military compensation system and concluded that piecemeal adjustments and a lack of overall guiding principles of compensation were a problem in establishing a basis for evaluating changes to the total compensation system. More recently, in 2005, we noted that some of the same underlying problems that we identified in 1979—including a lack of explicit compensation principles and difficulty in making major changes to compensation—still existed.

In discussions with DOD, officials indicated that the Department previously adjusted the basic pay table in order to make pay at all ranks and years of service more in line with the 70th percentile—as recommended by the 9th QRMC 2004. That review recommended that regular military compensation be set to equal the 70th percentile of comparable civilian compensation. At that time, the Department found that for some ranks and years of service, compensation was close to the 70th percentile, but for other ranks and years of service it was not so close. As a result, according to DOD officials, the Department relied on targeted pay increases to raise the level of pay for certain ranks and years of service in the pay table from about the year 2000 through 2005. However, according to one of these officials, 2005 was the first year in which pay for all ranks and years of service was increased in lockstep to bring pay more in line with the 70th percentile.

Regarding targeted changes to pay, we have reported that across-the-board pay increases fail to target resources where they are most needed and they affect a variety of other costs—such as retired pay. Rather, the targeted use of compensation—such as special pays and bonuses for particular occupational skills—tends to maximize limited resources and help make recruiting and retention gains in needed areas. Our prior work[15] recognizes DOD's ability to use the more than 60 different special and incentive pays—including reenlistment bonuses and hazardous duty pay, as well as other pays for specific duties like aviation and medical, and incentives for servicemembers to take certain assignments, among others. Because most compensation is determined by factors such as tenure, rank, location, and dependent status, these special pays and allowances are the primary monetary incentives DOD has for servicemembers other than promotions and are used to influence certain behaviors, such as extending a service contract or filling critical shortage occupations.

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[14] GAO, Military Personnel: DOD Needs to Improve the Transparency and Reassess the Reasonableness, Appropriateness, Affordability, and Sustainability of Its Military Compensation System, GAO–05–798 (Washington, DC: July 19, 2005) and The Congress Should Act To Establish Military Compensation Principles, GAO/FPCD–79–11 (Washington, DC: May 9, 1979).

[15] GAO–10–666T, GAO–10–561R, Military Personnel: DOD Needs to Establish a Strategy and Improve Transparency over Reserve and National Guard Compensation to Manage Significant Growth in Cost, GAO–07–828 (Washington, DC: June 20, 2007), and GAO–05–798.

Dr. MURRAY. CBO has not studied this issue in depth. However, recent trends in recruiting and retention suggest that the current pay table, supplemented by DOD with bonuses where needed, is adequately compensating the force for the hardships of military life.

Dr. HOSEK. Targeted increases were done in several years beginning with NDAA for Fiscal Year 2000. I do not know whether the pay table needs further adjustment. One of the motivations for targeting was to ensure adequate incentives and rewards for individuals who showed high performance in the military but who, because of their talent and expertise, might also have excellent job opportunities in the civilian world. Targeted pay raises and relieving pay compression were steps toward helping the military keep highly capable members and future leaders. Entry characteristics such as education and AFQT are valid predictors of early retention, successful completion of initial training, and proficiency in performing mission essential tasks, but our research at RAND indicates that much of the information about a member's fit with the military and performance in the military is revealed in service, not at entry. It is important for the military to have an incentive structure that works to retain these individuals who have distinguished themselves. To determine whether the pay table needs further adjustment, it might be useful to study whether the military is doing better today, or at least as well as before, in keeping high performers.

EFFECTS OF CLIFF VESTING

12. Senator GRAHAM. Mr. Carr, Ms. Farrell, Dr. Murray, and Dr. Hosek, various study groups in recent years have questioned the wisdom of the military's traditional 20-year requirement to earn retired pay, suggesting that vesting at an earlier milestone in a career—say 10 years—would more effectively help to achieve DOD's personnel goals. However, assuring retention of mid-level personnel beyond their first or second terms of service—especially in wartime—would seem to justify reliance on this approach. What do you think the effect of reducing the requirement for entitlement to retired pay below 20 years would be on the ability to retain the personnel we need in leadership positions in the Armed Forces?

Mr. CARR. Reducing the requirement for retired pay entitlement below 20 years will have a pronounced impact on retention patterns. The 20-year vesting requirement creates a strong incentive for personnel who have reached 10 to 12 years of service. As a result, the 20-year vesting requirement results in significantly greater retention of mid-grade members than would otherwise occur. To increase retention and maintain the desired numbers of mid-grade personnel, the Department would need to provide substantial additional bonuses or incentive pays.

The 20-year vesting also provides an equally strong incentive for those members who reach the 20-year threshold to leave. This has allowed the Department to minimize the use of involuntary separations and avoid the negative impact these separations would likely have on force morale. With significant portions of each 20-year cohort leaving every year, this ensures senior positions are available for rising junior personnel. Therefore, the Department does not support reducing the requirement for entitlement to retired pay below 20 years of service.

Ms. FARRELL. In the absence of any identified weaknesses in the overall recruiting and retention rates, it is difficult to determine if problems exist that would be best corrected through changes to the current retirement system. Further, our prior work[16] has shown that benefits, especially deferred benefits like retirement, are a relatively inefficient way to influence recruiting and retention, as compared with cash pay. Efficiency, as defined by DOD, is the amount of military compensation—no higher or lower than necessary—that is required to fulfill the basic objective of attracting, retaining, and motivating the kinds and numbers of Active Duty servicemembers needed. However, the efficiency of some benefits is difficult to assess because the value that servicemembers place on them is different and highly individualized. Therefore, understanding the effect of reducing the vesting requirement below 20 years requires an understanding of how servicemembers value retirement benefits, in general. Because the current military retirement benefit is: (1) a defined benefit plan with a 20-year cliff vesting requirement; and (2) a promise of future retirement payments made over the remainder of the servicemember's lifetime, calculating the value today—the present value—is difficult. In calculating the present value of the retirement benefit, two factors are critically important: the probability

[16] GAO–05–798.

of staying in the military until retirement and the discount rate used to calculate the present value of retirement.

DOD's current retirement system is meant to create a strong incentive for military personnel who stay beyond 8 to 10 years to complete 20 years and leave soon thereafter. Specifically, under DOD's current retirement system, according to the Department's Office of the Actuary, only 15 percent of enlisted and 47 percent of officers become eligible to receive retirement under the current plan that requires 20 years of service to vest.

If a military career is viewed as a continuum, retention rates will typically rise just before the point at which servicemembers may vest, and will subsequently decline on the far side of that point. As noted, under the current retirement system, servicemembers vest after 20 years and may immediately retire. Thus, moving the vesting milestone from 20 years to 10 years makes sense if the perceived challenge is getting people, who otherwise might have left after 5 years, to stay until 10 years, and/or getting people to leave after 10 years. However, moving the vesting requirement would eliminate a major incentive for servicemembers with 10 years of service to stay on until 20 years. Therefore, retention rates of experienced servicemembers with 10 years of service or more may decline. Lastly, vesting servicemembers at 10 years is likely to be less powerful in affecting behavior because the stakes are lower—specifically, a servicemember who leaves the Service at 9 years of service under 10-year vesting forfeits much less than someone who leaves after 19 years of service under 20-year vesting. However, these effects may differ based on the extent to which changes are made to the retirement system—for example, if changes are made solely to the vesting requirement but not to the number of years required to reach retirement eligibility. Another approach that would yield different results would maintain the immediate retirement standard at 20 years, but allow servicemembers to vest at an earlier point in their careers (e.g., 10 years) and make it a deferred vested benefit that servicemembers would receive at, for example, 65 years of age.

It is important, however, to consider all potential effects[17] of such a change. For example, reducing the requirement for vesting eligibility would potentially result in higher percentages of officers and enlisted servicemembers vesting and thus receiving a retirement pension, which could have significant cost implications for the Department in the future. Furthermore, the uniformed services are unlike nearly all other organizations in that: (1) they have closed personnel systems—that is, DOD relies almost exclusively on accession at the entry level (E–1 or 0–1), and on its higher-ranking members being retained and promoted from lower ranks; and (2) according to DOD, there is no private-sector labor market from which the military can hire for certain unique occupations—such as an infantry battalion commander. By contrast, most other organizations can and do hire from the outside at all levels. Thus, the failure to meet recruiting or retention goals at lower levels in a given year can have significant consequences for a Service's ability to produce experienced leaders for years to come.

Dr. MURRAY. Researchers generally agree that the relatively low value that young people place on deferred compensation, combined with the relatively low probability that a new recruit will stay for 20 years, suggests that the recruiting and retention value of the current retirement system is lower than that of current cash compensation, particularly among those serving less than 10 years. However, the promise of retirement pay does encourage personnel who have already served for at least 10 years to remain for the full 20-year career; it also encourages them to leave soon after, even if they might have productively served DOD beyond that time. In addition, some researchers argue that DOD is reluctant to involuntarily separate those mid-careerists, and instead treats them as though they have an implicit contract to stay for 20 years. Thus, the current system encourages some members to leave too soon, and it encourages others to stay too long. Changing the retirement system would alter the force profile, but the nature of the change, and the career incentives it would create, would depend on the specifics of the proposal.

Dr. HOSEK. The current military retirement system contains strong incentives to stay in an Active component until 20 years of service if a member has completed 10 or so years of service. The system also has strong incentives to leave after 20 years of service. Advantages of the system are that the incentives operate automatically; are well known to the servicemember and stable over time; are equitable in

[17] In 2005 and 2007, we provided Matters for Consideration that asked Congress to consider the long-term affordability and sustainability of any additional changes to pay and benefits for military personnel and veterans, including the long-term implications for the deficit and military readiness. Such a change to the current retirement system would most certainly have long-term implications for affordability and sustainability. See GAO–05–798 and GAO–07–828.

the sense that servicemembers (probably) perceive fairness in having the amount of benefit based on years of service and rank, which are well understood outcomes in a system with broadly equal ex ante opportunity for enlisted personnel and, separately, for officer personnel; and are largely independent of the size of the force, meaning that the force can be scaled up or down without affecting the servicemember's expected benefit so long as promotion opportunities and up-or-out rules remain the same. I list these aspects of the current system because each is relevant to the question of whether reducing the requirement for vesting to below 20 years would affect the ability to retain personnel needed in leadership positions.

Reducing vesting to say, 10 years of service, is not the same as reducing the time at which retirement benefits may be drawn. Keeping all other features of the retirement system as they are now but reducing vesting will increase the value of staying until 10 years. This is because today, with vesting at 20 years, a member who leaves at 10 years has a zero value of retirement benefits, whereas under 10-year vesting the value would be positive. Vesting at 10 years therefore increases the incentive to stay to year 10 at least and so should increase retention to 10 years, and it also increases the incentive to enter service. However, because there is no longer a "lock in" effect to stay until 20 years of service, there is, by comparison, a greater incentive to leave after completing 10 years. This can be counteracted by introducing an incentive to stay, such as a completion bonus at year 16. RAND explored complex changes to the compensation system such as these for the 10th QRMC, and drawing on the insights of our analysis I expect that a decrease in the year of vesting accompanied by a completion bonus of sufficient size could maintain the current retention profile of the force.

Still, the question draws attention to wartime—if vested at 10 years, would servicemembers in wartime be more likely to leave service than they would under the current system? I know of no research specifically addressing this question. Research on the effect of deployment for hostile duty on first- and second-term reenlistment, and on junior officer retention, finds that for the most part deployment has a positive effect on enlisted and officer retention. The exception to this occurs when a servicemember has extensive deployment, e.g., 12 or more months of hostile deployment in the previous 36 months, in which case deployment can have a negative effect on retention. This finding takes into account deployment-related pays. As a specific example, a negative effect of deployment occurred in 2006 to 2007 in the Army, and it was largely offset by the expanded use of reenlistment bonuses and an increase in the average amount of the bonuses (How Have Deployments During the War on Terrorism Affected Reenlistment?). Summarizing, evidence indicates that for the most part the effect of hostile deployment on enlisted and officer retention has been positive, but extensive deployment can cause a negative. When this has occurred, bonuses have been effective in counteracting the negative effect.

RECRUITING AND RETAINING HEALTH CARE PROFESSIONALS

13. Senator GRAHAM. Mr. Carr, there are significant shortages among certain health care professionals, coupled with historic low rates of acceptance of fully paid health professions scholarships. We knew that these problems could not be fixed overnight, and the committee stepped in to increase the ceilings on scholarships and update several medical and recruiting incentives. How much visibility does your office have and what oversight do you exercise into how well the medical community and personnel chiefs are doing in effectively recruiting and retaining medical personnel?

Mr. CARR. The Under Secretary of Defense for Personnel and Readiness has responsibility for the Department concerning all recruiting and retention matters. Many specific program authorities have been delegated to the Assistant Secretary of Defense for Health Affairs (ASD(HA)). For matters involving the health professions, ASD(HA) collaborates with Military Personnel Policy (MPP) to provide oversight and develop medical personnel policy guidance for the Military Department Secretaries regarding accessing and retaining personnel in health professions. The military departments program and budget for the necessary funds to recruit and retain their medical professionals.

To ensure oversight, DOD annually convenes the Medical-Personnel Executive Steering Committee, made up of the Deputy Chiefs of Staff for Personnel and the Surgeons General from each Service. The Department and Services review the annual Health Manpower Statistics Report, which is published by the Defense Manpower Data Center to check the status of medical manning. On a monthly basis, the Health Professions Incentives Working Group meets to review medical personnel

issues and make recommendations to leadership on incremental adjustments to the existing financial incentives.

14. Senator GRAHAM. Mr. Carr, please explain how the incentive pays for health care professionals are regulated to help the Services meet their recruiting and retention goals. How involved is your office (as opposed to the ASD(HA) in ensuring that personnel needs are met?

Mr. CARR. Deputy Under Secretary of Defense for MPP works closely with the ASD(HA) on matters pertaining to military medical force management. We rely on bonuses and special pays as critical tools for managing the medical force. Each year, the DOD convenes the Health Professions Incentives Working Group to make recommendations to leadership on incremental adjustments to the existing financial incentives for retention under the legislative limits. The Military Departments and Public Health Service participate. The process takes into account DOD staffing, civilian pay, operational demand, and service-specific issues.

The Office of the ASD(HA) develops the policy and establishes bonus and special pay amounts for health care professionals. In matters pertaining to recruiting and retention of medical military personnel, HA coordinates closely with the office of the Deputy Under Secretary of Defense for MPP. MPP is responsible for oversight and policy for recruiting and retention matters, with the exception of Reserve personnel and health professionals. Approval authority and reporting responsibility reside with the Principal Deputy Under Secretary of Defense for Personnel and Readiness. Annually, the Department provides Congress a report analyzing effects and future use of critical skills retention bonuses which includes bonuses for several health care professions.

15. Senator GRAHAM. Mr. Carr, what about retention of health care professionals? How much visibility do you have into how the Services' personnel chiefs are doing in effectively retaining mid-career personnel and what is your assessment of the Services' ability to recruit and retain doctors, dentists, nurses, et cetera?

Mr. CARR. The Office of the Deputy Under Secretary of Defense for MPP continuously monitors the retention of mid-career medical personnel by using reports from the Services and the annual Health Manpower Statistics Report, published by the Defense Manpower Data Center (DMDC). This report is used to check the status of medical manning for the DOD and provides a fiscal year-end snapshot of the status of medical manning as well as historical trend information on medical manpower and personnel for managers within the DOD. The report is produced in coordination with the ASD(HA), the Assistant Secretary of Defense for Reserve Affairs, DMDC, and Service representatives.

In assessing the data from the Health Manpower Statistics Report, the ASD(HA) and Services continually monitor and adjust and expand medical special pay plans and bonus structures where significant shortages exist for specific physician, dentist, nurse and other allied health specialties.

The DOD uses a comprehensive package of special and incentive pays to attract and retain health professionals. Physicians and dentists are eligible to receive special and incentive pays consisting of a multiyear retention bonus, variable special pay, additional special pay, incentive special pay, board certification pay, critical skills retention bonuses, critically short wartime specialties, and critical skills accession bonuses. Nurses and other health care professionals are eligible for accession, board certification, incentive, and retention pays and bonuses depending on their specialties and skill. The Department recently implemented the special bonus and incentive pay authorities for officers in health professions. This authority provides DOD the flexibility to react quickly to shortfalls in health care profession specialties, and was recently used to provide special pay to licensed clinical psychologists and clinical social workers.

VALUE OF HEALTH CARE BENEFITS

16. Senator GRAHAM. Dr. Murray and Dr. Hosek, there is widespread concern about the sustainability of military health care benefits. According to a Congressional Budget Office 2009 report, projections indicate that costs for medical care will rise more rapidly than overall resources for defense, and require an estimated 13 percent of total defense funding by 2026. What is your advice to Congress on how to strike an appropriate balance between the need to sustain military health care benefits in the future, and the obvious value of this benefit in recruiting and retaining needed military personnel?

Dr. MURRAY. CBO estimates that under DOD's plans for fiscal year 2010, the Department's medical funding will grow from $46 billion in 2010 to $90 billion by 2028, nearly doubling over and above the effects of general inflation. More than half of health care spending goes to military retirees and their families. However, only about 15 percent of enlisted members and about half of officers will serve long enough to retire. Thus, most of the current force, including most of those serving in Iraq and Afghanistan, will not receive the retiree health care benefit.

Most researchers agree that deferred benefits like retiree health care are not valued by younger personnel as highly as current cash compensation. Moreover, the military retirement system, in which members can receive retired pay only after serving 20 years or more, encourages those who have served 10 years or more to stay for a full career. In its budget request for 2009, DOD proposed increasing the copayments, enrollment fees, and deductibles paid by military retirees and their families to levels that reflect the growth seen in civilian health care spending. In analyzing the DOD proposal, CBO found that charging higher out-of-pocket costs could significantly reduce DOD's spending on health care for military retirees and their survivors and dependents. Most of the estimated savings would have come from a drop in enrollment in TRICARE—current users who would leave the program and prospective users who would choose not to enroll. Because some of those retired users would switch to other Federal programs, such as the services offered by the Veterans Health Administration, savings to DOD would be partially offset by increases in other Federal spending.

Dr. HOSEK. TRICARE provides military beneficiaries with comprehensive health benefits at no cost for most Active Duty beneficiaries and very low cost for retired beneficiaries. While costs have increased for all beneficiaries, consistent with the national pattern, the biggest share of the increase is attributable to retired beneficiaries. The benefit compares favorably with benefits offered by civilian employers and the Federal Employees Health Benefits Program, and the difference in out-of-pocket costs between TRICARE and employer insurance has continued to grow wider. Accordingly, military retirees have increasingly passed up the health benefits available to them through their employer in favor of TRICARE. The 2007 report of the Task Force on the Future of Military Health Care proposed a gradual increase in TRICARE's cost-sharing rates for military retirees and suggested piloting a new benefit that would augment benefits provided by civilian employers—e.g., by covering premium contributions. Careful redesign of the retiree benefit would maintain a high level of health coverage for these beneficiaries while controlling costs by encouraging use of the employer benefits to which they are eligible.

For all beneficiaries, the cost sharing provisions should be carefully reviewed now and regularly in the future to ensure that they induce the most appropriate care-seeking behavior. Similarly, it is worth considering strengthening the incentives of TRICARE's military and civilian network providers to provide cost-effective care. That said, research on the demand for health care indicates that individuals and families have low sensitivity to the price they pay for health care; in more technical terms, the demand elasticity is low, at about 0.2. This means that changes in cost sharing might have modest effect on care seeking behavior—but such changes deserve consideration because seemingly small changes might result in billions of dollars of savings.

Another aspect of controlling cost without diminishing the value of the health care benefit to servicemembers and retirees is to ensure that providers are providing the appropriate amount of care, and the care is evidenced-based. The Department of Veterans Affairs (VA), for instance, has a reputation for providing high-quality care, and the military system may want to adopt the VA's innovative quality improvement system. There may be more room for inquiring into the efficiency of providers: are they providing too much care, too little care (which might result in repeat visits and undetected conditions that are very costly to treat in advanced stages), or care that is inefficient and therefore too costly?

17. Senator GRAHAM. Dr. Murray and Dr. Hosek, what do studies reveal about the relationship of the value of noncash benefits, such as health care, and successful recruiting and retention?

Dr. MURRAY. Many researchers view noncash compensation as less economically efficient than cash compensation because it restricts the way in which people can choose to spend their earnings. For example, an economist might argue that on-base fitness centers are economically less efficient than a "fitness allowance" that can be spent in whatever way the employee chooses. To the extent that people value greater choice, the recruiting and retention effect of cash allowances should be greater than benefits provided in-kind. However, the popularity of noncash benefits—both in military and civilian life—may stem from the fact that many of them are not

taxed (or the tax liability may be postponed for many years). Another reason that employers might offer noncash compensation is to provide a way of screening for or maintaining desirable employee characteristics (e.g., physical fitness). In addition, some employers offer a noncash benefit if the benefit fosters goodwill or loyalty to the employer. Family-support benefits may provide that kind of gift effect, if deployed personnel value the feeling that their families are being cared for while they are away.

Dr. HOSEK. It is difficult to estimate this relationship because, over time, the benefit has been relatively stable and the effects of the notable benefit changes that have occurred (e.g., TRICARE and the 2001 benefit changes) are difficult to isolate from other events. I know of no evidence about the effects of noncash benefits on recruiting and retention; however, I know that Dr. Murray has studied this topic and would defer to her knowledge.

INCENTIVES FOR UNMANNED AIRCRAFT VEHICLE PILOTS

18. Senator GRAHAM. Mr. Carr, the importance of improving surveillance capabilities through unmanned aircraft is well-understood. Each Service, however, seems to approach the issue of who controls—or pilots—such aircraft, and the compensation they receive—differently. Please explain how the Office of the Secretary of Defense (OSD) is involved in determining what kinds of special pay and bonuses are appropriate for this occupational skill and career path?

Mr. CARR. Secretaries of Military Departments who elect to pay some form of special or incentive pay and/or bonus to unmanned aerial vehicle (UAV) operators must submit a UAV recruiting and retention compensation plan. The plan is then reviewed by the Office of the Under Secretary of Defense (Personnel and Readiness) and approved or disapproved as appropriate. To date, the Air Force is the only Service that has requested UAV-operator incentive pay. After dialogue between the OSD and the Air Force, the rationale for the requested incentive pay, statutory authorities, levels of pay, et cetera, the OSD approved an incentive pay plan that will extend through December 2010. If the Air Force determines UAV operators should be paid an incentive pay after December 2010, a new recruiting and retention compensation plan, or an extension request, must be submitted for approval.

The basis of approval or disapproval of a Service's UAV recruiting and retention compensation plan depends on a multitude of factors, such as UAVs flown (size, weight, complexity, et cetera), armed or unarmed status, altitude and airspace flown (FAA nationally controlled airspace versus restricted battlefield airspace), supply and demand of UAV pilots, as well as the technical difficulty of flying the particular UAV types and the associated rigor of the UAV training.

QUESTIONS SUBMITTED BY SENATOR SUSAN COLLINS

COMMISSARY BENEFITS

19. Senator COLLINS. Ms. Farrell, according to a Pentagon survey, 90 percent of military personnel utilize commissary benefits. Last year, the Navy Exchange Service Command generated more than $45 million in dividends. These figures seem to indicate that commissary and exchange benefits are not especially costly to DOD and that servicemembers place a high value on these benefits. How can these figures inform the Department in maintaining a competitive cash and noncash compensation package for servicemembers and providing it in such a way that is affordable to the Department?

Ms. FARRELL. While these figures are informative in terms of servicemember use of the commissary and the cost of operating the commissary, in the absence of additional data and information on how servicemembers value the commissary, these figures cannot appropriately inform DOD on affordably maintaining a competitive cash and noncash compensation package for servicemembers. We have previously reported[18] that military compensation includes a mix of cash, noncash benefits, and deferred compensation, and has been one of the primary tools used by DOD to recruit and retain servicemembers since the military transitioned to an All-Volunteer Force in 1973. The commissary benefit is just one of the noncash benefits available to servicemembers. In our recent report,[19] we noted that 90 percent of military personnel responding to the 2007 Status of Forces Survey for Active Duty Personnel indicated that they utilize commissary benefits. However, while these survey results

[18] GAO–10–666T, GAO–10–561R, GAO–07–828, and GAO–05–798.
[19] GAO–10–561R.

show that 90 percent—a large majority—of respondents reportedly used the commissary, the survey does not contain a question that asks about the value the individual places on the commissary benefit; therefore, the results of the survey could not take into account the value that an individual servicemember places on the commissary benefit.

In addition, the Navy Exchange Service Command is meant to provide quality goods and services at a savings and to support quality-of-life programs by providing dividends to Navy Morale, Welfare, and Recreation (MWR). In 2008, the Navy Exchange Service Command had total annual sales of $2.52 billion and generated more than $45 million in dividends for MWR quality-of-life programs. While this figure gives an indication of the Command's profitability, it does not take into account the value that a servicemember places on the benefit. Further, as we reported in 2005, servicemembers may not understand the full extent (i.e., the value) of their benefits—in this case, the commissary benefit.

As noted previously, DOD's compensation package is a mix of cash and noncash benefits—the commissary benefit being one of the noncash benefits available to servicemembers. However, in 2005,[20] we reported that DOD's mix of compensation (i.e., the ratio of cash to noncash to deferred benefits) was highly inefficient for meeting near-term recruiting and retention needs. We further reported that cash pay in the present is generally accepted as a far more efficient tool than future cash or benefits for recruiting and retention.

20. Senator COLLINS. Mr. Carr, given the rising costs associated with salary and health care benefits, is it fair to say that one of your goals in developing an effective compensation package for our men and women in uniform would be to maximize availability of benefits that incur little cost to the Department, but that are also highly valued by the Active Duty and retiree community, such as commissary and exchange benefits?

Mr. CARR. Yes. The first and foremost goal of an effective military compensation package is to attract, retain, motivate, distribute, and ultimately separate the force, both Active and Reserve, required to meet the Nation's needs. Within this compensation package, the Department strives to provide an appropriate mix of cash, noncash, and deferred benefits that meets the goals of the Department as well as the needs of military members. This overall package includes benefits such as healthcare, commissary, and exchanges.

[Whereupon, at 11:25 a.m., the subcommittee adjourned.]

[20] GAO–05–798.

DEPARTMENT OF DEFENSE AUTHORIZATION FOR APPROPRIATIONS FOR FISCAL YEAR 2011

WEDNESDAY, MAY 12, 2010

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

RESERVE COMPONENT PROGRAMS

The subcommittee met, pursuant to notice, at 10:02 a.m. in room SR–222, Russell Senate Office Building, Senator Jim Webb (chairman of the subcommittee) presiding.

Committee members present: Senators Webb, Hagan, Chambliss, and Graham.

Committee staff members present: Leah C. Brewer, nominations and hearings clerk; and Jennifer L. Stoker, security clerk.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, counsel; and Gerald J. Leeling, counsel.

Minority staff members present: Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Jennifer R. Knowles, Hannah I. Lloyd, and Brian F. Sebold.

Committee members' assistants present: Nick Ikeda, assistant to Senator Akaka; Roger Pena, assistant to Senator Hagan; Clyde A. Taylor IV, assistant to Senator Chambliss; and Walt Kuhn, assistant to Senator Graham.

OPENING STATEMENT OF SENATOR JIM WEBB, CHAIRMAN

Senator WEBB. Good morning. The subcommittee will come to order.

The subcommittee meets this morning to receive testimony on the Guard and Reserve programs of the Department of Defense (DOD).

We'll have two panels this morning. The first panel, we'll welcome the Honorable Dennis McCarthy, Assistant Secretary of Defense for Reserve Affairs; General Craig McKinley, Chief of the National Guard Bureau; Lieutenant General Harry Wyatt III, Director of the Air National Guard; and Major General Raymond Carpenter, Acting Director of the Army National Guard.

On the second panel, we'll have the Chiefs of the Reserve, and we'll introduce them when we bring in the second panel.

I should point out that we are expecting three consecutive roll call votes to begin at any time, and we're going to do our best to keep the hearing going rather than having to suspend it. That sounds like a vote being called. If we reach the point where we can't do that, then we're just going to have to declare a recess. But, we'll do our best.

The Guard and Reserve continue to transform from a Cold War-era strategic force to an operational force manned and equipped to face both the traditional and asymmetric threats of the 21st century. It's a transformation that started well more than 20 years ago, when the total force concept replaced the force structure that we had during conscription.

I was a part of this transformation, as many of you know, during the Reagan administration. I was the first Assistant Secretary of Defense for Reserve Affairs. It was one of the great leadership experiences of my life, quite frankly, to have put that office online. When we inherited the upgrade, it was composed of 14 full-time staff, plus a lot of Individual Mobilization Augmentees and others that we were able to use from time to time, but we took great care, back in 1984, in designing the structure of the staff and trying to put it into those functions that were necessary, should we have to mobilize and go into a full-out wartime environment. I believe that the office has survived the test of time and adapted to the issues that we face.

I used to say, during the first year, when you have all seven Guard and Reserve components, all four Active components, political appointees and career civilians on one staff, it was like trying to hold a meeting in Yugoslavia; there were so many different points of view at the table. I see some knowing nods, here. [Laughter.]

But, it's been a great addition to DOD, and we welcome the current leadership in those roles, today.

More than 2 years ago, the Commission on the National Guard and Reserve delivered its final report to Congress. One of its conclusions was that there is no reasonable alternative to the Nation's continued reliance on the Guard and Reserve for missions at home and abroad as a part of an operational force. The question this raises is whether this level of operational use is sustainable in the future. Will the Guard and Reserve still be able to recruit and retain the quality individuals they need, given their increased operational tempo? How will this evolution impact the military's relationship with civilian employers?

The operationalization of the Guard and Reserve also raises questions about their capacity to respond to unforeseen events, such as Hurricane Katrina or the earthquake in Haiti, which require surge capacity and specialized skills that the Active components may not be able to provide.

The use of the Guard and Reserve has increased, in large part, to ease the stress on the Active components, but we run the risk of overly stressing guardsmen and reservists, who, in addition to their military duties, hold down civilian careers.

After 9 years of overseas commitments, the Guard and Reserve remain stressed, including dwell times closer to 1 to 3 than the

stated goal of 1 to 5, and we need to look at these issues and many others.

I have a longer statement that I'm going to submit into the record at this point, but, in the interest of time—and also, I want to get into the views of our witnesses—I would like to just submit this into the record and call on a ranking Republican, Colonel Lindsey Graham to give his opening statement.

[The prepared statement of Senator Webb follows:]

PREPARED STATEMENT BY SENATOR JIM WEBB

The subcommittee meets this morning to receive testimony on the Guard and Reserve programs of the Department of Defense.

We will have two panels this morning. On the first panel, we welcome the Honorable Dennis M. McCarthy, Assistant Secretary of Defense for Reserve Affairs; General Craig R. McKinley, Chief, National Guard Bureau; Lieutenant General Harry M. Wyatt III, Director, Air National Guard; and Major General Raymond W. Carpenter, Acting Director, Army National Guard.

On our second panel, we will have the Chiefs of the Service Reserves, and I will introduce them when we convene the second panel.

The Guard and Reserve continue to transform from a Cold War-era strategic force to an operational force manned and equipped to face both the traditional and asymmetric threats of the 21st century. It is a transformation that started more than 20 years ago during the Reagan administration, and I bring a definite perspective to the table having been privileged to serve for 3 years as the first Assistant Secretary of Defense for Reserve Affairs. At the height of the Cold War, my staff and I broke new ground in determining if our Guard and Reserve components were, in fact, ready and available to be mobilized and deployed in the event of major crisis or hostilities.

More than 2 years ago, the Commission on the National Guard and Reserves delivered its final report to Congress. One of its conclusions was that there is no reasonable alternative to the Nation's continued reliance on the Guard and Reserve for missions at home and abroad as part of an operational force. The question this raises is whether this level of operational use is sustainable into the future. Will the Guard and Reserve still be able to recruit and retain the quality individuals they need given their increased operational tempo? How will this evolution impact the military's relationship with civilian employers?

The operationalization of the Guard and Reserve also raises questions about their capacity to respond to unforeseen events, like Hurricane Katrina or the earthquake in Haiti, which require the surge capacity and specialized skills that the Active component may not be able to provide. The use of the Guard and Reserve has increased in large part to ease the stress on the Active components, but we run the risk of overly stressing guardsmen and reservists, who in addition to their military duties, hold down civilian careers. The Guard and Reserve must be ready and able to meet their missions while retaining the character and essence of the citizen soldier.

After 9 years of continuous combat the Guard and Reserve remain stressed, including dwell times closer to 1 to 3 years than the stated goal of 1 to 5 years. We must increase the amount of time guardsmen and reservists receive between deployments. This is absolutely vital to the long-term health and sustainability of the Guard and Reserve. It ensures that our reservists and guardsmen remain trained and proficient, while providing predictability for their families and civilian employers. This predictability and transparency will help sustain the morale and mental health of our servicemembers, and allow them to plan both their military and civilian careers with a degree of surety and predictability that enhances retention. It is good for the servicemembers and their families, the military, the civilian sector, and for the Nation.

This subcommittee has over the past several years sponsored or supported many initiatives to address the well-being of reservists, guardsmen, and their families. Few countries, for instance, offer retirement benefits for Reserve or non-regular military service, and of those who do, the United States appropriately offers some of the most generous, including a retirement pension at age 60 (or earlier under certain conditions), health care, survivor benefits, and the full range of veteran benefits.

Over the past several years, Congress continued to enhance and expand benefits and programs for guardsmen, reservists, and their families. The committee authorized the Yellow Ribbon program, which has been a resounding success. In 2006,

Congress authorized income replacement for members of the Guard and Reserve subject to extended and frequent active-duty service. In 2007, Congress extended TRICARE eligibility to members of the Selected Reserve. Last year, Congress extended TRICARE eligibility to gray-area retirees and increased the number of days prior to mobilization that guardsmen and reservists have access to health care. In 2008, Congress authorized travel allowances for certain members of the Selected Reserve Forced to travel long distances to drill. Finally, we enacted the Post-9/11 GI Bill, complete with transferability. In recognition of their exceptional service since September 11, many guardsmen and reservists are eligible for these benefits.

Nevertheless, work remains to be done. Medical and dental readiness of guardsmen and reservists remains a challenge, despite legislation over the past two years to help improve it. Suicide rates in the Guard and Reserve continue to rise at disturbing rates. We must continue to work to integrate the Guard and Reserve with the active duty in a more seamless way. I look forward to hearing what challenges and obstacles exist that prevent a more seamless integration, what is being done to address them, and whether legislation is needed to help that effort.

Finally, I want to note that we are still waiting for the Department's final assessment of the remaining recommendations from the final report of the Commission on the National Guard and Reserves that was due April 1, 2009. I understand that the Department is implementing those recommendations with which it agreed, but we have yet to learn of its views on the remainder. At this hearing last year, the acting Assistant Secretary of Defense for Reserve Affairs stated that the Department's assessment was in the final coordination stages, and that we could expect it within weeks. A full year has passed. The Department's final assessment of the Commission's recommendations is long overdue. Such delinquent reports limit the ability of this subcommittee to exercise its oversight functions properly. Absent a compelling reason, we cannot tolerate such inordinate delays.

On our second panel we welcome Lieutenant General Jack C. Stultz, Chief of the Army Reserve; Vice Admiral Dirk J. Debbink, Chief of the Navy Reserve; Lieutenant General John F. Kelly, Commander, Marine Forces Reserve; Lieutenant General Charles E. Stenner, Chief of the Air Force Reserve; and Rear Admiral Sandra L. Stosz, Acting Director, U.S. Coast Guard Reserve.

Senator GRAHAM. I move I be promoted. [Laughter.]

I think I'd lose, two to one. [Laughter.]

Senator WEBB. I think you're looking at the right people on the other end of the table for that.

STATEMENT OF SENATOR LINDSEY GRAHAM

Senator GRAHAM. Yes. Anyway, I know we have to go vote, here.

The legal authorities that you would need to be able to activate the Reserves in a less bureaucratic manner, I want to hear about that. The Guard and Reserve, as Senator Webb said, is an indispensable part of this war effort. Civil affairs, military police, you name it, the Guard and Reserves are on the front lines of what we need in Iraq and Afghanistan. As you build out the 21st century threats, the Guard and Reserve are completely indispensable. The Cold War model has to be changed, because the Cold War—thank God, we won that; we need to win the war we're in now.

Senator Chambliss has some proposals regarding earlier retirement. I couldn't support his idea more. We need to deliver for the troops here.

Secretary Gates is a fine man. Don't even think about cutting military pay. That's on the Active Duty side. From the Guard and Reserves point of view, you're the best bang-for-the-buck for the American taxpayer, about 25 cents on the dollar, in terms of Active Duty cost, and you hit way above your weight. I want to talk to you about—when we have a chance here—deploying the National Guard along the border. Is that feasible? Do you think that would make a difference, and could you do it?

With that, Mr. Chairman, I'd just end with saying that our Guard and Reserve members and their families—we're doing the best we can to take care of you. TRICARE has been a good addition to the benefit package available to Guard and Reserve members and their families.

America should be very proud of the commitment of the citizen soldier. I know I am.

Thank you.

Senator WEBB. Thank you very much, Senator Graham.

Secretary McCarthy, welcome.

STATEMENT OF HON. DENNIS M. MCCARTHY, ASSISTANT SECRETARY OF DEFENSE FOR RESERVE AFFAIRS

Mr. MCCARTHY. Thank you, Mr. Chairman, Senator Graham, members of the subcommittee. I appreciate the opportunity to testify today and to engage with you about the direction and the future role of our Nation's Reserve components.

I'm honored to be present with my colleagues in uniform, all seven of the Reserve Chiefs. It's a pleasure to serve with them. I know they'd all join me, or will all join me, in saying thank you to the subcommittee for everything that you have done for the men and women in uniform, both Active and Reserve, and DOD civilians.

As we've all discussed many times, I think we're at a very significant point in the history of our Reserve components, and, frankly, at a point of great opportunity. I think there's three main themes that we ought to touch on, and I'll just summarize them.

First of all, every man and woman serving in uniform today has either enlisted or reenlisted since September 11. They've made a conscious decision to serve, with full understanding of what service in today's environment means. They know it means service in combat, they know it means repeated deployments; and, for members of the Reserve component, they know that it means, not just stress on themselves and their families, but also on their employers. Yet, they have continued to make that decision to serve.

Second of all, because we've had over 750,000 Reserve and Guard members mobilized since September 11, we have the most experienced, best-trained, best-equipped Reserve component we've had in anybody's recent memory. But, to sustain this force, we need to continue to support the families of those in uniform and their employers.

Third, I think there is an emerging consensus that, even after the high demand for forces in Afghanistan and Iraq come down, it still makes sense to utilize our Reserve components on a rotational basis. We've made a significant investment in them. They've made a significant investment. We should continue to use that so that we get return on that investment.

I would say that it's not just indispensable, which it is, but it's also a sensible use of this great Reserve component that we have. But, to do that, we're going to have to find some new ways to do things. As has been mentioned, finding a way to assure that we have access, and that those who plan for the use of Reserve component forces can make those plans confidently, knowing that they

will be able to get access to the forces, is very important. We need to find a constitutionally sound method to authorize that access.

We need to make progress on this thing that we've been talking about for years, the continuum of service, the ability of an individual to flow on and off of full-time duty without jeopardizing their pay or their medical care.

We need to find ways to continue to support families and employers, and, in particular, support employers so that they will continue to support us, as they have so tremendously done up until now.

Almost everything that is in that laundry list of things to do relates back to a recommendation that was made by the Commission on the National Guard and Reserve, and was approved by the Secretary of Defense. Quite frankly, we haven't made as much progress in implementing those recommendations as I would like, but I guarantee you, we are working hard on that.

I turn to my colleagues in uniform for their comments, but I do look forward, Senators, to answering your questions.

[The prepared statement of Mr. McCarthy follows:]

PREPARED STATEMENT BY HON. DENNIS M. MCCARTHY

INTRODUCTION

Chairman Webb, Ranking Member Graham, and members of the subcommittee; thank you for your invitation to present the capability of America's Reserve component (RC) forces to meet current and future operational requirements. This is my first appearance before this committee in my current role, and I would like to recap where we've been and where I think we need to go. The Senate Armed Services Committee has always been very supportive of our National Guard and Reserve Forces. On behalf of those men and women, our Citizen Warriors, their families and employers, I want to publicly thank you for all your help in providing for them as they have stepped up to answer the call to duty. We will do everything in our power to merit your continued support.

PREFACE

The office I hold was specifically mandated by Congress because of recognition that sustaining the Reserve components was essential to the success of the All-Volunteer Force. The statutorily mandated mission of the Assistant Secretary of Defense for Reserve Affairs (ASD/RA) in title 10 section 138 is, " . . . the overall supervision of Reserve component affairs of the Department of Defense." I take this responsibility very seriously because our Guard and Reserve perform vital national security functions and are closely interlocked with our States, cities, and communities. I have very specific guidance from the Under Secretary of Defense for Personnel and Readiness to focus on the readiness of our Reserve components, and to measure our success by our contribution to maintenance of the All-Volunteer Force. I know from first hand conversations with the men and women who comprise our National Guard and Reserve that this is a most welcome message. They too are focused on readiness and have every intention of being fully ready for whatever mission their country may assign them.

I believe the goal for the Reserve components should be to become; a force that is sustainable, seamlessly integrated with the Active components, and complementary in its capabilities to our overall national security requirements. Achieving this goal will require a coordinated effort between the legislative and executive branches.

WHERE WE'VE BEEN

I try to consistently speak about a few central themes that I believe are particularly relevant as the Department actively plans for the next few years. But first, let me briefly recap where we've been. In recent years, we have seen an unprecedented reliance on the Reserve components—since September 11, over 761,000 Citizen Warrior mobilizations have occurred; of that number over 232,000 Selected Reserve members have been activated two or more times. Their service has been magnificent, fully accessible, participating across the full spectrum of missions, abso-

lutely outstanding. I have visited the CENTCOM AOR several times and have witnessed first-hand the seamless integration of our forces in the field.

During the Cold War, the Reserve components were basically a force held in Reserve. The typical RC member trained for approximately 38 days a year and had little expectation of being mobilized. If he/she were called to duty, the expectation was that there would be plenty of time to mobilize, train, and deploy—an event that might happen perhaps once in a career. I think we can all safely say "This is not your father's, mother's, or even your older brother's Reserve component anymore." Today's Citizen Warriors have made a conscious decision to serve, with full knowledge that their decision may involve periodic recalls to active duty under arduous and hazardous conditions. They know this is no longer a "1 week-end a month" organization, and they didn't join up just for the college tuition. Also, it is clear that we have left the old model of, "maybe once in a lifetime mobilization" behind. In the nineties, the Active component (AC) and RC end strength drew down, but the world continued to be a dangerous place, so we increasingly relied on the National Guard and Reserves to support military mission requirements in the first Gulf War, Bosnia, Kosovo, Multinational Force and Observers (MFO) Sinai, air operations in and around Iraq, as well as daily operational support requirements. Even before September 11, we were evolving toward a total transformation in the way the Reserve component was being utilized.

Recognizing this change, the Department set about transforming the Guard and Reserve from a purely strategic force to a sustainable Reserve Force with both operational and strategic roles. Effective management of the Guard and Reserve as an operational force required changes in numerous policies, including: mobilization, force structure rebalancing, personnel management, training, readiness, equipping, and family and employer support. These changes have been critical to our success during what is now the largest mobilization of the Guard and Reserve since the Korean War, in a war that has lasted longer than World War II. It is important to note that in addition to these expanded operational capabilities, the Reserve components still provide strategic depth to meet U.S. defense requirements across the full spectrum of conflict. Additionally, the indisputable fact of high enlistment and retention rates in all services and components clearly demonstrates this generation's commitment to service; they are convinced that their service is valuable, and that it is valued. The six DOD Reserve components combined achieved 104 percent of their recruiting goal for fiscal year 2009 and retention is high. As a result, end-strength expectations are being met.

WHERE WE'RE GOING

Writing the next chapter in the history of our Nation's use of its Reserve components begins with the Quadrennial Defense Review (QDR) and other strategic planning processes, to include the findings and recommendations of the Commission on the National Guard and Reserves (CNGR). The Department continues to work the 53 CNGR recommendations the Secretary of Defense approved in his November 2008 memo. While much work still needs to be accomplished, there have been several high points. This includes improvements in the oversight of equipment readiness and transparency of Reserve component procurement funding and establishment of the Yellow Ribbon program. The fiscal year 2011 budget provides about $50 billion for pay, training, equipping and facilities to support the RCs. The funds provide about 43 percent of the total military end strength for 9 percent of the total base budget.

The CNGR recommendations that the Secretary of Defense approved will continue to be a high priority for me until they are fully implemented. The implementation of those recommendations will enable the proper utilization of the National Guard and Reserve, reducing the burden on all forces—a Presidential priority. Effective utilization of the Guard and Reserve increases the strategic capacity of the Total Force. We have authored mobilization policies which institutionalized "judicious use" as the core principle of Reserve component participation, and are the foundation of predictability (1-year mobilization and 1:5 utilization goals) for the operational reserve. This principle is widely supported by military members, families, and employers alike.

Another important concept emphasis in the CNGR is Continuum of Service (CoS). This phrase often appears in testimony and documents; however, there is little concrete description of what CoS actually is. CoS is an important aspect of retention that allows servicemembers to easily transfer from one component (Regular, Guard, Reserve, or civilian) to another. The CoS program provides greater flexibility and predictability for retaining valuable skills over a lifetime of service to the Nation.

In the future, DOD will seek necessary legislative changes to assist in duty status reform.

CoS initiatives have had a positive impact on our servicemembers. The Air Force initiated an on-line CoS Tracking Tool that provides a single comprehensive information source for capturing and monitoring Total Force CoS initiatives. This tool was incorporated by the Army and is now being adapted for use throughout the Department of Defense. Based on NDAA-authorization, the Navy initiated a Career Intermission Pilot Program allowing a break in service from active duty to the Nonparticipating Individual Ready Reserve for up to 3 years for personal or professional reasons. The Army and Air Force are now implementing this pilot program to retain valuable experience and training of our servicemembers who might otherwise be lost to permanent separation.

For Reserve components, CoS is an important force multiplier for balancing people and mission to ensure the right member to the fight.

I would note that the budget supports preparation of both units and individuals to participate in missions, across the full spectrum of military operations, in a cyclic or periodic manner that provides predictability for the combatant commands, the Services, servicemembers, their families, and civilian employers; potentially increasing the Department's overall capacity while reducing costs.

We now have a policy of notifying members 180 days prior to mobilization whenever possible. The Services are also striving to provide alerts to units 1 year or more in advance. In addition, this subcommittee helped provide a change in statute which doubled from 90 to 180 days the period prior to mobilization in which reservists are eligible for healthcare. I believe this change will have a positive impact on individual medical readiness. As the services perfect their rotational readiness models, it will be increasingly common to notify units of upcoming missions up to 2 years in advance. We have streamlined the mobilization and pre-deployment training processes, and these and other changes are sustaining the Reserve components during this extensive mobilization period. In addition we are implementing a "train-mobilize-deploy" construct, as opposed the old Cold War model of "mobilize-train-deploy," this means that the RCs must be ready, manned, trained, medically prepared, and equipped when their scheduled availability comes up, and they must be funded accordingly.

Clearly, your changes in compensation and benefits that recognized the increased operational role of the Guard and Reserve, as well as the pride they take in serving their country in these challenging times, are major factors in improving our abilities to recruit and retain a quality force.

Over the past 8 years, we developed a rebalancing effort in the Active and Reserve components that initially transitioned 89,000 billets in less-stressed career fields to more heavily used specialties. From 2003 until now, we have rebalanced over 180,000 billets and working with the Services, have planned and programmed an additional 121,900 billets for rebalancing between fiscal year 2010 and 2015. Although the amount and type of rebalancing varies by Service, key stressed capability areas include: Engineers, Civil Affairs, Intelligence, Special Operations, Military Police, Infantry, Aviation, Space and Combat Air Superiority. By 2015, we expect to have rebalanced over 302,000 billets. Rebalancing is a continuous and iterative process. The Department will continue to work closely with the Services as they review and refine their rebalancing plans to achieve the right mix of capabilities and alignment of force structure. For that reason, the QDR and the defense budget will continue the efforts the Secretary started, to rebalance the military's forces and programs to meet the current threats and to reform the way the Defense Department does business. The Under Secretary of Defense for Policy recently testified, "If the QDR has a bumper sticker it would be 'Rebalance and Reform'." This will greatly help reduce stress and increase support to the Active and Reserve operational force by providing a deeper bench for those skills that are in high demand. However, easing the stress on the force is more than just rebalancing, judicious use and notification.

"Rebalance and Reform" also means sustaining the readiness of our forces. One such program is the Innovative Readiness Training (IRT) Program. This program provides mission essential training opportunities for our National Guard and Reserve sustainment units while providing a critical link between the military and underserved civilian communities. The IRT program's focus is to provide a venue for Mission Essential Task List (METL) training requirements in engineering, health care, diving, and transportation. Each year new training opportunities are presented by Federal, State, or local government agencies or nonprofits. The IRT program's goal is to strive to ensure a varied and challenging menu of training opportunities that result in interoperability and ensure readiness training is available for our military personnel. Examples of IRT activities include, constructing rural roads and

runways, small building and warehouse construction, and providing medical and dental care to Native Americans, Alaska Natives and other medically underserved communities. IRT continues to evolve to meet the challenges of DOD transformational priorities to strengthen joint warfighting capabilities while ensuring our Nation maintains a fully capable National Guard and Reserve.

HOW WE GET THERE

We need a roadmap to list the waypoints, to foster dialog and change some widely held traditional beliefs. Extracting full value from our Reserve components will require a fundamental shift in the way many in DOD currently envision these forces. During the Cold War, military planning generally viewed the Guard and Reserve as essentially a "force of last resort," to be used after all possible Active component solutions have been attempted. Going forward, I believe the Services should not hesitate to use National Guard and Reserve formations as the "force of first choice" for requirements for which they are well suited. This will require many minds to transition from "what was," to "what is," then "what should be."

Predictability is perhaps one of the most important keys to tapping into the reservoir of Guard and Reserve capabilities. The process by which roles and missions are assigned to the Reserve and Guard should be characterized by a belief that these forces can, and frequently should be, the first choice for recurring or predictable missions within their capabilities, because they are and have been fully accessible. In this context, predictability encourages anticipatory planning—thinking ahead, not just in terms of the type of mission, but the timing and duration of the mission as well. Predictable missions create lead time for proper planning and training. That kind of anticipatory thinking can't be done when the Reserve components are used as the "last option." The other important parts of this "best advantage" equation are the assignment of challenging and relevant missions to the National Guard and Reserves, and ensuring that resources are available in order to set the conditions for their success.

Using the Reserve components on a rotational basis, especially where the cycle can be pointed toward a predictable mission, maintains their readiness and expands their availability and capability. The rotational availability models in use today—the Army Force Generation (ARFORGEN), or Air Force Expeditionary Force (AEF), etc.—are essential to ensuring that the Guard and Reserve are trained and ready when needed.

We must also ensure that the visibility, transparency and accountability of National Guard and Reserve equipment, from planning, programming, and budgeting, through acquisition and fielding, occurs at all levels. In addition, resetting the force is absolutely essential because it integrates the transformation, reconstitution, rebalancing, modernization, and recapitalization into a common action with a focus on the contribution to the Services' roles and missions. The Commission on the National Guard and Reserves had two specific recommendations to address this challenge. The Deputy Secretary of Defense directed, and agreed to an implementation plan that we have been executing since August 2009. The Reserve component of each military department must be properly equipped not just to deploy, but to also sustain itself as a trained and ready force. The design of the Reserve component equipping strategy is envisioned to procure and distribute required equipment; to maintain a degree of readiness that is responsive to the combatant commanders' request; while sustaining capabilities to respond when called upon here at home. This strategy takes into account the Department's support to each State's Homeland Defense mission, while maximizing equipment availability throughout the force.

Our ultimate goal is for the RC to be a ready force, equipped and supported with facilities, ranges, and simulators to succeed in fulfilling their domestic and overseas missions. Our efforts include the development of strategies and processes to ensure RC equipment readiness levels are not adversely affected by losses from "stay-behind" equipment, cross-leveling, and reset policies. We are striving to ensure the RCs have the right equipment, available in the right quantities, at the right time, and at the right place to support the "Train-Mobilize-Deploy" model for an operational reserve. We are expanding the use of simulators that increase proficiency while at the same time reducing equipment costs and range utilization. An effective "Train-Mobilize-Deploy" force must not encounter modern equipment for the first time after mobilization or after arriving in theater. We also support the RC in their Homeland Defense and civil support role. This is a Total Force responsibility, and one in which we are making considerable progress. Identifying and procuring critical dual use equipment (equipment that is used in both domestic and war fighting missions) is another effort that has realized tremendous dividends. As the Department embarks on a new RC equipment strategy, we are working hand-in-hand with the

Services to improve the transparency of equipment from the appropriation of funding to the delivery of that equipment.

There is a direct correlation between readiness and facilities, particularly in the RC. The move from a strategic reserve to an operational reserve doesn't change the fact that we owe our Guard and Reserve member's quality facilities in which to work and train. The fiscal year 2011 Military Construction (MILCON) program request for the Reserve components has increased, and will help alleviate some facility deficiencies. We continue to pursue joint construction opportunities as a way to combine the space and functional requirements of two or more Service components into one facility, thereby eliminating the need to build separate buildings. The benefits of doing this go far beyond cost savings by promoting cooperation, building trust, and providing opportunities for joint training.

Record levels of Guard and Reserve mobilizations over the past 8 years have highlighted a critical shortfall in facility requirements, re-emphasizing the need for meticulous analysis of funding and investment in order to fill the capability gap to support rotational readiness requirements, such as transient training facilities. The Army has developed an Operational Readiness Training Complex (ORTC) concept to provide permanent facilities in centralized locations that will improve unit cohesion, the efficient use of limited training time, and quality of life for members of the Guard and Reserves. The challenges in getting priority funding for these ORTCs have prompted us to engage with the Army in an analytical effort that documents current transient training facility status, assesses the current ORTC implementation plan, recommends changes/improvements in design, and develops a synchronized strategic communications plan in order to gain support for increased and accelerated ORTC funding in the Army budget formulation process.

We can't accomplish any of the foregoing without the support of the families and employers of our men and women. That support is critical to any endeavor the Department attempts. We have seen that where assigned missions are anticipated, planned in advance, and matched with the right supportive resources, families and employers will step up to support their Citizen Warriors. We must continue to engage and support families and employers through well planned and well resourced efforts such as: unit family readiness programs, the Yellow Ribbon Re-integration process, and the National Committee for Employer Support of Guard and Reserve.

The Yellow Ribbon Program (YRP) originates from the 2008 National Defense Authorization Act. It is a DOD-wide effort to help National Guard and Reserve servicemembers and their families connect with local resources before, during, and after deployments, especially during the reintegration phase that occurs months after they return home. Commanders and leaders play a critical role in assuring that Reserve servicemembers and their families attend Yellow Ribbon events where they can access information on health care, education/training opportunities, financial, and legal benefits. The DOD works in conjunction with Federal partners, including the Department of Veterans Affairs and the Department of Labor, to provide up-to-date and relevant information to servicemembers and their loved ones. This program has met with great success and continues to fill a definite need. In fiscal year 2009 the Yellow Ribbon Program conducted the following events:

	National Guard	U.S. Army Reserve	U.S. Marine Corps Reserve	U.S. Navy Reserve	U.S. Air Force Reserve	Total
Number of Events	906	180	120	145	93	1,444
Servicemembers served	54,472	11,701	2,500	18,313	4,115	91,101
Family members served	72,316	11,631	3,037	12,757	3,280	103,021

Employer Support of the Guard and Reserve (ESGR) engagement has grown significantly in recent years, ESGR's vision is, "to develop and promote a culture in which all American employers support and value the military service of their employees with ESGR as the principal advocate within DOD." The ESGR mission is "to develop and promote employer support for Guard and Reserve service by advocating relevant initiatives, recognizing outstanding support, increasing awareness of applicable laws, and resolving conflict between employers and servicemembers." ESGR has a footprint in all 50 States, U.S. Territories, and DC with over 4,600 volunteers assisting employers and servicemembers on a daily basis. In striving to enhance employer support, ESGR relies on recognition programs, including the servicemember-nominated Patriot Award and the Secretary of Defense Employer Support Freedom Award, where 15 employers are honored for their outstanding support of Guard and Reserve servicemembers annually. With current ongoing global operations, combat-related and humanitarian, the support of employers and families

has never been more critical to our national defense. The data below shows the improving trend of the ESGR programs/activities over the last 3 fiscal years.

ESGR BY THE NUMBERS

Fiscal Year	Employers Briefed	Servicemembers Briefed	USERRA Inquiries	Cases Mediated (Percent)	Average Mediated in Days
2007	69,614	232,808	13,116	1,742=73.4	19.9
2008	148,463	341,953	13,090	1,899=71.3	14.2
2009	162,849	443,833	15,870	1,982=80.1	6.7

Despite all of the good work done by our National Committee for Employer Support and by the Defense Advisory Board for ESGR, I believe more must be done. Historically, our efforts in this area have been to sustain and maintain existing employment relationships. But in today's very tough job environment, some Citizen Warriors return from a deployment to find their jobs sharply curtailed or gone entirely. All of us involved in the ESGR effort are looking for ways to support job development. This will not only help our Citizen Warriors, it will help those American businesses that are looking for the kind of high-skill, high integrity people who serve in the Reserve and National Guard.

We also have the unique opportunity to support the President's education agenda and manage two youth outreach programs in order to achieve our national security objectives. The President's Budget request continues to support the DOD STARBASE and National Guard Youth Challenge Programs. Both programs leverage the knowledge, experience, and skills of our DOD civilian and military members to help prepare our youth to become productive and contributing citizens of our society.

The President has made the learning of science, technology, engineering, and math (STEM) a national priority. The DOD STARBASE Program supports this effort and provides elementary and middle school students with real-world applications of STEM through experiential learning, simulations, and experiments. The STARBASE Program utilizes instructional modules with high benchmarks linked to State standards. Teamwork and goal setting are also integrated into the curriculum. The fiscal year 2011 budget will support over 65,000 students participating in the program from approximately 1,250 schools and 350 school districts, which includes schools from Native American communities in Mississippi, Oklahoma, and South Dakota. Since the program's inception, over 560,000 youths have attended the program, pre and post testing showed a significant improvement in student's understanding and interest in STEM, and a desire to pursue further education. Currently, there are 60 DOD STARBASE Program sites on military facilities in 34 states, the District of Columbia, and Puerto Rico.

Many of you may also be aware of the President's 2020 education goal of being first in the world in college completion, and how an important piece of work is reengaging high school dropouts. I am working with General McKinley, Chief of the National Guard Bureau, and the State Adjutants General to provide oversight, but more importantly to support the National Guard Youth Challenge Program so that every qualified high school dropout has an opportunity to attend a program. The National Guard Youth Challenge Program is currently operating at 32 sites in 27 States and Puerto Rico, and is one of several ways the administration is approaching the dropout crisis. The goal of the Program is to improve the education, life skills, and employment potential of America's high school dropouts. This is accomplished by providing quasi-military based training, supervised work experience and advancing the program core components. The core components include assisting participants to obtain a high school diploma or equivalent, developing leadership qualities, promoting fellowship and service to community, developing citizenship, life-coping and job skills, and improving physical fitness, health, and hygiene. Since the program's inception over 90,000 students have successfully graduated from the program, with 80 percent earning their high school diploma or GED. The average cost per Challenge student is approximately $16,800. The fiscal year 2011 budget will support increasing annual enrollment and/or start up new programs in states that have the fiscal resources to match the cost-share funding requirements and to sustain the program's viability in states that have budget limitations. These two successful DOD youth outreach programs provide the Department an opportunity to connect with the American public and work with our Nation's most valued resource—our young people.

WHAT CONSTITUTES SUCCESS

With appropriate advanced planning and proper support, Guard and Reserve Forces have the potential to greatly increase the Department's capacity both traditional and emerging mission areas. The long term, recurring, and predictable nature of many of the requirements we face in the contemporary strategic environment are ideally suited for the National Guard and Reserve. Such missions include post-hostility stabilization tasks, theater security cooperation requirements, and engagement activities that are essential to dissuade or deter potential foes and build partnership capacity.

A major factor in shaping the 2010 Quadrennial Defense Review was the realization that the complexity of the current security environment and the uncertainty of future threats requires the Nation to have " . . . a broad portfolio of military capabilities with maximum versatility across the widest possible spectrum of conflicts," as Defense Secretary Robert Gates testified on 2 February 2010.

Achieving the defense strategy articulated in the QDR requires a vibrant National Guard and Reserve, seamlessly integrated within the Total Force. If the National Guard and Reserve are utilized in a deliberately planned way, and are seamlessly integrated as members of a true Total Force, the Nation will reap the benefits deserved. We must recognize:

- RC servicemembers volunteered to serve with the expectation that they would be judiciously used, and they do not want to return to being exclusively a "strategic reserve."
- The National Guard and Reserves are cost-effective. Using a force in its 1 year of "rotational availability" permits a 5 year preparation with personnel costs that are only a fraction of a force on full time active duty, and without most of the support infrastructure and sustainment costs of active duty units.
- Using the National Guard and Reserve increases Active component dwell to deployment ratio, and helps to sustain that force for future use.
- Using the National Guard and Reserve allows us to take full advantage of unique skills and capabilities resident in our Reserve components. Guardsmen and reservists bring valuable professional, technical and managerial skills from the private sector that match well with many current and anticipated DOD requirements.
- Homeland Defense and Defense Support to Civil Authorities are Total Force responsibilities. Reserve components, particularly the National Guard, are the center of gravity for DOD Homeland Defense response operations. RC roles continue to evolve in this complex environment, but one thing is certain – the community basis of the Guard and Reserve have them already "forward deployed" in this critical AOR. They have the local knowledge necessary to succeed in times of greatest stress on local people and institutions.
- We can achieve higher utilization rates of expensive assets by increasing the use of equipment and facilities that are shared between Active and Reserve component units. In particular, increasing the Active and Reserve crew and maintainer ratios of our most modern and expensive aircraft seems to me to make good sense, and could be an immediate benefit.
- We must recruit and retain prior-service personnel—a proven capability of both the National Guard and Reserves—thereby preserving the expensive training costs invested in these personnel while they served on active duty. This is often an under-appreciated return on investment that must be taken into account when we calculate the cost and value of the Reserve components.
- When they are used correctly, there is a cumulative and positive readiness impact on Guard and Reserve Forces that will pay immediate dividends if they are called to respond to an unanticipated contingency and helps the Active components also.
- As a community-based force, the Reserve and National Guard provide a unique connection to the American people that facilitates an awareness and engagement on key national security issues. This connection is essential to maintaining the Nation's commitment to our armed forces.
- I ask your support of the legislative proposals that will enable the Department to accomplish many of the ideas promoted here:
  - The extension of bonuses and special pays
  - Authority to allow servicemembers to designate the best person to travel to Yellow Ribbon events
  - Special assignment of dual status military technicians
  - Revised structure and functions of the Reserve Forces Policy Board

We need your support of those proposals, particularly the increase in full-time support which forms an increasingly important part of the manning for the Reserve components. With more frequent unit mobilizations, the Guard and Reserves need more non-deploying full-time positions to perform those enduring "home station" administrative, maintenance, fiscal and support functions which otherwise are disrupted if performed by a military member who must be absent for a deployment. The 2010 QDR calls for a comprehensive review of the future role of the Reserve component, including an examination of the balance between Active and Reserve Forces. Effective use of the Reserve components will act as a force multiplier, increasing the capacity and expanding the range of available capabilities; thus enhancing and preserving the All-Volunteer Force. Force multiplication is generated through lower overall personnel and operating costs, a right mix and availability of equipment, a more efficient and effective use of defense assets, and an increased sustainability of both the Active and Reserve components. The National Guard and Reserves have capability and capacity to continue if properly funded and equipped.

CONCLUSION

As we reinforce policies, implement strategies and continue to call upon our Reserve components, we must remember that judicious use is still the watchword. The National Guard and Reserve continue to be a mission-ready critical element of our National Security Strategy. Because our Reserve components will be asked to continue in their role as an operational force, we must ensure a Total Force Policy exists that supports employment of the Reserve components in both an operational and strategic role. Working together, we can ensure that the Reserve components are trained, ready, and continue to perform to the level of excellence that they have repeatedly demonstrated. Thank you very much for this opportunity to testify on behalf of our Guard and Reserve.

Senator GRAHAM [presiding]. Thank you, Mr. Secretary.

I apologize, I think the best thing for us to do now is to recess, because time's about out. I'll go vote. We'll come back, and so we'll stand down for a few minutes.

We'll be in recess. Thank you.

[Recess.]

Senator WEBB [presiding]. The hearing will again come to order.

I was informed by staff that, Secretary McCarthy, you were able to finish your statement and we've not yet begun with General McKinley.

So, General, let me start by saying—I understand there's only one statement from the National Guard. Is that correct?

General MCKINLEY. Sir, I have brief remarks, and I was going to let the Directors of the Air and the Army just make very brief remarks also.

Senator WEBB. I would encourage them to do so. I was told by staff that we only got one written statement.

General MCKINLEY. I will introduce the two directors, and they represent the bulk of our portfolio.

Senator WEBB. So, is there a written statement from either of them?

General MCKINLEY. We have one written statement, and then we were going to make three verbal statements.

Senator WEBB. All right.

General MCKINLEY. Is that okay?

Senator WEBB. Proceed.

General MCKINLEY. Thanks, Senator.

STATEMENT OF GEN. CRAIG R. MCKINLEY, USAF, CHIEF, NATIONAL GUARD BUREAU

General MCKINLEY. Chairman Webb, it's an honor and privilege to be here today to discuss the National Guard's personnel issues related to its ongoing role as an operational force.

The evolution of today's threat environment has made it essential for the National Guard to strike the proper balance between operational force and strategic hedge. The asymmetry of our adversaries require us to have an adaptable force that is capable of efficiently engaging in the current fight while maintaining a cost-effective surge capability prepared for tomorrow's threat.

Today, there are about 460,000 members of the Army and the Air National Guard. Our strength is good, and our retention is even better.

With me today is Lieutenant General Bud Wyatt, the Director of the Air National Guard and a former adjutant general of Oklahoma. Also with me is Major General Ray Carpenter, the acting Director of the Army Guard from South Dakota, and Major General Mike Summeral, Director of our National Guard Joint Staff from Alabama, and a former adjutant general.

As the U.S. Armed Forces continue to conduct operations in Iraq, Afghanistan, and elsewhere around the world, units of the Army and the Air National Guard are participating as total force partners in that effort. I'd like to personally thank General Casey and General Schwartz and the Secretaries of the Army and the Air Force for including the National Guard in their force as planning constructs and all they do for the National Guard.

The National Guard has repeatedly, over the past decade, proven itself to be a ready, accessible, and, I would include, a reliable force. We have validated the total-force concept by showing that the men and women in our formations are ready to answer the call, to be mobilized, or, in the case of the Air National Guard, to be volunteered to deploy overseas, return home, and then become prepared to do it again and again.

The citizen soldiers and airmen of your National Guard are adding value to America every day that they serve. The capabilities they bring to bear would not have been possible without the strong support of this committee, and we thank you all very much for that support, to include your support of Yellow Ribbon and other personnel programs that take care of soldiers and airmen and their families.

The most critical part of the proven capability, however, is our National Guard men and women. Today's men and women volunteer to join or stay in the National Guard, fully expecting to be deployed. This shift in expectation is a central aspect of the National Guard and, I would argue, with my colleagues from the other Reserve components, shift to becoming a fully operational force, and no longer merely a strategic reserve. Indeed, the soldiers and airmen of your National Guard now serve with that expectation, and are proud of it. They want to remain central players in the Nation's defense, and would, indeed, be resistant to any move to return to a role limited to a strictly strategic reserve.

Overall, we can say that the budget request for fiscal year 2011 meets the critical needs of the Army and the Air National Guard

in this era of persistent conflict overseas and the ongoing threats to American lives and property here in the Homeland.

One of the longest-running joint programs in the National Guard, one which employs both Army and Air National Guard capabilities, is the National Guard Counterdrug Program. This unique program provides a mechanism under which National Guard military experience can be employed to assist civilian law enforcement agencies to fight the corrosive effect of illegal drugs in American society. Funding for our Counterdrug Program is included in the fiscal year 2011 budget request, and we would ask for your full support of that request. As we've seen with recent incidents along our southwest border, the scourge of drugs migrating across our borders constitutes a real threat. Consequently, our National Guard Counterdrug Program fills a very vital need.

We are well aware that last year, as it has done in previous years, this committee supported significant additional funds for that Counterdrug Program to fund capability enhancements. Nearly a quarter of the capability of the National Guard Counterdrug Program exists today because of additional funding provided in the past by Congress.

I would now like to turn to my colleagues from the Army and Air National Guard for their brief verbal comments. To my friend and flightmate, Bud Wyatt.

STATEMENT OF LT. GEN. HARRY M. WYATT III, USAF, DIRECTOR, AIR NATIONAL GUARD

General WYATT. Mr. Chairman and members of the committee, thank you very much for the opportunity to discuss issues of vital importance that impact——

Senator WEBB. General Wyatt, welcome. Let me just reiterate what I said a minute ago. It's my understanding this is the first time that there's not been separate written statements by all three witnesses from the National Guard.

General WYATT. Yes, sir. But, I would assure the chairman that my written inputs were included in those of General McKinley. I did have input.

Senator WEBB. It's traditional to receive separate written statements, and we would expect that. We'd certainly want to see that next year.

General WYATT. Yes, sir.

Senator WEBB. Thank you.

General WYATT. Mr. Chairman, Air National Guard airmen are volunteering at unprecedented rates and risking their lives daily because they believe strongly in what they're doing for their country and their communities.

Since September 11, 146,000 Air National Guard members have deployed overseas, many of them on second and third rotations to the combat zones. In the past year alone, we have deployed 18,366 servicemembers to 62 countries and every continent on the face of the Earth, including Antarctica.

The Air National Guard continues to prove the availability and accessibility of the Guard to our Nation and to our communities. In the past year, Air Guard members helped their fellow citizens

battle floods, mitigate the aftermath of ice storms, fight wildfires, and provide relief from the devastating effects of tsunamis.

Early last year, Guard members from Kentucky, Arizona, and Missouri responded to debilitating ice storms, which resulted in the largest National Guard callup in Kentucky's history.

Last spring, North Dakota, South Dakota, and Minnesota Air National Guard members provided rescue relief and manpower in response to midwest flooding. Similar efforts continue this year, with the recent flooding in Tennessee and surrounding areas.

Last September, the Hawaii Air National Guard sent personnel from their Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive Enhanced Response Force Package (CERFP), a command-and-control element, and a mortuary affairs team to American Samoa, in response to an 8.4-magnitude-earthquake-generated tsunami.

These are just a few of the examples of how the Air National Guard provides exceptional expertise, experience, and capabilities to mitigate disasters and their consequences. Without the stewardship of your committee, our airmen would have an incredibly difficult time doing their jobs and taking care of their families. We're thankful for everything that you and the committee have done, and continue to do, to let our members know that America cares about them and is grateful for their service.

In conclusion, with the continued support of Congress, the Air National Guard will continue to develop and field the most capable, cost-effective force that serves with pride and distinction at home and abroad. It's an honor and privilege to be here this morning. I look forward to answering any questions that you or the committee may have.

Thank you, sir.

Senator WEBB. Thank you, General Wyatt.

General Carpenter, welcome.

STATEMENT OF MG RAYMOND W. CARPENTER, ARNG, ACTING DIRECTOR, ARMY NATIONAL GUARD

General CARPENTER. Thank you, sir.

Mr. Chairman, I am honored to represent more than 362,000 citizen soldiers in the Army National Guard. As I speak, we have over 52,000 of our soldiers deployed, mobilized, and on point for this Nation. The sacrifice of those soldiers, their families, and their employers is something we must not only acknowledge, but certainly appreciate.

The National Guard of today is a far cry from the one I joined. The last 8 years have seen the Guard transform to an operational force. The enablers for the Army National Guard have been provided and sustained by congressional initiatives, and we thank you for your continued support.

Today, we would like to highlight our requested increase in non-dual status technicians. These civilian technicians have emerged as being more important, as the Army Guard has shifted from being a strategic reserve to being a frequently deployed operational force. The President's budget for fiscal year 2011 requests an increase in Army National Guard non-dual status employees from 1,600 to

2,520. We ask the committee to provide this increase in its mark of the National Defense Authorization Act for Fiscal Year 2011.

We also want to talk about accessibility today. We feel that our deployment numbers speak for themselves. In July 2009, mobilizations reached the highest point since 2005, of more than 65,000 soldiers. An additional 5,500 soldiers were mobilized for other contingency operations in Bosnia, Kosovo, Sinai, the Horn of Africa, and also for domestic operations. The National Guard has been there when called. We are accessible.

Many have expressed concern about the Army Guard's ability to continue to deploy and meet future requirements. I believe our personnel numbers answer the question. We continue to exceed recruiting goals, and our retention rate averages 110 percent. The men and women who serve in the Army National Guard today do so with full understanding that they are likely to be deployed overseas. Some of them join for that very reason. The shift in expectation is a central aspect of the National Guard's shift to being a fully operational force.

Today's Army National Guard soldiers join and reenlist with the expectation of serving at home and abroad, and they are proud of it. I appreciate the opportunity to be here today and look forward to your questions.

[The joint prepared statement of General McKinley, General Wyatt, and General Carpenter follows:]

JOINT PREPARED STATEMENT BY GEN. CRAIG R. MCKINLEY, USAF; LT. GEN. HARRY M. WYATT III, USAF; AND MG RAYMOND W. CARPENTER, ARNG

OPENING REMARKS

Chairman Webb, Ranking Member Graham, distinguished members of the subcommittee; I appreciate the opportunity to appear before you today to discuss the National Guard's personnel issues related to its ongoing role as an operational force. The evolution of today's threat environment has made it essential for the National Guard to strike the proper balance between operational force and strategic hedge. The diversity of our adversaries require us to have an adaptable force that is capable of efficiently engaging in the current fight while maintaining a cost-effective surge capability prepared for tomorrow's threat.

Today there are about 460,000 members of the Army and the Air National Guard. Our strength is good and our retention is even better.

As the U.S. Armed Forces continue to conduct operations in Iraq, Afghanistan and elsewhere around the world, units of the Army and Air National Guard are participating as total force partners in that effort.

The National Guard has repeatedly proven itself to be a ready, accessible force. We have validated the total force concept by showing that the men and women in our formations are ready to answer the call, to be mobilized, to deploy overseas, return home, and then become prepared to do it again and again.

The citizen soldiers and airmen of your National Guard are adding value to America every day that they serve. The capabilities they bring to bear would not have been possible without the strong support of this committee, and we thank you all very much for that support.

The most critical part of that proven capability, however, is our National Guard men and women. Today's men and women volunteer to join or stay in the National Guard fully expecting to be deployed. This shift in expectation is a central aspect of the National Guard shift to being a fully operational force and no longer merely a strategic reserve.

Indeed, the soldiers and airmen of your National Guard now serve with that expectation and are proud of it. They want to remain central players in the Nation's defense and would, indeed, be resistant to any move to return to a role limited to strictly strategic reserve.

In addition, the Department of Defense is moving forward to identify a nominee for the position of Director of the Army National Guard. Once that occurs we would be most grateful for your support and that the Senate move quickly to confirmation.

Overall, the budget request for fiscal year 2011 meets the critical needs of the Army and Air National Guard in this era of persistent conflict overseas and ongoing threats to American lives and property here in the homeland.

One of the longest running joint programs in the National Guard, one which employs both Army and Air National Guard capabilities, is the National Guard Counterdrug Program. This unique program provides a mechanism under which National Guard military experience can be employed to assist civilian law enforcement agencies to fight the corrosive effect of illegal drugs in American society.

Funding for our counterdrug program is included in the fiscal year 2011 budget request, and it is important that the program is fully funded. The recent incidents along the southwest border and the scourge of drugs migrating across our borders constitutes a real threat. Consequently, our National Guard counter drug program fills a very vital need.

Below you will find detailed information about personnel matters as they pertain to the Air and Army National Guard.

AIR NATIONAL GUARD

America's Exceptional Force, Home and Away

The Air National Guard anchors the Total Air Force team, providing trained and equipped units and personnel to protect domestic life and property; preserving peace, order, and public safety; and providing interoperable capabilities required for Overseas Contingency Operations. The Air National Guard, therefore, is unique by virtue of serving as both a Reserve component of the Total Air Force and as the Air component of the National Guard.

Upon founding in 1947, the Air Guard served primarily as a strategic reserve for the U.S. Air Force. Increasingly and dramatically, the Air National Guard has become more of an operational force, fulfilling U.S. Air Force routine and contingency commitments daily. Since September 11, over 146,000 Guard airmen have deployed overseas. A snapshot of U.S. forces at any time shows Air Guard members in all corners of the globe supporting joint and coalition forces in mission areas such as security; medical support; civil engineering; air refueling; strike; airlift; and intelligence, surveillance, and reconnaissance.

By any measure, the Air National Guard is accessible and available to the combatant commanders, Air Force and our Nation's governors. Currently, the Nation has over 13,000 Air National Guard members deployed in Iraq, Afghanistan, and other overseas regions. At 16 alert sites, three air defense sectors, and Northern Command, 1,200 Guard airmen vigilantly stand watch over America's skies. Amazingly, 75 percent of our deployed individuals are volunteers, and 60 percent are on their second or third rotations to combat zones. Percentages like these speak volumes about the quality and sense of duty of America's Air National Guard force!

The Air National Guard supports State and local civil authorities with airlift, search and rescue, aerial firefighting, and aerial reconnaissance. In addition, we provide critical capabilities in medical triage and aerial evacuation, civil engineering, infrastructure protection, and hazardous materials response with our Civil Support Teams and our Chemical, Biological, Radiological, Nuclear, and high-yield Explosive Enhanced Response Force Packages (CERFPs).

In the past year, Air Guard members helped their fellow citizens battle floods, mitigate the aftermath of ice storms, fight wild fires, and provide relief from the devastating effects of a tsunami. Early in the year, Guard members from Kentucky, Arizona, and Missouri responded to debilitating ice storms, which resulted in the largest National Guard call-up in Kentucky's history. Last spring, North Dakota, South Dakota, and Minnesota Air National Guard members provided rescue relief and manpower in response to Midwest flooding. In September, the Hawaii Air National Guard sent personnel from their CERFP, a command and control element, and a mortuary affairs team, to American Samoa in response to an 8.4 magnitude earthquake-generated tsunami. These are just a few examples of how the Air Guard provides exceptional expertise, experience, and capabilities to mitigate disasters and their consequences.

Within the Total Force, the Air National Guard provides extraordinary value in terms of delivering the most immediately available capability for cost in meeting America's national defense needs. In its domestic role, the Air Guard provides capabilities to support local emergency responders with life and property saving capabilities and expertise in consequence management not usually found elsewhere in the Total Force.

The changing nature of our force and our mission causes us to relook the rank structure of our full-time support personnel, particularly at the more senior mid-management levels. Specifically, we are examining whether we face a growing need for majors, lieutenant colonels and colonels as well as Senior Master Sergeants and Chief Master Sergeants. The number of airmen we are allowed to have in these grades is limited by law.

Best Value for America

The outstanding men and women of the Air National Guard continue to defend American interests around the world. Throughout 2009, the Air National Guard projected global presence in a variety of missions in regions ranging from the Balkans to Southwest Asia and from Eastern Europe to Latin America. We have provided much more than airpower, contributing our exceptional capabilities in security, medical, logistics, communications, civil support, and engineering, in order to support our Nation's national security.

While the strategic environment has continually changed throughout history, the Air Guard has proven itself an adaptive force, able to meet any new challenges. One reason for this success is that Guard members normally live in the same communities in which they serve during times of natural disasters or when called upon to respond to national emergencies. Our Guard members know the folks they support very well, because they work together, their children attend the same schools, and they shop at the same business establishments. Our fellow citizens know the local Guard members and their contributions, and their appreciation has been illustrated through countless welcome home parades and outpouring of support over the years.

Throughout history, many of the issues our forbearers faced are essentially the same issues we face today: aging capabilities and declining budgetary resources. The Air National Guard has consistently provided the answer in an efficient, cost-effective, community-based force that is ready and responsive to domestic and national security needs.

Best Value in Personnel, Operations, and Infrastructure

During the past year, the Air National Guard has deployed 18,366 servicemembers to 62 countries and every continent, including Antarctica. The Air National Guard provides a trained, equipped, and ready force for a fraction of the cost. We provide a third of Total Air Force capabilities for less than 7 percent of the Total Force budget. In all three areas—personnel, operations, and facilities—the Air Guard provides the "Best Value for America."

A key Air National Guard efficiency is the part-time/full-time force structure mix. The predominantly part-time (traditional) force can mobilize quickly when needed for State disaster response missions, homeland defense, or when we need to take the fight overseas.

We have the ability to maintain a stable force with considerably fewer personnel moves than the Regular Air Force, which is a critical factor in our cost-effectiveness. Traditional National Guard members cost little, unless on paid duty status. Some Air National Guard efficiencies compared to regular military components include:

- Fewer "paydays" per year
- Lower medical costs
- Significantly lower training costs beyond initial qualification training
- Virtually no costs for moving families and household goods to new duty assignments every 3 or 4 years
- Fewer entitlements, such as basic allowances for housing
- Lower base support costs, in terms of services, facilities, including commissaries, base housing, base exchanges, child care facilities, etc.

The Air National Guard is an operational reserve with surge potential, with 2,200 mobilized and 5,700 volunteering per day. If this force were full-time active duty, the military personnel budget would be $7.62 billion. Air National Guard military personnel pay in fiscal year 2009, including military technician pay, was $4.77 billion, for a yearly cost savings of $2.85 billion, or a daily cost savings of $7.8 million.

Whether compared to another major Air Force command, or even to the militaries of other countries, the Air National Guard is an extraordinary value. In direct comparison with the militaries of France and Italy, for example, our Air National Guard members cost only $76,961 per member, while the bills of those countries respectively run to $128,791 and $110,787 per member. Further, compared to the U.S. Air Force, cost per Air Guard member is less than a fifth of that of the Regular Air Force. Comparisons such as these illustrate well the cost savings realized with an operational reserve possessing surge potential.

Operational savings are due to the Air National Guard's experienced force and lean operating methods. An examination of the Air National Guard's F–16 maintenance by Rand Corporation last year highlighted the ability of our maintenance personnel to generate double the amount of flying hours in a one-to-one comparison of full-time equivalents.

Recruiting and Retention

Air National Guard Recruiting and Retention programs play a critical role in supporting today's fight and how we posture our force for the future. The commitment of our field commanders and their exceptional recruiters are key factors in recruiting successes. Their partnership with the National Guard Bureau has enabled us to remove barriers that traditionally prevented the ability to meet end strength. The Air National Guard continues to build on that success and has focused its efforts to target critical needs.

As of April 22, 2010, Air National Guard end strength is 108,420. The challenge as we move forward is to strike a delicate balance of remaining close to end strength while strengthening "effective" recruiting. We show troubling signs in specific areas of officer recruiting (currently 1,500 short) and critically manned mission areas including Health Care Professionals, Chaplains, Engineers, Intelligence, and Mobility aviators. To compensate for lagging prior service numbers, the Air National Guard increased its emphasis on the non-prior service market. This required increases in advertising to the non-prior service market through radio, theatre, print media and web sites, as well as additional recruiters, community presence with store-front offices and additional advertising dollars. The continued support of the Air Force, Department of Defense, and Congress will undoubtedly shape the foundation of their success.

The quality of Air National Guard recruits has not declined and their retention rate remains strong at 96.9 percent. The Air National Guard saves on average $62,000 in training cost for every qualified member retained or recruited. Our focus in this area allows us to retain critical skills lost from the Active component and save valuable training dollars.

In 2009, through the use of our 14 In-Service Air National Guard recruiters strategically placed at active duty bases, the Air National Guard garnered approximately 896 confirmed accessions of a total of 5,309 accessions. The bonuses and incentive programs are a key component to that success.

Our Air National Guard incentive program is a critical component in our Recruiting and Retention efforts and serves to motivate and support manning requirements in units with skills that are severely or chronically undermanned. It is established to encourage the reenlistment of qualified and experienced personnel. Stable funding for the Air National Guard Recruiting and Retention program is critical to our success.

Airman and Family Readiness Programs

In focusing on our airmen we must also focus on the most important people in their lives—their families. The Air National Guard is a wing-centered organization. Our 92 Wing Family Program Coordinators around the Nation are at the center of our efforts to ensure our airmen and their families receive the support they need.

In past year we were successful in having these coordinator positions upgraded from GS–9 to GS–11. Our coordinators are one-deep positions for us, so most of the effort is done through part-time support.

This is one area where we differ dramatically from our Regular Air Force counterparts. The Air National Guard does not have Airman and Family Readiness Centers as they have on active duty bases. In a culture that does not believe in saying "no," our program coordinators have more and more piled onto their plates, thereby threatening the overall quality of service, if the Air National Guard maintains its pace as an operational force.

Programs like Operation Military Child Care have been very helpful. Also, military and community partners like Military OneSource, Military Family Life Consultants, and Operation Military Kids, just to name a few, are extremely beneficial in meeting the needs of the Guard airmen, especially while deployed. Youth Development Camps like Air Force Teen Aviation, Air Force Space Camp, and the Air Force Reserve/Air National Guard Leadership Summits are huge successes as well. Additionally, this year we are conducting training such as Community Healing and Response Training, which is part of the Yellow Ribbon Reintegration Program, and essential in our suicide prevention efforts.

For the Air National Guard, we believe maintaining strong family support programs are critical to ensuring the overall health of our force and our Guard airmen.

Employer Support for the Guard and Reserve

We must recognize the importance of support for military service by families, military leadership and civilian employers. This is referred to as the "Triad of Support." It is important to maintain an overall climate in which military service is honored and supported. The Department of Defense's organization that addresses civilian employer support is Employer Support for the Guard and Reserve. Their vision is to develop and promote a culture in which all American employers support and value the military service of their employees serving in the Guard and Reserve. Employer Support for the Guard and Reserve accomplishes this by gaining and maintaining employer support for Guard and Reserve service by recognizing outstanding support, increasing awareness of the law, and resolving conflict through mediation. A Statement of Support, a formal statement voluntarily signed by an employer, is one way to demonstrate support and acknowledge employer rights and responsibilities under the Uniformed Services Employment and Reemployment Rights Act. During fiscal year 2009, 54,965 employers signed Statements of Support for their employees serving in the Guard or Reserve. This is an increase from the 44,861 employers that signed Statements of Support in fiscal year 2008. Another indicator of the current employer support climate is the number of Uniformed Services Employment and Reemployment Rights Act cases requiring mediation. The average number of cases mediated has remained consistent over the last 3 fiscal years: 2007 = 2,374, 2008 = 2,664 and 2009 = 2,475. These numbers indicate less than .01-percent of all Selective Reserve members who have opened a case to address employer issues. Based on these two indicators, it appears American employers are continuing to support their employees serving our Nation.

ARMY NATIONAL GUARD

Today, 76,949 of our soldiers are mobilized, deployed, and on point for this Nation. The sacrifice of those soldiers, their families, and employers is something we must acknowledge and appreciate.

The last 8 years have seen the Guard transform to an operational force. The enablers for the Army National Guard—one of the greatest forces for good— have been provided and sustained by congressional initiatives. Thank you for your continued support.

Today we would like to discuss the role of the Army National Guard as an operational force. We plan to describe our personnel challenges, significant accomplishments, and future operational requirements. Since September 11, 2001, the Army National Guard has transformed in several ways. The organization is no longer a strategic reserve; we are now and have been, for several years, an Operational Force.

Budget Requested Increase in Full-time Non-Dual Status Technicians

The President's budget for fiscal year 2011 requests an increase in funding for Army National Guard non-dual status technicians from 1,600 to 2,520—an additional 920 positions. We ask the committee to provide this increase in its mark of the National Defense Authorization Act for 2011.

Non-dual status technicians work primarily in personnel administration, contract management, information technology and similar support functions with the Army National Guard's frequent mobilizations, we find that we need these non-deploying civilian technicians to fill critical positions in our generating force. Filling these positions with dual-status military members who deploy creates a disruption in workflow. Thanks to a special wartime exception, the Army National Guard has been able to hire some additional temporary non-dual status technicians, but these hires are only on a year-to-year basis. Reliance on "temporary" technicians, however, causes instability for the employees themselves and in the work produced. For this reason we are asking for a formal increase in the authorization level of Army National Guard non-dual status technicians in the National Defense Authorization Act for Fiscal Year 2011.

Last year, the conference committee directed the Secretary of Defense to submit to the defense committees an extensive report on the duties of and requirements for National Guard non-dual status technicians. We at National Guard Bureau are completing our input to that Department of Defense report.

Duties Performed by Non-Dual Status Technicians

National Guard non-dual status technicians are employed in positions that do not have an associated deployable position. These positions are typically not inherently military in nature, are lower graded, and are not supervisory except when the supervision is over other non-mobilization positions. More than 88 percent of non-dual status technicians work in the areas of human resources, administrative services,

financial services, and information technology. More than 95 percent are in pay grades of GS–12 and below. Non-dual status technicians serve in positions that provide continuity of services in functional areas that continue to be required especially after large scale mobilizations within the State.

Current Authority for Non-Dual Status Technicians

Under section 10217 of title 10, the Air National Guard and Army National Guard are limited to a total of 1,950 non-dual status technicians across the two organizations. This limit of the current law has been in place unchanged since 1997. The National Defense Authorization Act has been annually prescribing the number of positions for the Army National Guard and Air National Guard at 1,600 and 350 respectively.

As the Army National Guard has transitioned from a strictly strategic reserve to more of a frequently and rotationally mobilized and deployed operational force both at home and abroad, it has become clear that more of the supporting positions at the State level need to transition from being held by deployable military members of the National Guard to being held by nondeployable civilian technicians. The Constitution Reserves to the States the authority of training the militia. Consequently it is necessary to provide the States with the type of staffing needed to achieve the goal of continuing to produce a ready operational force over the long term.

Current and Near-Term Means of Addressing the Technician Shortfall

The Office of Personnel Management has delegated emergency hire authority for temporary non-dual status technicians. Each emergency hire technician is not to exceed a 2-year employment period for that position. This process is consistent with the stipulations of the Extension of Declaration of National Emergency. Using temporary non-dual status technicians helps fill critical requirements left unfilled due to the 1,600 limit for the Army National Guard.

Future Technician Requirements

The National Guard Bureau is in the process of assessing the overall longer-term needs of the force, including both the Army and the Air National Guard, to determine whether legislative changes are needed regarding non-dual status technicians to manage and support the National Guard beyond fiscal year 2011. This effort continues to be actively deliberated through processes inside the Department of Defense and we will communicate any additional requirements or requests to the committee once final determinations are made concerning the long-term appropriate levels of non-dual status technicians in the National Guard.

Full-Time Support and Active Duty Operational Support

Adequate full-time support is essential for Reserve component unit readiness, training, administration, logistics, family assistance and maintenance, and a unit's readiness to deploy.

Since September 11, 2001, the Army, the Army National Guard, and the Army Reserve have maintained a tremendous operational tempo (OPTEMPO). This high OPTEMPO has required an increased level of full-time manning in order to prepare individuals and units for deployment. The Army National Guard and the Army Reserve have been able to meet the operational needs of the Army through the use of Active Duty Operational Support (ADOS) soldiers and other full-time equivalent manning, such as temporarily hired military technicians, to bridge full-time manning shortfalls.

As a result it is clear that a robust authorization for Active Duty Operational Support is critical to the ability of the ARNG to continue its success in meeting Army mission requirements as a fully operational force.

Significant Achievements and Adequate Resources

The intensive use of the Army National Guard over the last 8 years demonstrates the value-added role our citizen soldiers render in the defense and protection of our Nation at home and the support of the Nation's strategic missions abroad. In order to sustain the Army National Guard as an operational force and to provide consequence management response forces adequate resources are required. Our key goals in support of the transition to an operational force are: maintain end strength of at least 358,200; train the force to the desired levels of proficiency in accordance with the Army Force Generation Model (ARFORGEN). Our current manning level enables us to meet ARFORGEN readiness goals and provide the logistics train for maintaining and improving our infrastructure of buildings and equipment. In addition, the Army Equipping Strategy must ensure mission readiness, interoperability, and compatibility across all three Army organizations: Active Army, Army National Guard, and U.S. Army Reserve. As part of our domestic mission requirements, the

Army National Guard must have a minimum of 80 percent of critical dual use equipment on-hand and available at all times.

As stewards of a 373-year militia tradition, we are privileged to uphold the institutions and maintain the infrastructure of our national readiness. Over 1,400 of our readiness centers are 50 years old or older. The Army National Guard requests continued support from the Army to provide necessary improvements, including energy saving initiatives for our readiness centers and other facilities. Another goal is to care for the force by improving soldier medical, dental, and family readiness.

In order to minimize force structure turbulence, we need to retain our current key force structure elements of 8 Divisions, 8 Combat Aviation Brigades (CABs), 28 Brigade Combat Teams (BCTs) and functional brigades while addressing key Homeland Defense and Homeland Security requirements.

The Army National Guard has made significant progress modernizing and converting to an operational force. The Army has transformed from a division-centric force to a more flexible brigade-centric force and is restructuring to create units that are more stand-alone and alike while enhancing full-spectrum capabilities. The Army National Guard BCTs are structured and manned identically to those in the active Army and can be combined with other BCTs or elements of the joint force to facilitate integration, interoperability, and compatibility across all components. The Army National Guard has transformed more than 2,800 operating force units to modular designs.

In fiscal year 2009, 46,220 Army National Guard soldiers were mobilized in support of combat operations (Iraq, Afghanistan, and Kuwait). Overlapping with soldiers deployed in fiscal year 2008, mobilizations reached the highest point since 2005 of more than 65,000 soldiers. An additional 5,500 soldiers were mobilized for other contingency operations in Bosnia, Kosovo, Sinai, and the Horn of Africa and also for domestic operations.

As part of transformation to an operational force, the ARNG rebalanced its force by reducing overall Force Structure Allowance (FSA) to approximately 350,000 authorizations while Congress maintained End Strength at 358,200. The resulting variance between FSA and end strength of ~8,000 provided the ARNG some flexibility to implement an 8,000 soldier trainees, transients, holdees and students account within the authorized end strength of 358,200 starting in fiscal year 2011. The initial program will concentrate on the medically non-deployable within the ARNG.

Recruiting

We achieved our recruiting goals in fiscal year 2009 and we are on track to meet our fiscal year 2010 goal of maintaining our congressionally authorized end strength of 358,200 soldiers (actual strength is 361,904 as of March 31, 2010). We have shifted our focus from increasing the quantity of our assigned strength to improving the quality of our force. We applaud the leadership of Congress, Governors, adjutants general, and our communities for their incredible efforts and achievements in helping us build and maintain the Army National Guard as our Nation's largest community-based defense force. We are extremely proud of the overwhelming response of our patriotic communities and most grateful for congressional support to our citizen soldiers.

Stabilize the Force to Build Readiness

One of the enduring lessons learned from the overseas contingency operations is that we need to stabilize and sustain our forces mentally, physically, and spiritually. This includes having an outstanding full-time support team. Today's full-time personnel are major contributors across the full spectrum of Army National Guard operations. Meeting the needs of the persistent conflict underscores the vital role full-time support personnel have in preparing units for the multitude of missions at home and abroad. The ARNG program consists of both military technicians and Active Guard Reserve soldiers. full-time personnel sustain the day-to-day operations of the entire ARNG. The readiness levels of Army National Guard units are directly tied to the full-time support program. Congress has supported the ARNG full-time support (FTS) through increased authorization over the last several years. Those increases coupled with the soldiers we have put on ADOS have allowed the ARNG to increase its readiness and be able to continue fighting the overseas contingency operations and become an operational force.

To provide the best support and transition assistance for wounded, injured, and ill soldiers, the Army National Guard continued to support the Army's warrior transition units and community-based warrior transition units. The transition units provide non-clinical support, complex case management, and transition assistance for soldiers of all components at medical treatment facilities on Active Army installa-

tions. The community-based warrior transition units provide high-quality health care, administrative processing, and transition assistance for recuperating Reserve component soldiers while allowing them to live at home and perform duties close to their homes and families. At the end of fiscal year 2009, the warrior transition units managed more than 1,500 Army National Guard soldiers and the community-based warrior transition units managed more than 900 ARNG soldiers throughout the United States.

The Army National Guard remains committed to supporting the families of deployed soldiers throughout the deployment cycle. Every soldier needs a support structure and a network of protection that includes self readiness, within a circle of family support, within a band of unit and community brothers and sisters, and within the larger networks of State and national organizations.

Army National Guard families were supported in numerous ways in fiscal year 2009. The National Guard Bureau's Family Program Office provided families with training via computer-based modules, centralized classes, and locally-provided lectures to help make families self-reliant throughout the deployment cycle process. The Army Well-Being Program established the Army Families Online website, an information portal for families of National Guard soldiers. The Department of Defense Military OneSource Program provided benefits which include counseling services, resources for parents, assistance with consumer credit, and online tax return preparation for military families.

The Resiliency Training Center focuses on prevention through proactive marriage workshops and stress-relief training before, during, and after deployments. The main goal of the resiliency program is to create "resilient" servicemembers and families. The mission of the program is to provide a continuum of care, including a comprehensive range of education, training, and the tools necessary to cope with high levels of stress. This includes the skills to identify potential problems and the team effort of developing both individual and group techniques for surviving and prospering in times of great stress.

The Resiliency Training Program rolled out several courses in fiscal year 2009 by collaborating on their course material with Army and Battlemind leaders, leading military personnel and mental health experts, and leading researchers in the stress management field. This included teaming with course developers from the American Association of Emergency Psychiatrists, the Walter Reed Institute for Research, the National Defense University, the Military Family Institute at Kansas State University, and partnering with the Tragedy Assistance Program for Survivors.

The Resiliency Training Center plans to continue to use all available traditional and modern communication tools, including onland and online training, Podcasts, web sites, social networking, professional speakers and trainers, videos, and small group discussions. The Army National Guard has appointed suicide intervention officers to every ARNG company nationwide. Each State and territory has a trained suicide prevention program manager. Also, each State and territory has hired a Director of Psychological Health to provide case management and resourcing support for soldiers in crisis.

Soldier and Family Support

The Army National Guard strives to provide our soldiers and families with a continuum of care with a special emphasis on the Deployment Cycle Support process.

Some of our family readiness efforts include Family Assistance Centers, the Yellow Ribbon Reintegration Program, the Freedom Salute Program, the Strong Bonds Program, and Suicide Prevention training. The Army National Guard operates 369 Family Assistance Centers across all 54 States and Territories. The Family Assistance Centers service all components and are strategically placed in each State and Territory to overcome geographic dispersion.

The National Guard Yellow Ribbon Reintegration program provides information services, referral, and proactive outreach opportunities for soldiers, families, employers, and youth throughout the entire deployment cycle: predeployment, deployment, post-deployment, and return to civilian life. The Yellow Ribbon program benefits servicemembers from all Reserve components.

The Yellow Ribbon Reintegration program is a flexible soldier and family support system that meets the soldier and family readiness needs of geographically dispersed families. The Yellow Ribbon Reintegration program has hosted 40,421 soldiers and 34,513 family members at hometown events so far this fiscal year. In fiscal year 2009, the Yellow Ribbon program supported 54,472 soldiers and 72,316 family members.

Fiscal year 2009 was a very active year for the Freedom Salute Campaign. As one of the largest Army National Guard recognition endeavors in history, the Freedom

Salute Campaign publicly acknowledges Army National Guard soldiers and those who supported them during the President's call to duty.

The Freedom Salute Campaign is an important tool in the recruiting and retention program. The way an organization treats its people is a direct reflection of organizational values. The entire Army community pays attention to how the ARNG treats returning soldiers. The Freedom Salute Campaign increases community awareness throughout the Nation of the good work being done by National Guard soldiers. In a recent survey, soldiers returning from Operation Iraqi Freedom indicated that recognition for their service and sacrifice was one of the most important contributing factors in their decision to continue to serve in the Guard.

The Strong Bonds program is a commander's program that is unit-based and chaplain-led to help soldiers and their families build and rebuild strong relationships, especially when getting ready for or recovering from a deployment.

The Army National Guard recently initiated the Job Connection Education Program (JCEP). This program improves National Guard force stability by advancing member skills at seeking, obtaining, and retaining civilian employment, much like the Army Career and Alumni Program, but at the local level. A key component of this jobs program is its proactive approach to connecting soldiers, and where applicable, potential employers, to new and existing Federal, State and Guard programs and resources, coordinating job expositions and fairs, and conducting seminars, webinars, and workshops. JCEP team members work closely with local employers to ensure they are aware of all the resources available to them in their effort to hire local Guard soldiers. Classroom activities and practical exercises result in improved employment and reemployment rates for laid-off, under-employed, and unemployed Guard soldiers. The JCEP introduces and connects soldiers to the evolving Employment Partnership Office efforts and the emerging formal relationships between Reserve component and private sector businesses with a focus at the local community level. The State of Texas is the pilot test site with the first location in the Dallas area. This program can be used by Army Reserve soldiers as well as National Guard soldiers.

The Army National Guard is also partnering with the Army Reserve in the Employer Partnership Office. The Guard and Reserve soldiers rely on a demographic segment that balances two careers. Service in the Army National Guard and Army Reserve is vocational in nature and represents a motivation to serve in other than an active duty capacity. The Army National Guard and Army Reserve cannot exist without citizen-soldiers, the bulk of whose livelihoods are provided by civilian employers. Under the ARFORGEN concept, all Guard and Reserve servicemembers are virtually assured of at least 1 year-long mobilization over the course of their careers. This affects small businesses much more than larger firms, in addition to the known effects on the soldier and his or her family. We recognize that readiness has three dimensions: unit, family, and employer. The broad aims of this initiative are threefold: (1) to foster employer readiness for mobilization; (2) to make employing and retaining Reserve component servicemembers attractive to employers; and (3) to identify areas where the Reserve component and civilian employers can share costs for benefit programs.

In order to provide assistance to the soldiers to improve their job skills the Army National Guard has started an initiative called—Guard Apprenticeship Program Initiative (GAPI). This initiative involves partnering with the Department of Labor and coordinating with the Department of Veterans Affairs while National Guard soldiers work in their civilian jobs and participate in the program. Apprenticeship is a training opportunity for ARNG soldiers to earn national certification and skills in a specific field while earning wages. In certain cases, eligible ARNG soldiers can receive their VA educational benefits while they pursue an apprenticeship program. Apprenticeship combines classroom studies with on-the-job training supervised by a trade professional or supervisor. Apprenticeship training takes 1 to 5 years to complete or 2,000 documented workhours to become fully qualified in the occupation or trade. Soldiers earn money while they learn on the job. This collaboration is essential to the sustainability of the ARNG and the vitality of the best-trained and dependable professionals our Nation has to offer, which are our volunteer soldiers. This is an opportunity to gain civilian employment and certification, while serving in the ARNG. This program can also be used by the Army Reserve.

We must recognize the importance of support for military service by families, military leadership and civilian employers. This is referred to as the "Triad of Support". It is important to maintain an overall climate in which military service is honored and supported. DOD's organization that addresses civilian employer support is Employer Support the Guard and Reserve (ESGR). ESGR's vision is to develop and promote a culture in which all American employers support and value the military service of their employees serving in the Guard and Reserve. ESGR accomplishes

this by gaining and maintaining employer support for Guard and Reserve service by recognizing outstanding support, increasing awareness of the law, and resolving conflict through mediation. A Statement of Support, a formal statement voluntarily signed by an employer, is one way to demonstrate support and acknowledge employer rights and responsibilities under the Uniformed Services Employment and Reemployment Rights Act (USERRA). During fiscal year 2009, 54,965 employers signed Statements of Support for their employees serving in the Guard or Reserve. This is an increase from the 44,861 employers that signed Statements of Support in fiscal year 2008. Another indicator of the current employer support climate is the number of USERRA cases ESGR has mediated. The average number of cases ESGR mediated has remained consistent over the last 3 fiscal years: fiscal year 2007—2,374, fiscal year 2008—2,664, fiscal year 2009—2,475. These numbers indicate less than .01 percent of all SELRES have opened a case to address employer issues. Based on these two indicators, it appears American employers are continuing to support their employees serving our Nation.

Reserve Retirement

The current Reserve Retirement system was implemented in 1949 to enhance volunteerism, bolster recruiting, enable unit cohesion all while ensuring a ready force available for deployment based on lessons learned in World War I and II. Over these 61 years, the system has undergone few modifications. Congress recently made a critical shift in the retirement program paradigm of an operational reserve when they passed legislation authorizing Reduced Retirement Age Eligibility on 28 January 2008. The Army National Guard will continue to be employed as a major operational element of the Army, and as such, citizen soldier benefits and entitlements should reflect their continued and often extended active duty service.

Medical and Dental Readiness

The Army National Guard has three primary medical readiness goals: deploying a healthy force; deploying the medical force-units; and facilitating warriors in transition and family care-beneficiaries.

In fiscal year 2009, the ARNG Office of the Chief Surgeon received funding for the following programs: medical readiness, $126.5 million; overseas contingency operations, $9.5 million; and dental treatment, $21.2 million. These funds went toward period health assessments, immunizations, contracts in support of medical readiness, and deployment of 41,500 soldiers who met physical, dental, and mental health standards.

Readiness increased from 35 percent fully-ready in fiscal year 2008 to 46 percent in fiscal year 2009. This success resulted from increased targeted funding and a concerted effort by National Guard Bureau (NGB) staff to act as liaisons between NGB and Army medical commands to meet funding, manning, and equipment requirements.

Dental readiness at mobilization stations continued to increase to over 90 percent in fiscal year 2009. Funding of $21.2 million and National Guard Bureau/State coordination were instrumental in providing a drop in dental releases from active duty and soldiers who were dentally disqualified. The First Term Dental Readiness Program moved forward to phase two with the goal of 95 percent in Dental Fitness Category 1 or 2 for soldiers completing advanced individual training. Demobilization Dental Reset was implemented by U.S. Army Dental Command with a goal of 95 percent in Dental Readiness Category 1 or 2 upon release from active duty. To date over 90 percent of ARNG soldiers processed by Dental Command facilities have been reset to a dental condition of Dental Readiness Category 1 or 2.

The Army Selected Reserve Dental Readiness System enables dental treatment of soldiers throughout ARFORGEN. Program objective memorandum (POM) efforts to fund this initiative were successful for fiscal year 2010 through fiscal year 2015, achieving $1.1 billion in critical requirements across the POM years.

ARFORGEN Cycle

Unit stability in the ARNG is a key enabler of the ARFORGEN model to work most effectively. The annual personnel turbulence rate in a typical BCT, prior to a Notice of Sourcing, is 15.6 percent. This includes gains, losses, transfers in, and transfers out.

During the Sourcing period of the ARFORGEN cycle, between 6 and 12 percent of soldiers assigned to units are untrained and cannot be deployed by law. These soldiers are new enlistments who have signed up for service, but who have not yet completed initial entry training. The Army National Guard and Training Doctrine Command (TRADOC) have worked hard to alleviate this problem by increasing the capacity for initial entry training at the key times that ARNG soldiers are available

to attend (for example, during the summer months). The training pipeline has been reduced by more than 10,000 soldiers.

Accelerated initial training

Once a unit receives an Alert Order, additional training seats need to be made available in order to return Duty Military Occupational Skills Qualification (DMOSQ) soldiers that are assigned to that unit. On average, new recruits take 11 months to complete initial entry training. Our Recruit Sustainment Program (RSP) decreases training ship time, as well as pre-training and in-training losses. Since the ARNG initiated RSP, the rolling 12-month average number of soldiers lost during initial entry training has decreased by 3.6 percent resulting in positive control of DMOSQ drop. Training seat availability is directly linked to personnel readiness. Additionally, the Recruit Force Pool (RFP) reduces the period of time in which non-MOSQ soldiers are holding paragraph and line numbers in MTOE units and gives the ARNG the ability to target the available seats.

Upon an Alert Order, units enter the pre-mobilization cycle with personnel shortages due to untrained and medically nondeployable soldiers occupying positions in the operational force, as well as normal attrition. Mobilizing BCTs must cross-level on average 37 percent of their authorized strength in order to meet mobilization requirements. This depletes donor units and creates a cascade of unreadiness across the ARNG. The ARNG is working an initiative to anticipate so as to better manage this cross-leveling and minimize the impact to units preparing for deployment.

INCREASING THE STABILITY OF UNITS PRIOR TO MOBILIZATION

Retention incentives to minimize cross-leveling: The Deployment Extension Stabilization Pay (DESP) program stabilizes ARNG units from the period of sourcing through mobilization. This program has a positive impact on unit readiness by reducing cross-leveling and attrition well in advance of the unit's mobilization date. By fixing end strength at 358,200, each soldier retained by DESP reduces the loss rate and simultaneously reduces the requirement for an accession by one in addition to stabilizing the unit through the next subsequent mobilization. As retention increases, losses and accessions decrease. In other words, the ARNG 'trades losses' between DESP takers and other ETS-eligible soldiers in order to meet programmed losses where end strength is fixed at 358,200.

Access to the ARNG

The Army has determined that it must rely on an operational reserve to meet the demands of the Army in today's environment and will need to continue to rely on an operational reserve to meet expected near-term demands of the Nation. The soldiers in the Army National Guard also want to be part of an Operational Force as well. We know this from the discussions we have had with our soldiers and their leaders; but more indicative are the recruiting and retention rates of Army National Guard soldiers. Everyone of our soldiers have had to make a decision to either enlist, stay or leave the Army National Guard during the current conflict, knowing they will more than likely deploy at least once in their initial period of service. As I have stated earlier, the Army National Guard continues to meet its authorized end strength of 358,200. Our current reenlistment rate is 116 percent of our plan. As long as our soldiers are doing meaningful missions and provided the resources to accomplish those missions, Army National Guard soldiers want to continue to be an operational part of the Nation's defense solution.

The Army National Guard is a fully accessible Reserve component of the U.S. Army. It has met every request for forces to date. The Reserve components provide significant capability to the Department of Defense at a very cost effective rate. A number of authorities exist that permit the executive branch to access the Reserve component. We are working with the Office of the Secretary of Defense and the Army to ensure there is a clear understanding of the authorities and the policies that allow the exercise of those authorities, particularly in light of the current and future operational and funding environment.

The Army with Congressional support has invested a significant amount to bring up the readiness of the Army National Guard. It is important to maintain the capabilities of that investment. The alternative means a larger Active Force at a considerably higher cost. The Army National Guard is better equipped, trained and ready than it has ever been in its history. The 12 month mobilization policy enacted by the Secretary of Defense goes a long way in protecting the Reserve component soldiers and allowing more predictability for mobilizations. This is key to our soldiers.

We need to continue to educate our senior leaders on the capability of the Army National Guard and advise them if we are getting over used; however, the Army National Guard is committed to the ARFORGEN model. In my view, it is able to

provide about 55,000 soldiers every year based on the rotational rate of 1 year mobilized and 5 years at home.

Our Nation was built as a militia nation and the Reserve components are the tie back to the communities we serve. The Army National Guard has provided over 300,000 soldiers to Operations Iraqi Freedom and Enduring Freedom. At the height of the Operation Iraqi Freedom surge when the Army National Guard had over 90,000 mobilized or deployed overseas, more than 50,000 others responded to the support Hurricane Katrina recovery efforts within 11 days. This proves that the militia concept remains strong in the face of 21st century challenges.

CLOSING REMARKS

The men and women of the National Guard greatly appreciate the cooperation and support you have provided in the past and look forward to working with you as we meet today's challenges.

Thank you for the opportunity to be here today. I look forward to your questions.

Senator WEBB. Thank you very much, General Carpenter, and all of you, for your testimony.

I note in the bios that General McKinley and General Wyatt both went to SMU. Is there something in the water down there?

General MCKINLEY. Coincidental, sir. [Laughter.]

General WYATT. Sir, I'm actually a couple of years ahead, but obviously he's a much faster burner than I am.

General MCKINLEY. Yes, thanks. [Laughter.]

Senator WEBB. I also notice that General Carpenter studied Vietnamese language before he deployed to Vietnam in the Navy.

General CARPENTER. Yes, Senator.

Senator WEBB. [Said something in Vietnamese.]

General CARPENTER. Sir, that was 30 years ago. [Laughter.]

Senator WEBB. We appreciate all of your service, and yours as well, Secretary McCarthy.

General McKinley, it's been, I think, 2 years since your position was elevated to a four-star position. You're the first four-star to serve in this position. Would you like to tell this committee how these changes have affected your role, what difference they've made?

General MCKINLEY. Mr. Chairman, I think what I have sensed over the past 14, 15 months in the position is, the position has allowed me to enter discussions and forums that were not previously afforded my predecessor. To be very specific, I'm a member of the Defense Advisory Working Group, which Deputy Secretary Lynn chairs. Going through the Quadrennial Defense Review (QDR), that was a programmatic session where I was able to shape and influence for the 460,000 guardsmen those things which I felt were important for the QDR. I've also been included by the Chairman, Admiral Mullen, in all of the tank discussions. I'm not a voting member, but I'm certainly able to offer my best military advice to the Chairman and to the Secretary, through the Defense Senior Leadership Conferences that Secretary Gates holds to specifically address the needs of the National Guard force. That, coupled with the fact that Secretary McCarthy and I are working extremely closely together, and along with Secretary Stockton, the venues and the numbers of meetings, and the number of forums available to me now has grown exponentially. To take that into context in DOD, that has made a significant improvement in my quality of advice to the senior leaders of the Department.

Senator WEBB. Thank you.

Secretary McCarthy, when I held the position that you have right now, I sat on what was then called the Defense Resources Board. I'm not sure the same board exists. But, do you sit on that board or on an equivalent?

Mr. MCCARTHY. Short answer: No, sir. I don't think the Defense Resources Board exists. If it does, I'm not aware of it. I think that the Defense Advisory Working Group that General McKinley mentioned is perhaps a comparable forum today. I do not routinely sit on that. Quite frankly, I'm working closely with both Under Secretary Stanley, and occasionally with Secretary Gates, to figure out what the right level of my participation is.

Senator WEBB. The Defense Resources Board, at the time that I was in the Pentagon, had input on all budget recommendations of all Services at the level of $60 million or higher during the formation of the budget. It was very important when this position was created that someone overseeing the Guard and Reserve programs had that sort of direct input. Is there any similar forum where you can have direct input today?

Mr. MCCARTHY. No, sir, there is not. Not today.

Senator WEBB. All right. I may have a followup question for you on that.

I'd like to ask General Wyatt and General Carpenter, separately, a couple of questions, just datapoints—the percentage of the Air Guard and the Army Guard that are prior service, and the percentage that are over the age of 40.

General WYATT. Senator, we have about a 60 percent prior-service membership in the Air National Guard. I think that question, and the answer, points out the—one of the benefits of having an operational and robust National Guard. It is that it does allow for the active duty members who want to continue serving their country—it affords them the opportunity to do so when they, perhaps, make that choice not to serve in a full-time capacity.

The second part of your question, sir?

Senator WEBB. The percentage of the Air Guard that is over the age of 40.

General WYATT. I can't get you the exact percentages, but we are an older force, with more experience than the Active component. But, if I could take that for the record, sir, I'll get you the exact percentages.

Senator WEBB. Actually, what I would request is—Secretary McCarthy, if you could get me a breakdown of the Guard and Reserve components, in terms of age.

[The information referred to follows:]

The average age of Reserve component officer servicemembers (all Services) is 40.2 years old (median age is 40.0), while the average enlisted age is 30.8 years old (median 28). The average and median ages for all Reserve component members (all Services) are 32.2 years old (median 30).

Age	ARNG	USAR	USNR	USMCR	ANG	USAFR	USCGR
Approx. Average Age	30.6	32.1	35.1	26	35.1	36.3	34.7
Percent over age 40	23.6	29.5	38.4	0.9	38.0	43.0	34.0

Senator WEBB. When I had your position, it was one out of five was over the age of 40. It impacted a lot of policies, such as over-

40 stress testing and that sort of thing. It's one that you would expect, particularly on the aviation side, to have a higher number of prior service and a higher age level. It's amortizing a very precious asset that you don't have to retrain over and over again. But, I'd like to be able to see the numbers.

General Carpenter, do you have data on those two points?

General CARPENTER. Senator, a couple of specific comments on your questions.

One is, we have seen the average age of the force in the Army National Guard become younger. That's a function of increased deployments and a change in the culture from where we were at before September 11. We were an average of over 30 years old, in terms of our force, and we're now somewhere around 29 years of age, and so we've become younger, and it's a function of the OPTEMPO.

The other datapoint that's probably of note here is the number of prior service. Before September 11, we recruited a lot of prior-service soldiers into our organization, and that was one of our mainstays. Frankly, after September 11, what's happened is that people leave the Army, and they want to leave the entire mobilization piece. They know that the National Guard is a mobilizing and deploying force, and so, we have had to turn more to the non-prior-service market, in terms of where we go to recruit and sustain our end strength.

Senator WEBB. How does that affect your ability to train up a ground soldier?

General CARPENTER. Sir, I think the offset of that is the mobilization and the deployments that we've seen inside the Guard. We have over 60 percent of our soldiers that are combat and deployed veterans inside of our formations. Now, we haven't seen that kind of a statistic since World War II. So, we have not necessarily gotten the experience level that you allude to from the Active component coming into our ranks. We've actually gotten firsthand experience, in terms of the deploying units.

Senator WEBB. All right.

General McKinley, I know that Senator Graham is going to have some questions on this, but I would be interested in your thoughts on the border security and drug interdiction efforts that—the different areas where the Guard can participate in that.

Secretary McCarthy, if you had thoughts on that, I'd like to hear them, as well.

But, General McKinley, specifically with the Guard; and if Secretary McCarthy has something broader.

General MCKINLEY. Mr. Chairman, I'm sure you're well aware of Operation Jump Start, which my predecessor worked with the Department on to put up to 6,000 members of the National Guard on the border. It was originally planned for a 1-year event; it ended up being 2 years.

The express mission assignment was to relieve the stress on the U.S. Customs and Border Protection Agency so that they could hire more agents. From all accounts, that was accomplished.

I have had no personal discussions in the Department on any future mission along the southwest border. That doesn't mean that our Governors along the southwest border have not sent me copies

of letters that they've sent to Secretary Gates. We know that many of the Governors along the southwest border are seeking some support.

We have small footprints of National Guard forces serving today along the border, under the Governors' consent. Those are mainly counterdrug personnel assigned to that mission I referenced in my opening remarks.

We have had preliminary planning sessions to discuss capabilities that we might afford. But, without specific tasking, I would offer my personal opinion that any future mission involving National Guard would be different; the circumstances are different, the complexities along the border have changed dramatically since Operation Jump Start. But, personally, I've not been involved in any discussions. I know that Secretary Napolitano, Secretary Gates, and their staffs, have had some discussions. But, until given official tasking, I think it would be premature for me to speculate on any specific missions that the National Guard can perform, other than to say, the Governors are interested in seeking that support.

Senator WEBB. Thank you.

Secretary McCarthy?

Mr. MCCARTHY. Senator, the most direct responsibility for this is really in the lane of Assistant Secretary Paul Stockton, Homeland Defense. But, he and I work extremely closely together, and one of the things that I believe is—best states current policy is that the requirements on the border, as we see them right now, are law enforcement rather than military. So, I don't believe that there is any plan—and I talked to Secretary Stockton as recently as Monday of this week—I don't think there's any current plan or inclination to change that assessment.

Senator WEBB. I have about 3 minutes before the second vote ends. What I'm going to do is—since Senator Graham isn't back, I'm going to have to interrupt the hearing again. When I come back, I think what we'll do is just get the second panel up, except, Secretary McCarthy, I'd like for you to stay so I can follow up on some of the DOD policy.

Gentlemen, thank you very much for your testimony. We may have some followup written questions. But, we appreciate the data that we requested.

Again, my best to all of the men and women who are serving under your jurisdiction.

I'll be back after the second vote. [Recess.]

Senator GRAHAM [presiding]. Ladies and gentlemen, I want to apologize, but Senator Webb is voting. I just voted. I'm going to have to leave; he'll come back. But, we'll get this done.

So, where were we?

VOICE. The first panel was dismissed. However, Secretary McCarthy was asked to stay.

Senator GRAHAM. Okay.

VOICE. So we're ready for opening statements.

Senator GRAHAM. Let's start with the next panel, starting with the Army and working our way downstream.

STATEMENT OF LTG JACK C. STULTZ, USAR, CHIEF OF ARMY RESERVE; AND COMMANDING GENERAL, U.S. ARMY RESERVE COMMAND

General STULTZ. Yes, sir. In the interest of time, because I know that we are trying to be as concise as possible, we have submitted our written statement, and I would just say that, on behalf of the 208,000 soldiers that are in uniform for the Army Reserve today, first and foremost, thanks for the support that we're getting from Congress, in terms of our compensation, in terms of our medical, in terms of the other benefits, in terms of the ability to be trained and ready when the Nation needs.

We do have, as I mentioned, 208,000 soldiers, which puts us in a situation today of being 3,000 over what our authorized end strength is. That is a reflection of the tremendous success we've had in recruiting, but also the tremendous success we've had in retention. Our retention goals right now are at 124 percent.

Senator GRAHAM. How much do you think that's due to the job situation?

General STULTZ. Sir, I think there is a portion of that that is economically-related. But, I would submit to you, I think a lot of it is due, in fact, that the soldiers we have today in the Army Reserve feel good about what they're doing——

Senator GRAHAM. Great.

General STULTZ.—serving their Nation. All they're asking me is, really, when I get around the world, traveling—and I've been in 11 countries since January, visiting Reserve soldiers that are on duty for this Nation, and they tell me two things. Number one, "Give me some predictability because I do have a civilian job"——

Senator GRAHAM. Right.

General STULTZ.—"I do have a family." Number two, "Don't waste my time. If you're going to use me, use me. If you're going to train me, train me."

Senator GRAHAM. Fair enough.

General STULTZ. Yes, sir.

[The prepared statement of General Stultz follows:]

PREPARED STATEMENT BY LTG JACK STULTZ, USAR

Against the backdrop of the second longest war in our Nation's history and the longest ever fought by an All-Volunteer Force, the Army Reserve continues to be a positive return on investment for America. The fiscal year 2009 $8.2 billion Army Reserve appropriation represented only 4 percent of the total Army budget, yet we supply the Army seven to eight brigade-size elements. Since September 11, 2001, the Army Reserve mobilized 183,144 soldiers, and now has 29,000 deployed in support of Army missions. We supply the Army with 87 percent of its Civil Affairs capability, 65 percent of its Psychological Operations, and 59 percent of its Medical support—to highlight a few of our top contributing specialized functions. Compared to the cost of expanding the full-time force, the small investment in the Army Reserve provides security at home and fights terrorism abroad. We respond to domestic disasters and participate in security cooperation operations while protecting national interests around the globe. In support of contingency operations, we foster stability in underdeveloped nations where conditions are ripe for terrorists to gain a foothold.

The events of September 11, 2001 forever changed the way in which the Army Reserve provides combat support and combat service support to the Army and to the Joint Forces. Operational demands for Army Reserve support have been heavy and enduring. The reality is, current operations are consuming Army Reserve readiness as fast as we can build it, but Congress' support for the Army Reserve in recent years has gone far toward both meeting current demands and reshaping the Army Reserve for future national security requirements.

As sustained operational demands on the Army Reserve became heavier after September 11, it became ever apparent we could no longer function as a part-time strategic reserve. Based on the operational requirements outlined for the Army Reserve in the 2010 Quadrennial Defense Review, and while fighting two wars, we continue our efforts to fully transition from a strategic reserve to an operational force, based on current resourcing and mission requirements. An operational Army Reserve is a good return on investment for America because now we are in a stronger position to provide the Army with predictable, trained, equipped, and ready forces to meet global and contingency requirements. What remains is an ongoing effort to sustain an operational posture, with a fully functioning Army Force Generation model—that receives full funding.

Thanks to Congress' leadership, we have made great progress in a number of initiatives required to complete Army Reserve transformation. We have re-organized operational commands to better support theater requirements, opened new training centers, and restructured training commands to support the total force. Through Base Realignment and Closure (BRAC), we have closed scattered facilities in favor of more efficient, multi-service Reserve centers. Through the Army Reserve Enterprise process, we are restructuring our strategic and operational efforts to maximize productivity, efficiency, and responsiveness in four Enterprise areas: Human Capital, Materiel, Readiness, and Services and Infrastructure.

We have identified "Five Imperatives" to facilitate Army Reserve continued transformation to a stronger and more capable operational force. They are Shaping the Force, Operationalizing the Army Reserve, Building the Army Reserve Enterprise, Executing BRAC, and Sustaining the Force.

SHAPING THE FORCE

As we look ahead, we know that building the right force is crucial for success. In 2010, we will leverage human capital management strategies to better shape the force into a more affordable and effective Army Reserve capable of supporting national security objectives and our combatant commanders' warfighting needs. We are developing a more precise human capital strategy to meet our Nation's future military needs by ensuring the right people, with the right skills, in the right units, are in place at the right time.

In today's competitive recruitment environment, incentives matter because they allow the Army Reserve to sustain and shape the force. We achieved our fiscal year 2009 end strength due to the hard work and dedication of our recruiters and our soldiers. We also attribute this success to the recruiting and retention initiatives that support the Army Reserve's manning strategy. These include the Army Reserve Recruiter assistant Program that promotes strength from within by recognizing and rewarding those soldiers, family members, and Department of the Army civilians working for the Army Reserve who bring talent to the team. The second is enlistment bonuses, which help us recruit the critically short/high demand Military Occupational Specialties. In fiscal year 2009, our focused incentives increased Army Reserve End Strength. As we met the objective, it became evident that not all of our new soldiers possessed the skill sets needed to support the Army Reserve structure while also fulfilling our wartime requirements.

Successful recruiting added an abundance of soldiers in the lowest three pay grades, but recruiting new soldiers as privates and second lieutenants cannot fill the thousands of mid-grade noncommissioned and commissioned officer vacancies that currently exist. Despite excellent retention results, these shortages continue.

U.S. Army Reserve authorizations for Medical Corps, Dental Corps, and the Specialist Corps have not changed much materially for 2000–2009 (2614 vs. 2572), but the inventory has decreased dramatically from 165 percent of authorized end strength in 2000 to the current 89 percent in 2009. This attrition has come predominately at the expense of its senior providers with more than 20 years of clinical experience in a military environment who now represent only 9 percent of Medical Corps inventory, 17 percent of Dental Corps inventory and 11 percent of the current Specialist Corps inventory. In the coming year, we must do more to retain these uniquely qualified medical providers and seek to build a system that incentivizes these most skilled clinicians.

Our recruitment efforts will focus on more prior-service recruits who are slightly older and bring more experience than most first-term soldiers. These experienced soldiers can fill shortages among mid-level commissioned and noncommissioned officers. Targeted incentives have been crucial to rebuilding our end strength and addressing critical shortages in some grades and job specialties. Continuing these incentives allows the Army Reserve to shape the force to better meet the requirements

of our National security strategy and to give soldiers, families, and employers stability and predictability.

Ensuring a Continuum of Service (COS) is a human capital objective that seeks to inspire soldiers to a lifetime of service. Active (full-time) and Reserve (part-time) military service are two elements of valuable service to the Nation. Continuum of Service provides Active and Reserve components some of the means necessary to offer soldiers career options while maintaining capability for the Operational Force. COS also recognizes the tremendous cost of accessing and training each servicemember and seeks to avoid unnecessary replication of those costs. To reach our objective, it is our intention to work with Army to propose recommended changes t current statutes and policies that will ease restrictions on statutes limiting Reserve component soldiers from serving on active duty.

OPERATIONALIZING THE ARMY RESERVE

Our status as an Operational Force means that the Army Reserve is no longer a force in waiting—we are an Operational Force in being. We can continue providing that positive return on investment to the Nation when the Army Reserve is given the proper resources to succeed.

The Army Reserve plays a vital operational role in overseas contingency operations and will for the foreseeable future. Since September 11, 185,660 Army Reserve soldiers have mobilized in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF); 33,754 have mobilized more than once. In 2009, the Army Reserve mobilized 39,150 soldiers to support combatant commanders' requests for forces. We execute a readiness strategy to deploy highly ready units and soldiers to support OIF and OEF requirements. This readiness strategy synchronizes those strategic planning and resourcing actions necessary to generate sufficient manning, training, and equipping levels to meet combatant commander mission requirements. The Army Force Generation process allows for a structured progression of increased unit readiness over time, and provides the Army recurring access to Army Reserve trained, ready, and cohesive units, which translates to predictability for soldiers, their families, and employers. In effect, ARFORGEN drives the battle rhythm of the Army Reserve.

ARFORGEN works for the Army Reserve. It has enduring qualities that have been apparent in providing support to emergencies such as Hurricane Katrina and the Haiti earthquake relief efforts, for training soldiers in Afghanistan, to supporting the African Contingency Operations Training and Assistance Program with training and equipment for selected militaries engaged in humanitarian or peace operations. The Army Reserve seeks continued support from Congress to be an effective responder to missions such as these.

Within the transformation process, we realigned our force structure to meet the Army's global mission requirements in both the Operational and Generating Force categories. The Army Reserve is ready to take on additional missions as the Department of Defense and U.S. Army validate emerging requirements. Authorized growth in end strength will enable the Army Reserve to activate validated units to meet these emerging requirements and maintain the number of units we have in our ARFORGEN process. Plans reflect an increase of 1,000 to 205,000 spaces of Authorized End Strength (ESA) to provide the Army Reserve capability to meet emerging mission requirements within our ability to operate the force.

Full-time support personnel comprise a select group of people who organize, administer, instruct, recruit, and train our people; and who maintain supplies, equipment, and aircraft. They also perform other functions required on a daily basis to maintain readiness in support of operational missions. Without these critical soldiers and civilians, the Army Reserve could not function as an Operational Force.

Although resourced to the Department of the Army "High Risk" funding methodology (meets minimal acceptable risk in support of a strategic reserve force), it is imperative that future planning ensure full-time support is fully resourced as an operational reserve. Adequate resourcing is critical in meeting the readiness requirements of the Army Force Generation (ARFORGEN) model.

The current full-time support model remains a strategic reserve legacy. Key legislative and policy modifications are required to change personnel support processes. Manpower models and programming processes require review and modifications to provide flexibility and rapid response adjusting resources amid changing priorities across the ARFORGEN process.

Our Active Guard Reserve (AGR) and Military Technician (MT) programs provide the bulk of full-time support at the unit level. They provide the day-to-day operational support needed to ensure Army Reserve units are trained and ready to mobilize within the ARFORGEN process. The AGR and MT programs are vital to the

successful transition to—and sustainment of—an operational reserve. The Army Reserve requires added flexibility in its hiring practices to sustain its commitments to ARFORGEN. We must take action to create a new category of Non-Dual Status Technician, which allows retention and direct hire of personnel from outside the Selected Reserve. This new capability will allow us to support non-mobilizing/deploying organizations while authorizing Dual Status Military Technicians to meet conditions of employment with a military assignment anywhere within the Selected Reserve. We are working with Army to relax legacy full-time support policies in order to provide flexibility in the reallocation of resources within AFORGEN cycle.

As an Operational Force, the Army Reserve must have the most effective and sustainable equipment for soldiers and units at the right place and at the right time. The Army Reserve supports the Army Equipping Strategy of Cyclical Readiness, which means all units are equipped based on their position in the ARFORGEN process and their mission—regardless of component. The Equipment Readiness levels increase as units move through the ARFORGEN process from the RESET to the Available Phase. Those units that are within the RESET phase will have a chance to reintegrate soldiers and families, then organize, man, equip, and train as a unit. As the units move to the Train/Ready phase, they will be resourced from 80 percent growing to 90 percent; and once the units enter the Available Phase, they are resourced to ensure 90 percent plus equipment readiness. To maximize collective and individual training opportunities for our units in the ARFORGEN process on high demand/low density systems, the Army Reserve must address the challenge with small pools of current generation systems. Additionally, while the Army Reserve units in the Reset Phase should have minimal specific equipping expectations; the Army Reserve is identifying equipment requirements that a unit can properly maintain at a Reserve Unit Home Station while sustaining soldiers and training readiness. We are thankful to Congress for helping us meet this goal with National Guard and Reserve Equipment Appropriation (NGREA) funding. These funds greatly add toward operationalizing the Army Reserve by supporting Army Modularity, Homeland Defense/Homeland Security, and the Army Force Generation cycle with a fully modern and interoperable force. With continued NGREA funding, we will be able to train our soldiers on the latest combat equipment before they deploy into harm's way.

SUSTAINING THE FORCE

The Warrior-Citizens of the Army Reserve and their families embody a lasting commitment to serve America. The Army Reserve recognizes the strain of this era of persistent conflict on soldiers and families. We know family readiness is inextricably linked to mission readiness, recruitment, and retention. Operationalizing of the Army Reserve creates a requirement for an enduring level of support. As the Army Reserve transforms, so must family programs. Our way ahead includes realignment actions to: support the Army Reserve Enterprise management approach, sustain services to soldiers and families in the expeditionary force, standardize existing programs and services across the Army Reserve, and build partnerships with Army families and communities. Our end state is to optimize programs and services to connect soldiers and families to the right service at the right time.

The cornerstone of our planning effort is to ensure the integration of Family Support services with the ARFORGEN process. By doing so, we ensure that our Warrior-Citizens and their families have solid programs that are ready for execution any time during the training and deployment cycle. Appropriate resourcing will allow us to assess structure requirements, staffing needs, and develop effective processes that ensure the consistent delivery of programs and services that meet the needs of ARFORGEN and especially for those of our geographically dispersed customers.

The Army Reserve Family Programs Virtual Installation Program is an exciting new initiative that ensures the same services provided to Active component soldiers are available to all servicemembers and their families not living close to a military installation. Leveraging assets we have on hand is allowing us to test the program through a series of pilots located in selected communities. Funding for this priority will allow us to expand Virtual Installation within Army Strong Community Centers around the country and overseas.

We must continue to increase the quantity and quality of support for Army Reserve children and youth. We can increase opportunities for youth to develop leadership skills and strategies for coping with separation. Teen panels provide forums for our youth to propose solutions for concerns that affect their lives during mobilization and deployment. Additional online teen deployment classes support youth living in the "new normal" of repetitive deployments. With additional resources, we will

work with our community partners to expand childcare for geographically dispersed families and respite care for mobilized families.

This year we provided new opportunities for children of Army Reserve families to attend camps. While the Department of Defense (DOD) "Purple Camps" were a great initiative, they distributed opportunities among all military communities in DOD. This resulted in fewer opportunities for Army Reserve children than needed. Additionally, Army Reserve children are usually unable to travel, and require activities located in areas near their homes. By operating our own camps, we increased these opportunities to Army Reserve families in their communities and tailored them to our communities. The goal of the program is to prepare Army Reserve soldiers and their family members for mobilization, sustain families during deployment, and reintegrate soldiers with their families, communities, and employers upon release from active duty. The Army Reserve Yellow Ribbon Reintegration Program (YRRP) provides information, services and support, referral, and proactive outreach to Army Reserve soldiers and their families through all phases of the deployment cycle. The program includes information on current benefits and resources available to help overcome the challenges encountered with Army Reserve mobilization and reintegration.

The Army Reserve successfully launched its Yellow Ribbon Reintegration Program. We have coordinated with other military agencies, Federal/State/local government agencies, community organizations, and faith-based organizations to provide robust, preventive, proactive programs for soldiers and their families. Elements of the program include promoting preparedness through education, conducting effective family outreach, leveraging available resources, and supporting the All-Volunteer Force. During fiscal year 2009, the Army Reserve executed more than 250 Yellow Ribbon events, serving some 12,000 redeploying soldiers and 12,000 family members. In interviews conducted by the Office of the Secretary of Defense, soldiers and family members reported positive experiences with the Army Reserve Yellow Ribbon Reintegration Program.

The challenge to the Army Reserve remains to develop, improve, and sustain the mental, spiritual, and emotional health that fosters resilient soldiers and families.

We are moving out aggressively to mitigate the effects of persistent conflict and build a strong, resilient force. Multi-symptom conditions including those signature wounds not visibly apparent (for example: Post-Traumatic Stress Disorder and Traumatic Brain Injury, exist for soldiers with military service in Southwest Asia. We will work with Health Affairs and the other Services to continue to provide the care necessary for the wounds from the current conflicts.

We appreciate the resources that Congress has provided to date to further programs such as the new GI Bill and TRICARE. The benefit of TRICARE Reserve Select provides our soldiers and families peace of mind knowing that if a soldier decides to better him/herself career-wise with the skills gained while deployed, medical care will not be a worry if he or she decides to change careers.

We are teaming with civilian industry to shape the Army Reserve into America's premier reservoir of shared military-civilian skills and capabilities through our Employer Partnerships programs. Through these mutually beneficial alliances with businesses that share our valuable human capital, we can strengthen soldier-employees, families, employers, and communities.

We seek to identify locations where our soldiers can simultaneously add value to both the civilian workforce and the Army Reserve. This effort ties into our objective of achieving a continuum of service for soldiers who want the option to transition from Active and Reserve components, and vice versa, to provide soldiers flexibility with their career objectives, while allowing the Army Reserve to retain the best talent and critical skills capability.

ENTERPRISE TRANSFORMATION

Using an enterprise approach to managing our internal processes, we add value to the Army by applying a holistic approach to managing our resources and shape the force into what is beneficial for the Army Reserve and supports the needs of the Army. By "shape the force," I mean taking a fresh approach to how we recruit and retain the best and brightest, and positioning them in the right place, in the right job, and at the right time.

The Army Reserve Enterprise consists of four core management areas: Human Capital, Readiness, Materiel, and Services & Infrastructure. To optimize the enterprise we must: Attract and retain the very best Warrior Citizens to serve our Nation (Human Capital), Prepare, train, and equip soldiers (Readiness); provide our soldiers with the latest mission ready modular force equipment, (Materiel); provide for the well-being of our soldiers, families, Army civilians, and employers while pro-

viding training and unit facilities and secure, redundant communications (Services and Infrastructure). Working together, these core management areas enable the Army Reserve enterprise to realize its ultimate goal: predictable, trained, and ready units—the essential components that define Capability.

BASE REALIGNMENT AND CLOSURE

We have facility responsibilities at more than 1,100 Reserve Centers and the installations of Fort McCoy, Fort Buchanan, and Fort Hunter-Liggett installations. We also are responsible for significant training areas at Jolliet, Devens Reserve Forces Training Area, and Parks Reserve Forces Training Area. Moving toward completion of the current BRAC cycle of 2005, the Army Reserve military construction priority is to complete the remaining projects budgeted at $357 million for fiscal year 2010. In addition to BRAC, we will implement 26 construction projects at a cost of $318 million supporting the transformation of the Army Reserve from a strategic reserve to an Operational Force. Our construction effort supports the realignment of the field command organizations into Operational Supporting Commands. In fiscal year 2011, the Regional Support Commands will invest $577 million in base operations and $344 million in maintenance and repair of facilities that allows mission accomplishment for the Operational Commands.

We are committed to minimizing turbulence to soldiers and their families while providing the most effective and efficient trained and ready units and forces to meet world-wide requirements. We must maintain current levels of predictability while making plans to increase it. The Army Force Generation process allows for a structured progression of increased unit readiness over time, and provides the Army recurring access to Army Reserve trained, ready, and cohesive units. While our commitment in Iraq may draw down, the requirement for forces to commit to other global missions will only increase. In 2010, we will work with Congress to ensure we obtain the necessary resources to sustain a viable Army Force Generation cycle that supports global commitments and new missions.

Thank you.

Senator GRAHAM. Admiral Debbink.

STATEMENT OF VADM DIRK J. DEBBINK, USN, CHIEF OF NAVY RESERVE; AND COMMANDER, NAVY RESERVE FORCE

Admiral DEBBINK. Senator Graham, thank you for the opportunity to appear before you this morning.

I definitely want to start out by expressing my appreciation for the support of this Congress for the 65,671 members of the Navy Reserve sailors and their families.

Of course, my written testimony will go into great length describing the programs that we utilize to ensure the Navy Reserve is a ready and capable force, responsive to the needs of the Navy/Marine Corps team and joint forces for both strategic depth and operational capabilities, while providing the necessary support to our sailors and their families, and also showing our appreciation for our sailors' employers' support.

As the Chief of Naval Operations, Admiral Gary Roughead, has said: "We are one Navy with an Active component and a Reserve component." As I testify this morning, Navy Reserve sailors are operating in every corner of the world, shoulder to shoulder with Active Duty sailors, as well as airmen, coastguardsmen, marines, soldiers, and, I think, importantly, interagency personnel.

On any given day, more than 30 percent of your Navy Reserve is providing support to DOD operations. The Navy Reserve is ready now, anytime, anywhere, as our motto and our sailors proudly claim.

[The prepared statement of Admiral Debbink follows:]

PREPARED STATEMENT BY VADM DIRK J. DEBBINK, USN

I. INTRODUCTION

Chairman Webb, Senator Graham, and distinguished members of the Personnel Subcommittee, thank you for the opportunity to speak with you today about the capabilities, capacity, and readiness of the dedicated men and women who serve in our Navy's Reserve component (RC). I offer my heartfelt thanks for all of the support you have provided these great sailors.

I have now had the honor of serving as the Chief of Navy Reserve for 22 months. In that capacity, I am privileged to work for more than 65,671 sailors in our Navy's RC, an elite fighting force which recently celebrated its 95th birthday. I am continuously amazed and humbled by the daily sacrifices our Reserve sailors are making for our Nation and our Navy. Witnessing such great deeds helps me to focus on the services that I can provide to each of them: to ensure they are given real and meaningful work every day they are on duty; to ensure that they receive every practical material and organizational advantage to support them in their work; and to provide their families and employers with the proper support to honor and ease their sacrifices.

Our Navy needs, and our sailors deserve, the best Navy Reserve possible, and today's Navy Reserve is as strong and as relevant as it has ever been. Our success is a direct result of the dedication and professionalism of our sailors, which is a reflection of the tremendous support those sailors receive from their families and civilian employers.

Last year, the Navy Reserve adopted an official Force Motto: "Ready Now. Anytime, Anywhere." This motto is our pledge to our shipmates, our Navy, and our Nation and serves as the guiding principle of the Navy Reserve Strategic Plan. In that Plan, the mission of the Navy Reserve is defined: "to provide strategic depth and deliver operational capabilities to our Navy and Marine Corps team, and joint forces, from peace to war." As Chief of Navy Reserve, I can report without reservation that our Navy Reserve sailors accomplish this mission every day.

The Navy Total Force is aligned with and supports the six core capabilities articulated in the Maritime Strategy and is managed by Navy leadership to enable the Chief of Naval Operation's priorities: (1) build tomorrow's Navy; (2) remain ready to fight today; and (3) develop and support our sailors, Navy civilians, and their families. The Navy Reserve is integral to the Navy Total Force—we stand shoulder-to-shoulder with our Active Duty component executing full spectrum operations that represent every facet of our Navy's Global Maritime Strategy. Within this Total Force framework, I would like to take this opportunity to update you on the programs that support the Chief of Naval Operations' focus areas, while also highlighting some key contributions from Navy reservists in 2009.

II. CARE FOR OUR WARRIOR FORCE

This country owes a great debt to the men and women who have gone in harm's way in support of contingency operations around the globe and it is our obligation to provide them not just with every opportunity to succeed while deployed, but also with the means to reintegrate once they return from overseas.

Secretary of Defense Robert Gates has stated, "apart from the wars in Afghanistan and Iraq, my highest priority as Secretary of Defense is improving the outpatient care and transition experience for troops that have been wounded in combat." The Navy Reserve takes this commitment to heart and is setting a higher standard every day for the care and well-being of our Wounded Warriors. In 2009, we completed implementing programs recommended in the Naval Inspector General's Navy Reserve Wounded Warrior Care report, highlighted by the functional stand-up of the Reserve Policy and Integration organization (M–10) within the Bureau of Medicine and Surgery (BUMED). This organization provides BUMED with a Reserve perspective related to medical policies and issues impacting the Total Force. We continue to provide exceptional service to sailors assigned to the Navy's Medical Hold (MEDHOLD) units. These units provide necessary medical and non-medical case management to the Navy's RC Wounded, Ill, and Injured (WII) population. For those sailors and Coast Guardsmen who are seriously wounded, ill, or injured, the Navy Safe Harbor program is the Navy's lead organization for coordinating non-medical care for the warrior and their family members. Through proactive leadership, MEDHOLD helps RC WII members return to service and their communities, and Safe Harbor provides individually tailored assistance designed to optimize the successful recovery, rehabilitation, and reintegration of our shipmates.

Superior care is not reserved for injured sailors alone. Medical research indicates that health concerns, particularly those involving psychological health, are fre-

quently identified during the months leading up to and following return from an operational deployment. Current Navy programs, such as Operational Stress Control Training, the Psychological Health Outreach Program, and BUMED's Wounded, Ill, and Injured Warrior Support, are designed to align with critical stages of the deployment cycle.

An integral component of Force Health Protection calls for ensuring all servicemembers are fit to deploy, and Navy has improved the screening procedures for mobilizing sailors to ensure they are medically able to meet theater requirements. For example, the Medical Readiness Reporting System (MRRS) has improved tracking of each sailor's suitability for Area of Responsibility-specific expeditionary assignments. In addition, annual Physical Health Assessments (PHA), coupled with the new, standardized consolidated pre-deployment screening and local line support will streamline screening requirements while maintaining fidelity on issues which impact medical readiness. Early screening and associated fitness determinations help alleviate unnecessary stress on our sailors and provides supported commands with a steady stream of well-prepared and able workforce. We are also actively engaged in implementing the new legislation that makes reservists eligible for Tricare coverage up to 180 days before a mobilization event. We are thankful to Congress for their work in providing this benefit to our mobilizing servicemembers.

Sailors returning from overseas mobilizations are encouraged to attend a Returning Warrior Workshop (RWW), which is the Navy's "signature event" within the Department of Defense (DOD) Yellow Ribbon Reintegration Program (YRRP). In the 8 years since September 11, the overwhelming majority of Reserve sailors mobilized to active duty have deployed as Individual Augmentees (IAs). Deployed apart from their parent unit and often assigned duties which differ greatly from their primary specialty, these combat zone deployments can be uniquely stressful. The RWW is a dedicated weekend for sailors to reconnect with spouses, significant others, and each other following an IA deployment. Staged at a high-quality location at no cost to the participants, the RWW employs trained facilitators to lead Warriors and their families/ guests through a series of presentations and tailored break-out group discussions that address post-combat stress and the challenges of transitioning back to civilian life. Additionally, my goal is to have a Navy Flag Officer in attendance at every RWW to make a visible statement of Department of the Navy support for this valuable program. A total of 47 RWWs have been held as of 1 May 2010, attended by 3,376 military personnel and 2,617 guests/family members. The fiscal year 2011 budget supports up to another 25 events. Pioneered by the Navy Reserve, these workshops are now available for all Navy IAs. RWWs are a true success story in honoring our sailors and their families. It is one of my top priorities to ensure this program continues to have both the full support of Navy leadership and the widest possible participation by all returning sailors.

RWWs serve as a key component of the Navy Reserve Psychological Health Outreach Program. Outreach teams assigned to each Navy Region Reserve Component Command facilitate the RWWs and engage in other critical aspects of the Deployment Health Assessment (DHA) process. DHAs are regularly scheduled encounters used to screen servicemembers prior to and after deployment and to facilitate appropriate psychological care. The DHA process supports the DOD health protection strategy to deploy healthy, fit, and medically-ready forces; to minimize illnesses and injuries during deployments; and to evaluate and treat physical, psychological, and deployment-related health concerns. The process is designed to identify stress injuries and other health concerns requiring further assessment or treatment as appropriate. The Navy Reserve now has dedicated mental health professionals and associated assets available to provide psychological health services for the Navy and Marine Corps Reserve communities. Providing psychological health assessment services for deploying reservists will assist in identifying potential stress disorders and facilitate early intervention before these disorders accelerate to a more critical "injured or ill" stage, keeping Navy and Marine Corps reservists psychologically healthy for continued retention in the Reserves and for future overseas and CONUS mobilizations. Also recently established as part of the YRRP, the Pre-Deployment Family Readiness Conference (PDFRC) utilizes Psychological Health outreach teams to provide education and information to ensure that sailors and their families are ready for the rigors of deployment and the challenges of family separation.

Additionally, Navy's formalization and emphasis of the Operational Stress Control (OSC) Program is working to de-stigmatize psychological health issues, which can improve sailors' participation in valuable psychological health programs for those in need. The Navy Reserve team is a charter member of the OSC Governance Board. The Psychological Health Outreach teams provide the OSC Awareness brief during periodic visits to Navy Operational Support Centers (NOSCs) across the country. As of 1 April 2010, the psychological health outreach team members have made 225

visits to NOSCs, providing the Operational Stress Control Awareness brief to over 23,400 reservists and staff personnel.

Finally, and although not solely related to mobilized sailors, the Navy Reserve has aligned closely with the Chief of Naval Personnel on programs that detect and help individuals who are at risk of suicide. Families, often the first people to notice a desperate change in a sailor, are included in programs such as the PDFRC and the RWW. A Suicide Event Report (SER) is completed on all actual or attempted suicides, regardless of duty status, which has provided a more complete picture of the problems afflicting all Navy sailors. In every instance where the chain of command knows of a Navy reservist who has attempted suicide, either in a duty or non-duty status, the reservist is referred to the Navy Reserve Psychological Health Coordinators for follow-up and referral to the appropriate mental health care services. The aforementioned OSC Awareness briefs provided by the Psychological Health Outreach teams also include Suicide Prevention briefs.

III. PROGRESS IN PROGRAMS FOR OUR PEOPLE

The Navy Reserve Strategic Plan defines the vision for the Navy Reserve as follows: "Our vision for the Navy Reserve is to be a provider of choice for essential naval warfighting capabilities and expertise, strategically aligned with mission requirements and valued for our readiness, innovation, and agility to respond to any situation." During the last 8 years, the Navy Reserve has demonstrated the ability to continue sustained and valuable contributions to the Total Force, in the full spectrum of missions, at home and abroad, and as both an operational and strategic force. We continue to forge ahead with ideas and programs that will allow us to continuously contribute to the strategic aims of the Navy and the Joint Force.

As defined in the Strategic Plan, one of the three Focus Areas for the Navy Reserve is to enable the Continuum of Service (CoS). CoS reflects the reality of our Navy. As our Chief of Naval Operations, Admiral Gary Roughhead, states, "we are one force today. One Navy, with an Active component and a Reserve component." CoS initiatives provide for seamless movement between the Active component (AC), RC, and civilian service, while delivering operational flexibility and strategic depth at the best value for the Navy. Responding to the CoS philosophy, we recruit sailors once and retain them for life through variable and flexible service options that provide a career continuum of meaningful and valued work.

Not long ago, we spoke of creating active duty "on ramps" and "off ramps." Today, a better analogy is that we're all on the same career highway, and during our career we may wish to change lanes several times, moving from Active to Reserve and back. Our commitment to our sailors is to make these lane changes easier and faster.

CoS is forcing us to think differently and make big changes in the way we do business. Changing our culture might be the hardest part. Too often we think the only way to have a Navy career is by serving on active duty alone. Our Navy Reserve gives Navy sailors many other possible ways to have a full Navy career

There were many important accomplishments associated with our CoS efforts in fiscal year 2009. Beginning last year, the Career Management System-Interactive Detailing (CMS/ID) allowed our AC career counselors to assist sailors transitioning from active duty to consider Reserve units in the location where they planned to live. This is a good example of how an effective career development program can be a fantastic opportunity for Sailors to Stay Navy for Life. Additionally, sailors in selected ratings and designators are informed about their eligibility for bonuses of up to $20,000 for affiliating with the Navy Reserve in the specialties we need most.

Our Perform to Serve (PTS) program has given AC sailors avenues for continued service in the AC Navy, primarily through transitions from overmanned rates into undermanned rates. Last fall, Navy expanded this program to allow AC sailors the option to affiliate with the RC in their current rate to continue their Navy career. Integrating Reserve opportunities early into the sailor's transition process demonstrates the AC's commitment to CoS initiatives.

One of the most exciting developments supporting CoS is the new Career Transition Office (CTO) within Navy Personnel Command. The goal of the CTO is to counsel sailors before they leave active duty and through the transition process in order to help them to take full advantage of the opportunities in the Navy Reserve. By engaging our fully qualified, world-wide assignable personnel before they leave active duty, we can turn a personnel loss into a retention transaction without the need to involve a Navy recruiter. We started with officers transitioning from AC to RC, and immediately reaped success by nearly doubling Navy Veteran officer affiliation rates from 28 percent to 55 percent. We have recently expanded the program to include enlisted sailors who elected the Selected Reserve (SELRES) option in PTS. In

the future, the CTO will handle all officer and enlisted transitions from AC-to-RC and RC-to-AC, except mobilizations.

Expanding our CoS efforts is one of my top priorities for fiscal year 2010. In the upcoming year, we will further our participation in the World Class Modeling initiative sponsored by the Chief of Naval Personnel to anticipate Navy warfighting needs, identify associated personnel capabilities, and recruit, develop, manage, and deploy those capabilities in an agile, cost-effective manner. Additionally, we will place Reserve information in the Navy Retention Monitoring System to provide enhanced reporting and analysis capabilities for retention metrics.

With regard to educating a ready and accessible force, we thank Congress for its support of the Post-September 11 GI Bill. The opportunity to transfer post-secondary education funds to a spouse or child is a significant benefit for our sailors and their families. Since implementation on 1 August 2009, over 3,899 Reserve members have been approved for transferability. We will continue to assess the impact of transferability on enlisted and officer retention.

Another focus area for the Navy Reserve is to deliver a ready and accessible force. Reserve support for contingency operations in the Central Command Area of Responsibility (AOR) is one of the most critical elements in the success our forces have experienced throughout Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In fiscal year 2009, Navy Mobilization Processing Sites (NMPS) processed more than 7,400 sailors for long-term active duty service. Of those sailors, over 6,100 were mobilized to support Operation Iraqi Freedom and Operation Enduring Freedom in combat, combat support, and combat service support missions; the remaining 1,300 were on Active Duty for special work orders providing valued support throughout the Fleet.

In fiscal year 2010, Navy will continue to improve advance notification of personnel for upcoming mobilizations, with a goal of consistently providing at least 180 days prior notification for all recurrent and rotational mobilization assignments. Further, the Navy Reserve will continue to leverage the already robust Total Force Command IA Coordinator (CIAC) program at all NOSCs in order to optimize the frequency, quality, and depth of communications with mobilized reservists and their families throughout the deployment cycle. The CIAC program, complemented by the extraordinary efforts of our command and unit leadership teams, is significantly increasing quality of life for our deployed warriors and their families. Also, full-time, long-term support of Navy and Joint Flag Officer requirements by reservists will help expand the expertise and knowledge of the Navy, and I thank you for the increased ability for Reserve participation in those assignments due to the legislation passed as part of last year's National Defense Authorization Act (NDAA).

The Navy Reserve executed the Navy Reserve Personnel (RPN) and Operations and Maintenance (OMNR) accounts, valued at $3.2 billion, at 99.9 percent in fiscal year 2009. The force executed nearly $150 million in discretionary Reserve Personnel funding in support of missions world-wide, including $98 million in Active Duty for Training (ADT) funding—a 32 percent increase over fiscal year 2008—contributing 311,345 man-days of on-demand expertise to our Navy and Marine Corps team and Joint Forces. This operational support is a critical enabler to the Navy as Navy reservists provide full-time excellence through part-time and full-time service. In fiscal year 2011, the budget requests $1.94 billion in baseline RPN, to include $190 million in discretionary RPN, and $1.37 billion in baseline OMNR appropriations.

In addition to personnel support, Navy Reserve units and hardware contribute to Navy's warfighting effort across multiple mediums, in missions ranging from combat operations or combat support operations, to logistics support around the globe, to training and readiness facilitation for soon-to-be-deploying units. The wide spectrum of missions that can be completed with Reserve units is in keeping with the third of our focus areas: Provide Valued Capabilities. Even when a Reserve unit itself is not mobilizing, our focus is centered on guaranteeing that sailors are ready to provide necessary capabilities to the supported combatant commander.

In fiscal year 2010, it is one of my top priorities to ensure the use of long-term budgeting processes to ensure sufficient Operational Support funding to meet Navy and Joint Force requirements. Demand for the services of our talented sailors has never been greater, and we must solidify our access to the ADT dollars used to fund this on-demand expertise. Navy Reserve sailors can be incredibly cost-effective, but there is a cost, and that cost must be incorporated in any long-term plan. This means planning and budgeting for the Navy Reserve to do the part-time work of the Navy.

Some of the Navy's work is ideally suited for the RC. For example, billets that require specialized skill sets on a periodic and predictable basis are the billets where the Navy Reserve can deliver great value on an ongoing basis while at the

same time providing critical strategic depth in case of emergency. By working closely with the Navy to identify and quantify the work for the Navy Reserve, we can ensure the Fleet receives the support it requires and our sailors will have real and meaningful work, delivering full-time excellence through part-time and full-time service.

The Office of the Secretary of Defense (OSD) designated the Navy Reserve as the lead agency for managing the RC Foreign Language/Culture Pilot Program. This exciting new program encourages our Reserve sailors to take classes at institutions of higher learning to expand their awareness of critical foreign language and cultures. Incentivizing our sailors' natural desire to learn will foster understanding across cultural lines which will shape our force for the better. Bonuses are awarded based on performance which can add up to $5,000 for strategic languages and cultural areas studied which are in high demand within DOD.

The Navy continues to strive for "Top 50 Employer" recognition and the Navy Reserve is in lock-step with those efforts. Top 50 organizations encourage innovation and focus on performance while taking care of their people through programs and policies that support a culture of trust, respect, communication, and collaboration. Maintaining a work environment that is conducive to quality work and leads to equal treatment of all personnel is paramount to the success of any organization. Sexual assault is a detractor from a healthy work environment, and it will not be tolerated in the Navy. The Navy Reserve participates in the Navy's Sexual Assault Prevention and Response (SAPR) Cross Functional Team to ensure compliance with the Navy's Total Force SAPR program instructions, policies, and procedures. Navy leadership continually communicates a "Not in my Navy" stance towards Sexual Assault through the ranks.

The policies focused on enhancing the quality of life in the Navy have paid dividends for the Force. fiscal year 2009 marked the second consecutive year Navy attained enlisted and officer recruiting goals in both Active and Reserve components. In the Reserve, enlisted recruiting was at 100.6 percent of goal; officer recruiting finished at 107.7 percent of goal. Not only did Navy find the quantity of recruits necessary to meet requirements, but the measured educational achievement of our recruits was at the highest level in years. SELRES retention numbers were equally strong, with attrition rates approximately 20 percent improved from fiscal year 2008 totals. There is still room for improvement in SELRES Officer strength, and numerous initiatives are underway to get SELRES Officer communities "healthy" by 2014, including targeted Officer affiliation and future retention bonuses, the increase of accession goals, refinements in the CTO process, and development of retention measurements and benchmarks. The value of recruiting incentives and special pays has been critical to every success the Force has enjoyed in this arena, and I thank you for providing us with the tools necessary to populate the Navy Reserve in the right manner while working towards the fiscal year 2011 budgeted end strength of 65,500. Bonuses have helped shape the "Fit versus Fill" successes of recent years; however, for certain enlisted wartime skills sets and in the officer inventory in general, the Navy Reserve requires the help bonuses provide to continue to meet recruiting and retention goals.

IV. WAY AHEAD

In addition to the continuing attention to the programs and policies listed above, there are several other topics that have priority status this fiscal year to enhance our force-wide effectiveness, make it easier for each of us to serve, and to fully support our deploying members and their families.

Foremost among my list of priorities is to achieve resolution on a path to fielding a Total Force Future Pay and Personnel System (FPPS). The Navy and Navy Reserve currently have separate pay and personnel systems, designed and built in an era when sailors rarely mobilized or transitioned between components. With the present system, it can take weeks to properly transition a sailor from one pay and personnel system to another. This creates a barrier to realizing our CoS goals.

FPPS would enable sailors to transition quickly and seamlessly on and off active duty without the commensurate delays and confusion regarding pay and benefits. The Navy Total Force goal is to transition a sailor from one component to another within 72 hours. Navy leadership understands the urgency of resolving this issue, which impacts every sailor. I am confident that in fiscal year 2010, we will make considerable progress towards this goal.

Another top priority this year is to ensure Navy has the funding allowing the RC to perform directed missions. In addition to working through the long-term budgeting process needed to pay for our sailors, we are fully engaged in the development

of Naval Aviation Plan 2030 to ensure that the valued capabilities delivered by the Navy Reserve are properly resourced.

Navy Reserve aviation trains the Fleet, moves the Fleet, and when needed, surges to the fight. Twenty-eight squadrons, 8 Fleet Replacement Squadron Augment Units (SAUs), and 17 Chief of Naval Aviation and Training SAUs provided more than 70,000 flight hours in fiscal year 2009, including 80 percent of the Navy's direct and indirect Fleet operational support. Our four adversary squadrons provided 76 percent of Navy capacity, and the Fleet Logistics Support Wing provided 100 percent of the shore-based Navy Unique Fleet Essential Airlift with an average weekly cost avoidance of $655,000. These assets provide strategic surge capacity and maintain warfighting readiness at a lower cost, both in terms of payroll and airframe life, than AC squadrons. Navy Reserve's lower Fatigue Life Expenditure has provided Navy inventory managers increased options that have been a valuable part of Naval Aviation's recapitalization plan generally, and of P–3Cs and F/A–18s in particular.

Historically, Reserve aircraft have been procured via a combination of routine procurement processes, the use of National Guard and Reserve Equipment Appropriations (NGREA), Congressional buys, and the transfer of aircraft from the AC to the RC as new production aircraft enter the Total Force inventory.

Current aviation procurement trends will challenge RC aviation capabilities as the Navy Reserve continues to recapitalize assets. Priorities include completing the C–40A (airlift) procurement and recapitalizing the electronic attack capability that is fully integrated into the Airborne Electronic Attack (AEA) deployment plan that has provided 12 years of combat deployments in support of COCOM requirements. I am very appreciative of Congress' support for the purchase of three C–40A aircraft in the last two budgets. The C–40A provides twice the range, twice the cargo load, and twice the Ready for Tasking (RFT) days of the C–9B it replaces. The overall burdened hourly operating cost of the C–9B is $8,147/flight hour versus the C–40A cost of $6,141/flight hour. As a result, a $42 million per year cost avoidance will be realized by completing C–40A procurement and retiring the 15 remaining C–9Bs.

The fiscal year 2011 budget also supports the creation of a fourth Riverine Squadron for the Navy Expeditionary Combat Command (NECC). This additional unit was expressly addressed in the most recent Quadrennial Defense Review, and recognizes the unique skills and capabilities that the joint forces desire for current operations. NECC is manned equally by AC and RC personnel.

We will continue to utilize NGREA as available to meet the needs of the Navy. NGREA has been a high impact capital infusion for the Navy Reserve since its inception in 1981, but has taken on added importance in recent years. While the Navy Reserve's NGREA service allocation has decreased from 11.3 percent in 2004 to 5.0 percent in 2009, the appropriation has been instrumental in resourcing the capability of the NECC and has bolstered the recapitalization of critical RC equipment in both Naval Aviation and the Surface Navy. In fiscal year 2009, the Navy Reserve executed NGREA funding to equip the Maritime Expeditionary Support Force, Explosive Ordnance Disposal, Naval Construction Force, Naval Expeditionary Logistics Support Group, Naval Aviation and Surface Warfare units with: tactical and armored vehicles; Civil Engineering Support Equipment; communications equipment; Table of Allowance equipment; aviation modernization upgrades; and Rigid Hull Inflatable Boats. I am thankful for the $55 million NGREA allocated to the Navy Reserve for fiscal year 2010.

Secretary of the Navy Ray Mabus has committed the Navy and Marine Corps to meet bold, ambitious goals to advance Navy's energy strategy. The Navy Reserve, in cooperation with the Naval Installations Command, is committed to providing the Secretary an innovative and agile RC that can and will be a significant force multiplier in the pursuit of these goals.

Navy Reserve Military Construction and Facilities Sustainment, Restoration and Modernization (FSRM) projects will be stringently evaluated for efficient use of energy and water, use of new and emerging energy technologies, employment of innovative strategies and best practices, use of renewable energy sources, and energy-efficient mobility. Large-scale, comprehensive organizational efforts will be made in the use of energy efficiency and management tools. All Navy Reserve Military Construction and FSRM projects will incorporate conservation measures and environmental stewardship practices into their design and execution. The focus will be to reduce the cost and environmental impact of Navy Reserve construction projects by advancing energy efficiency and water conservation, promoting the use of distributed and renewable energy, and improving utility management decisions at all Reserve facilities.

Additionally, these energy goals can be helpful in facilitating transformation of the force; for example, completion of C–40A fleet logistics squadron recapitalization will offer a 13.2 percent fuel consumption reduction over the aging C–9B. Fuel sav-

ings in excess of 43,300 barrels per year will be realized when the C–9s are finally retired.

The Navy Reserve is an agile, innovative force, and in no arena is that description more apt than in the realm of Information Dominance. Navy Reserve has engaged in a directed, efficient transition from legacy systems and has successfully piloted state of the art solutions that are currently in use and will be used by the Fleet of the future. Continued use of this responsive Force as the Navy's' test platform is critical in successfully deploying the latest technology in the most timely and cost effective manner possible.

The threat posed to the government from aggressive actors in the cyber arena grows every day, and the Navy is engaged in actions to keep our country's systems protected. Key to the Cyber Manpower Strategy is the development of an RC Surge capability. The vision is to transition current Cyber manpower into Reserve Cyber Units that would serve in this capacity. Also, an enhanced direct-commission program would allow for increased accession of Cyber specialists. Finally, the Navy is considering a Civilian Cyber Augment Force: an "on call" team of experts that can provide strategic relevance and depth to the Navy as the cyber environment changes and technical progress is made. Civilian experts and consultants can be rapidly hired under existing authorities to meet the emerging critical requirements of Fleet Cyber Command/Commander 10th Fleet. We feel this effort can open unexplored areas of expertise in support of Navy's Cyber vision and mission execution.

V. CONCLUSION

Since September 11, more than 63,000 mobilization requirements have been filled by SELRES personnel, along with an additional 4,600 deployments by FTS sailors in support of the ongoing conflicts in Iraq, Afghanistan, and the Horn of Africa. On any given day, more than 20,000 Navy reservists, or about 30 percent of the Force, are on some type of orders providing support to global operational requirements of Fleet Commanders and COCOM global operational requirements. Our Navy Reserve Force—65,671 sailors—are forward deployed in support of coalition forces, at their supported commands around the world, or in strategic reserve and ready to surge 24/7 if and when additional Navy Total Force requirements arise.

I am proud to be a Navy reservist, and I am humbled by the commitment of the men and women of our Navy Reserve. It is very rewarding and fulfilling to stand shoulder to shoulder with the Navy's AC as we meet our Nation's call to duty. I am honored to receive the support of Congress on key initiatives, such as providing TRICARE eligibility to "gray area" retirees. Although I readily admit my bias, there has never been a better time to be part of the Navy-Marine Corps team, and our Navy Reserve is clearly an integral part of the this hard-working, high-spirited, and amazingly capable force.

The Navy's ability to be present in support of any operation, in war and peace, without permanent infrastructure in the area of operations, is a key advantage that will become even more important in the future. Our Navy remains the preeminent maritime power, providing our Nation with a global naval expeditionary force that is committed to global security, while defending our homeland as well as our vital interests globally. The Navy Reserve's flexibility, responsiveness, and ability to serve across a wide spectrum of operations clearly enhances the Navy Total Force, acts as a true force multiplier, and provides unique skill sets towards fulfilling Navy's requirements in an increasingly uncertain world.

On behalf of the sailors, civilians, and contract personnel of our Navy Reserve, we thank you for the continued support within Congress and your commitment to the Navy Reserve and our Navy's Total Force.

Senator GRAHAM. What's your biggest challenge, as a head of the Navy Reserve?

Admiral DEBBINK. Our biggest challenge right now, today, is our pay and personnel system and our travel claim system, sir. We're working hard to develop an integrated pay and personnel system, the Future Pay and Personnel System, as it's called. We appreciate the opportunity to move off of the DIMHRS.

Senator GRAHAM. Are you going to get us some ideas about how to fix that?

Admiral DEBBINK. Yes, sir. We're working right now on a number of alternatives, analysis of alternatives. We think we have a couple of solutions that we're very close to being able to implement.

Senator GRAHAM. Okay.

Admiral DEBBINK. We believe it'll take probably until at least 2012 for initial operating capability.

Senator GRAHAM. Will you need legislative action to change it, or can you do it internally?

Admiral DEBBINK. We can do it internally, sir.

Senator GRAHAM. Okay.

Admiral DEBBINK. We simply need the funding to be able to do it, of course.

Senator GRAHAM. From the recruiting/retention point of view, are you similar to where the Army's at?

Admiral DEBBINK. Yes, sir, we're doing very well, overall, with our recruiting and our retention. The challenges we have right now are in our medical programs—specialty medical officers and Nurse Corps. Two challenges there are, we have very few coming off Active Duty, which is a primary source of recruiting for us, as well as, I think all of us have experienced the same problems with medical. Otherwise, we're doing very well.

Senator GRAHAM. Thank you.

General Kelly.

STATEMENT OF LT. GEN. JOHN F. KELLY, USMC, COMMANDER, MARINE FORCES RESERVE; AND COMMANDER, MARINE FORCES NORTH

General KELLY. Sir, good morning. It's certainly an honor to be here this morning and to appear——

Senator GRAHAM. Congratulations, by the way.

General KELLY. Thank you, sir.

A couple of details, sir. I command 39,600 drilling reservists, and an additional 55,000 Individual Ready Reserve (IRR) reservists, in 83 locations around the country. In the 6 months I've been in command, my sense is, the strength of the Marine Corps Reserve is that it has a relatively large number of prior-service marines that serve.

Senator GRAHAM. How much do you depend on the Active Duty going to the Reserve for your recruiting? How big a part of that?

General KELLY. On the officer side, it's almost 100 percent. We've had some shortfalls, recently, that we're making up with a couple of small programs——

Senator GRAHAM. So, 100 percent of the Marine Corps Reserve officers are former Active Duty people.

General KELLY. Have had some length of—at least 4 years Active Duty.

Senator GRAHAM. So, with a downturn economy, General Kelly, does that present problems? People are less likely to get off Active Duty?

General KELLY. No, sir. In fact, the problem we had, in terms of maintaining officer numbers, is that when the Marine Corps was growing—and it's just completed that—up to 202,000——

Senator GRAHAM. Right.

General KELLY.—the encouragement was to stay in the Marine Corps. So, the pool of individuals getting off Active Duty just wasn't there; they were staying in the Marine Corps. In fact, we

were going into the Reserve, encouraging reservists to also go back on Active Duty.

Senator GRAHAM. Okay. So, you really don't have a problem with that. You have the opposite problem.

General KELLY. Right. Exactly right.

Senator GRAHAM. Okay.

General KELLY. To just finish up, I've experienced a total force Marine Corps, we don't think in terms of reservists and Active Duty. I know all of the other Services do that, as well. I would just end with—because I know time is of the essence—that the recruiting is good, troops are good and happy, and so are the families.

I stand by to answer your questions, sir.

[The prepared statement of General Kelly follows:]

PREPARED STATEMENT BY LT. GEN. JOHN F. KELLY, USMC

Chairman Webb, Ranking Member Graham, and distinguished members of the subcommittee, it is my honor to report to you on the state of the Nation's Marine Corps Reserve.

I assumed command of Marine Forces Reserve (MFR) and Marine Forces North (MFN) in October of last year; however, these past months have by no means been my first experience with the Reserve component (RC). Over my many years as a Marine, but particularly over the course of three tours totaling nearly 3 years in Iraq, I have served with and fought alongside Marine reservists and know first hand the mettle of these men and women. My appearance here today represents my first opportunity to share with you my assessment of these tremendous marines, and to outline my priorities for the Force going forward and as we work toward a better, more complete understanding of what the operational reserve means for the defense of the Nation and in the support of our international partners.

First and foremost Marine Forces Reserve continues to be an integral element of the Marine Corps' "Total Force." We share the culture of deployment and expeditionary mindset that has dominated Marine Corps culture, ethos and thinking since our beginning more than 2 centuries ago. All marines stand eternally ready to answer the Nation's 911 call and as our charter requires, is to "be most ready when the Nation is least ready." The Reserve component is trained, organized and equipped in the same way the Active Forces are, and consequently we are interchangeable and forever leaning forward to deploy as the Nation requires. The Commandant of the Marine Corps recently stated that Marine Forces Reserve can be "whatever the Nation needs it to be," an operational or a strategic reserve. Sustained combat operations and worldwide theater security cooperation and training commitments over the last 9 years more than suggest the essential need for the Reserves to continue focusing at the operational vice strategic end of the continuum. Indeed, in the just-published U.S. Marine Corps Service Campaign Plan 2009–2015, Marine Forces Reserve is tasked no less than five times to train, organize and equip for participation as an "operational reserve" within the Corps' Total Force. The marines themselves, most of whom came to the Nation's colors after September 11 and have deployed deep into harms way, prefer this model and do not desire to assume lives as so called "weekend warriors." This high level of flexibility, responsiveness and élan is only possible by the ever deepening bench of combat tested and uniquely qualified citizen "Soldiers of the Sea." I am humbled daily by my interactions with these magnificent young Americans. Like their active duty brothers and sisters they sacrifice so much of their time, and so much of themselves, to protect and serve this Nation. The way they balance their family responsibilities, and civilian lives and occupations—and still stay Marine—amazes me. They do it with humility, without fanfare, and with a sense of pride and dedication that is consistent with the great sacrifices of marines of every generation. They continue to affirm the Commandant's conviction that today's marines are cut from the same cloth as those who fought conspicuously upon the battlefields of our Corps' long history.

I. TODAY'S MARINE CORPS RESERVE

The Commandant has said the Marine Corps Reserve will be whatever the Nation needs it to be. In the last decade, the Nation has needed its Marine Reserves to be continuously engaged in combat operations in Iraq and Afghanistan and in regional security cooperation and crisis prevention activities. This tempo has built a momentum among our warfighters and a depth of experience throughout the ranks

that is unprecedented in generations. The Marine Corps Service Campaign Plan calls for the employment of an operational reserve no less than 5 times. Understanding that we are fighting a transnational enemy and that partner nations will continue to seek our training and mentoring capabilities, I expect our Marine reservists to be in great demand during the coming years in a sustained manner. We are prepared to provide that persistent capacity. Our Commandant has further stated that marines, Active or Reserve component, join the Marine Corps to do the things they are now doing—deploying and winning our Nation's battles. The nature of the fight in Afghanistan for instance, is particularly suited to our Marine Reserves. It is a thinking man's fight that requires solutions at the grassroots level, where our marines operate best, among the population, as evidenced by our combat prowess in Iraq and humanitarian assistance today in Haiti. Our successes in Iraq were hastened by the types of individuals we have in our ranks, who were utilizing civilian skills in ways not necessarily anticipated, but ultimately pivotal to the success in Al Anbar. That maturity, creativity and confidence is what an operational reserve brings to the fight. Your Marine Corps Reserve is more highly-trained, capable, and battle-tested than at any time since the Korean War. As an integral part of the Total Force Marine Corps, it blends seamlessly into the gaining force regardless of whether marines come as individual augments, detachments, or as operational units.

As of January 31, 2010, more than 54,000 Reserve marines have executed over seventy thousand mobilizations in support of Overseas Contingency Operations (OCO) since September 11, 2001. The vast majority of these marines deployed to the U.S. Central Command area of responsibility. One-hundred percent of Marine Corps Reserve units at the battalion and squadron level have either been activated in their entirety or activated task-organized detachments. Again, the vast majority deployed to the U.S. Central Command area of responsibility. Without going into too many specifics, 4,000 marines and sailors—citizens from Texas, California, Missouri, Nevada, Utah, Maryland, and Virginia—from the 4th Marine Division deployed to both war zones and went a long way to achieving success in al Anbar Province, Iraq and training security forces in Afghanistan. Thousands of other division marines also deployed in support of Combatant Commander Theater Security Cooperation initiatives to South America, Eastern Europe, Asia, Africa, Australia, and various Pacific island nations. This year will be no different with exercises planned for Norway, Peru, Belize, Uganda, Estonia and Morocco, and again in various nations in Asia and the Pacific islands.

Our Reserve aviators of the 4th Marine Aircraft Wing are no less busy supporting Marine and joint training requirements here in the United States, as well as deploying fighter and helicopter squadrons to the war zones and Horn of Africa, and supporting Combatant Commander initiatives across the globe as well. Of particular note the Total Force Marine Corps has had to rely heavily on the 4th Marine Aircraft Wing in support of the Marine Corps Aviation Transition Strategy. Modernizing from, in some cases, 40 plus year-old legacy aviation systems, to the leap ahead capabilities inherent in the V–22 "Osprey" and the Joint Strike Fighter, we have had to temporarily transfer manpower, airframe, and support structure to the Active component. Beginning in 2014, Marine Forces Reserve will commence the process of transitioning to the new systems and capabilities, but in the mean time is in total support of the overall Total Force modernization efforts.

The third Major Subordinate Command of the Reserve component is 4th Marine Logistics Group. Anyone who understands the Marine Air Ground Task Force (MAGTF) concept knows full well the ground fighters of the division, and aviators of the wing, go nowhere without the logistics professionals in the Group. In addition to service in both wars, and every 1 of the 57 events—large and small—that have contributed so mightily to all the combatant commanders' efforts across the globe, there were 2 special endeavors I want to highlight. The first was the command element's service as operational logistic providers in the Korean Theater last April during exercise Key Resolve, made necessary by a dearth of joint logistics capability due to the demands of Iraq and Afghanistan, and particularly the additional expeditionary demands of transitioning Marine forces in large numbers out of Iraq and into Afghanistan. The second is the increased support provided to various Maritime Prepositioning Exercises, again made necessary by wartime demands experienced by the Total Force.

Unique inside the Marine Corps is the Mobilization Command (MOBCOM), of Marine Forces Reserve. As the increased use of the Individual Ready Reserve (IRR) has grown over the last several years, so too has the workload of Mobilization Command. During the last fiscal year, more than 900 sets of mobilization orders were issued with a total of 653 IRR marines reporting for activation. MOBCOM also processed more than 9,400 sets of shorter duration orders. Mobilization Command devel-

oped and participated in family readiness programs that are particularly difficult within the IRR construct. Initiatives like the congressionally-mandated "Yellow Ribbon Programs" seek to provide support to families from initial call up through return and demobilization. Additionally, Mobilization Command conducted regional IRR musters, often partnering with other government agencies like the Department of Veterans Affairs, to maintain required annual contact with marines once they have left active service but still "owe" the Nation Reserve time.

Let me touch again on one of the important planning mechanisms for an operational reserve. Our Force Generation Model, developed and implemented in October 2006, continues to provide long-term and essential predictability of future activations and deployments. The Model provides my marines, their families, and just as importantly their employers, the capability to plan their lives 5 or more years out. It enables them to strike the critical balance between family, civilian career, and service to the Nation, while allowing employers time to manage the loss of valued employees. The Force Generation Model also assists service and joint force planners in maintaining a consistent and predictable flow of fully capable Marine Corps Reserve units. Internal to the Marine Corps this flow of fully trained and capable Reserve units has proven essential in reaching the Secretary of Defense established target of a 1:2 dwell for our Active component. The Model is a relatively simple management tool based on 1-year activations, to 4-plus years in a non-activated status. This makes continued programmed utilization of the Reserve component sustainable at 1:5 over the long term and supports the momentum about which I spoke in my introduction.

Predictable activation dates, mission assignments and geographical destination years out now permits me to orient training on core mission requirements early in the dwell period, then transitioning training focus to specific mission tasks once the unit is 12–18 months from activation.

In each of the past 3 years, between the wars in the Middle East and South Asia, and theater security cooperation activities to include mobile training teams conducting "Phase Zero" operations, nearly one-third of our 39,600 marines have deployed outside the continental United States both in an activated and non-activated status. In fiscal year 2009 alone, 7,500 marines were activated and deployed in support of the war in Iraq and Afghanistan, and an additional 5,800 were sent overseas to many locations on several continents in support of joint and combined theater security cooperation exercises.

For the second year in a row Marine Forces Reserve stateside will sponsor exercise "Javelin Thrust" in June focusing on Marine Air-Ground Task Force (MAGTF) core competency training. The scenario of this year's event is tailored to the current operating environment, and participating units have been identified consistent with their future deployment schedule as defined by the Force Generation Model. The end state of the exercise (Javelin Thrust) is that the headquarters staffs of the participating organizations (regiments, aircraft groups, battalions, and squadrons) are prepared for activation and are provided an in-depth roadmap to guide future pre-activation training. Additionally, individuals serving on those staffs will receive training allowing them to take their place as individual augments on a MAGTF or joint staff overseas, while other individuals in those units will be prepared for activation and the conduct of pre-deployment training. Last year's Javelin Thrust was the first large scale MAGTF exercise involving all three Major Subordinate Commands (Division, Wing and Marine Logistics Group) in 6 years. The 2009 distributed operations Afghan scenario also allowed other Department of Defense (DOD) agencies to participate and to test advanced technologies and transformational concepts. This year's exercise will also be conducted aboard installations throughout the Western United States with both virtual and real world aspects to the exercise.

II. PERSONNEL

The Selected Marine Corps Reserve is comprised of marines in Reserve units, those in Active Reserve status, Individual Mobilization Augmentees, and those in initial training. When taken together, these various categories of marines form the inventory of the 39,600 authorized end strength in the Selected Marine Corps Reserve.

Although we continue to enjoy strong volunteerism there has recently been some slight degradation in our ability to maintain authorized end strength. We were above 100 percent of our authorized end strength during fiscal years 2002–2005. There was a very slight drop to 99.71 percent in fiscal year 2006. In fiscal years 2007 and 2008 percentages of authorized end strength dropped to 97.36 and 94.76 percent—shortfalls of 1,044 and 2,077 individuals—respectively. This past fiscal year (2009), end strength improved to 97.25 percent. This is within the mandated

3 percent of authorization. When the 138 marines who had served on active duty for more than 3 of the last 4 years were taken into account, our shortfall increased to 3.1 percent (1,228). The dip below authorized strength experienced in 2007 and 2008 was predicted at the time due in large measure to the pressure put on the recruiting and retention of individuals to serve in the Active Force as the Marine Corps built to 202,000 active duty marines. Now that the 202,000 goal has been met and surpassed well ahead of schedule, we are now institutionally focusing on Reserve recruiting and retention efforts to maintain required Reserve component end strength. For fiscal year 2010, we project an end strength of 39,266, a shortfall of less than 1 percent (prior to accounting for marines who have served on active duty for more than 3 of the last 4 years). The bonus and incentive programs that you provide for recruiting and retention will remain essential tools to continue achieving this goal.

The Total Force Marine Corps will undoubtedly continue to rely heavily upon augmentation and reinforcement provided by Marine Forces Reserve. I believe our authorized end strength of 39,600 is still an appropriate number and will consequently drive recruiting and retention. This number provides us with the marines we require to support the Force, and achieve the Commandant's goal of a 1:5 deployment-to-dwell ratio in the Selected Marine Corps Reserve.

The Marine Corps – Navy Reserve Team is as strong as ever. In the past year the Navy ensured Marine Reserve units were fully manned and supported with Program 9 (U.S. Navy personnel in support of Marine Forces) and HSAP (Health Service Augmentation Program) personnel during all phases of the deployment (pre, operational, post). More 500 Navy personnel were sourced to staff Marine Forces Reserve units deploying to Iraq and Afghanistan, as well as numerous joint/combined exercises. These individuals focused almost entirely on providing medical, dental and religious services. The Navy Mobilization Office works with my headquarters, as well as with the four major subordinate commands, sourcing 100 percent of all requirements. As the demand increases throughout the forces, Program 9/HSAP support commands a high level of attention to fulfill not only Marine Corps missions, but Army and Navy missions as well. I am confident this process will continue ensuring Marine Forces Reserve units are supported with qualified Program 9 and HSAP personnel to accomplish the mission.

The Marine Corps is unique in that all recruiting efforts—officer, enlisted, Active and Reserve component, and prior-service—fall under the direction of the Commanding General, Marine Corps Recruiting Command. This approach provides tremendous flexibility and unity of command in annually achieving Total Force recruiting objectives. Like the Active component, Marine Corps Reserve units rely primarily upon a first-term enlisted force. Recruiting Command achieved 100 percent of its recruiting goal for non-prior service recruiting (4,235) and prior service recruiting (4,501) in fiscal year 2008. It also exceeded its recruiting goal for non-prior service recruiting (5,296) and exceeded 100 percent of its goal for enlisted prior service recruiting (3,862) during fiscal year 2009. As of January 31, 2010, 2,359 non-prior service and 1,397 enlisted prior service marines have been accessed, reflecting 46 percent of the annual enlisted recruiting mission for the Selected Marine Corps Reserve. We fully expect to meet our Selected Marine Corps Reserve recruiting goals again this year.

The Selected Marine Corps Reserve Affiliation Involuntary Activation Deferment Policy was implemented during June 2006. The policy allows a Marine who has recently completed a deployment with an active unit an option for a 2-year deferment from involuntary activation if they join a Selected Marine Corps Reserve once they leave active duty. The intent of the 2-year involuntary deferment is to allow transitioning marines the opportunity to participate in the Selected Marine Corps Reserve, while at the same time giving them a break and an opportunity to start the process of building their new civilian career.

Officer recruiting remains our most challenging area. Historically, the Active component has been the exclusive source of lieutenants and captains for the Reserves. This arrangement has paid tremendous dividends. Responding to the critical challenge of manning the Reserves with quality company grade officers, we have implemented three commissioning initiatives that focus exclusively on officer accessions for the Reserve component: Reserve Enlisted Commissioning Program (expanded to qualified active duty enlisted marines as well); Meritorious Commissioning Program-Reserve (open to individuals of either component holding an Associates Degree or equivalent in semester hours); Officer Candidate Course-Reserve (OCC–R). Since 2004 these 3 programs have produced a total of 190 lieutenants for the Reserves with OCC–R being the most successful of the 3, producing 161 officers. The program focuses on ground billets with an emphasis on ground combat and combat service support and within specific Reserve units that are scheduled for mobilization. The

priority to man units with these officers is once again tied to the Force Generation Model.

All commanders and senior enlisted leaders across the force are tasked to retain quality marines through example, information and retention programs, and mentoring. This takes place across the Marine experience and not just in the final days of a marine's contract. For those approaching the end of their current contracts—Active or Reserve component—they receive more focused counseling on the tangible and intangible aspects of remaining associated with, or joining, the Selected Marine Corps Reserve.

With Congress' help, affiliation bonuses, officer loan repayment and other initiatives have effectively supported our efforts to gain and retain the very best. The Commandant and certainly all of us in Marine Forces Reserve, greatly appreciate the continuance of all of the many programs that help us recruit and retain the best young men and women this Nation produces.

III. EQUIPMENT

As mentioned previously we are as good today as we have been since at least the Korean War, if not World War II. This level of proficiency as warfighters is due, in large part, to the amount and frequency of combat the Reserve Forces have accumulated over the past 9 years while serving as an operational reserve. In addition, the quality of our equipment is on par with that of the active duty. Therefore, it is imperative we spend the relatively small amount required to maintain our operational reserve and provide a reasonable return on that investment. The end result is a better trained and more capable force than ever operating alongside our active duty brethren on the ground, in the air, and at sea. To achieve and maintain this high level of readiness and proficiency we have like all of DOD relied heavily on supplemental funding in the Overseas Contingency Operational account. As we move forward it is in the best interests of the Nation to not lose these historically high levels of proficiency. The current strong and operationally competent Reserve component has cost us much in lives and budgetary treasure to achieve over the last 9 years.

As part of the Total Force, Marine Forces Reserve has two primary equipping priorities. The priority is to equip units and individuals set to deploy, and the second is to ensure units that are accomplishing normal training within the first 2–3 years of their dwell cycle have what they need in training allowance. We will always continue to provide those next into the fight all that they need in the latest generation of individual combat and protective equipment, and unit suites, to fight, accomplish the mission, and come home with the fewest number of casualties possible. Those not as close to deploying overseas to combat will also continue to be equipped with the best of everything and tailored specifically to whatever is next in their lives as defined by the Force Generation Model.

The Marine Corps approaches equipment procurement and fielding from a Total Force perspective with the Reserve component treated in exactly the way as the three active Operational Marine Forces organizations. In many cases we have achieved lateral fielding when Active and Reserve component organizations are receiving equipment sets simultaneously. Again, fielding is prioritized by who is next to the fight. If they need it to train with post-deployment, they have it, otherwise in some cases they will pick it up in theater in the normal transfer of equipment that has marked the way the Marine Corps has done business since 2003.

The National Guard and Reserve Equipment Appropriation (NGREA) allows me to mitigate any equipment deficiencies here in CONUS. For fiscal year 2009, Marine Forces Reserve received two sources of NGREA funding totaling $62.4 million. By providing the flexibility to purchase or accelerate the fielding of mission essential equipment, our units are better trained during pre-deployment and integrate effectively once they get in theater.

As the Commandant consistently states, our number one focus will be the individual Marine and Sailor in combat. Ongoing efforts to equip and train this most valued resource have resulted in obtaining the latest generation individual combat and protective equipment: M16A4 service rifles, M4 carbines, Rifle Combat Optic scopes, Lightweight Helmets, enhanced Small Arms Protective Insert plates, Modular Tactical Vests, and the latest generation Flame Resistant Organizational Gear (FROG.) Every member of Marine Forces Reserve has deployed fully equipped with the most current authorized Individual Combat Clothing and Equipment to include Personal Protective Equipment. The decisions regarding what they deploy with are made by commanders with a great deal of combat experience, and nothing is left to chance. However, as personal protective equipment has evolved over the years of this conflict there is now so much equipment and it is so heavy that the way we

fight is adversely impacted. In particular the infantrymen are so heavy, in some cases carrying more than 100 pounds of equipment; they are more beasts of burden than they are agile hunters. It is not simply a matter of reducing the weight of individual items as these only add up to marginal weight savings, but hard decisions about what they carry and how much they carry are essential.

The Commandant's unit equipping priority for Marine Corps Reserve units inside their dwell periods is to provide sufficient equipment to train with, but not burden the organizations with so much gear that they use all of their training time or unit funds maintaining it. We call this a Reserve unit's Training Allowance (TA.) This TA is the amount of equipment required by each unit to conduct home station training. Our goal is to ensure that the Reserve TA contains the same equipment utilized by the Active component. It is imperative that our units train with the same equipment they will utilize while deployed. The Marine Corps Reserve maintains a training allowance at each of its Reserve centers. As a whole, we are adequately equipped to effectively conduct training.

NGREA funding from 2009 continues to be used to purchase much needed Light Armored Vehicles, ruggedized command and control laptops, aircraft systems and survivability upgrades and continued procurement of the Logistics Vehicle Replacement System Cargo variant.

Marines are exceptionally good stewards of American taxpayer dollars, and the public property procured by those monies. In order to sustain an inventory of current equipment necessary to conduct home station training several resources and programs are utilized. The first is the routine preventive and corrective maintenance performed locally by user and organic maintenance personnel. Second, we have expanded ground equipment maintenance efforts, which rely largely on contracted services and depot-level capabilities. Third is our reliance on Marine Corps Logistics Command mobile maintenance teams providing preventive and corrective maintenance support to all 183 Marine Reserve sites across the Nation. This partnership provides a uniquely tailored Repair and Return Program. Fourth, we are intimately involved in the Marine Corps Enterprise Lifecycle Maintenance Program rebuilding and modifying an array of principal end items as required. Finally, we field the Corrosion Prevention and Control Program. Cumulatively all of these initiatives have resulted in a Marine Forces Reserve ground equipment readiness rate of 97 percent. Our 4th Marine Aircraft Wing "mission capable" rate in 2009 was 73 percent which is consistent with recent year rates and with the Active component rate of 71 through November 2009.

IV. TRAINING

The reality today is that the Reserve component has transitioned from what was considered a strategic reserve, to what is today the "operational reserve." Forever gone are the days when Reserve marines were considered mere "weekend warriors" and held in Reserve to reinforce the Active Force when it experienced catastrophic casualties from a World War III scenario against the former Soviet Union. For the last 9 years our Reserves have been a fully integrated force, routinely deployed to fight in Iraq and Afghanistan, and to execute theater cooperation engagement operations around the world at the behest of the combatant commanders. From all of these experiences we have captured important lessons that we have put to immediate use in improving every facet of our training. In this regard, one of the most exciting areas where we are continuing to transform the depth and scope of our training remains the cutting-edge arena of Modeling and Simulations Technology.

Marine Forces Reserve is fielding several immersive complex digital video-based training systems, complete with the sights, sounds and chaos of today's battlefield environments. These systems are particularly important considering the limited training time and facilities available to our commanders. Last year we completed the fielding and upgrading of the Indoor Simulated Marksmanship Trainer-XP (ISMT). These simulators make it possible for the marines to "employ" a variety of infantry weapons (pistols through heavy machineguns) in rifle squad scenarios. These simulators now serve as regional training centers and more are planned. The Virtual Combat Convoy Trainer-Reconfigurable Vehicle System provides invaluable pre-deployment training for the drivers or all makes and models of tactical vehicles. The conditions of terrain, road, weather, visibility and vehicle condition can all be varied, as can the combat scenario (routine movement, ambush, IED, etc.) The simulator is a mobile, trailer-configured platform that utilizes a HMMWV mock-up, small arms, crew-served weapons, 360-degree visual display with after-action review/instant replay capability. We are now preparing to accept the fourth generation of this system, with student throughput doubling.

Another simulation technology being fielded is the Deployable Virtual Training Environment (DVTE.) The DVTE also provides small-unit echelons with the opportunity to continuously review and rehearse command and control procedures and battlefield concepts in a virtual environment. All of this provides individual, fire team, squad and platoon-level training associated with patrolling, ambushes and convoy operations. Additional features include supporting arms upgrades (for virtual combined arms indirect fire and forward air control training), combat engineer training, small-unit tactics training, tactical foreign language training and event-driven, ethics-based, decision-making training. It is important to recognize the key role Congress has played in the fielding these advanced training systems, all of which have been rapidly acquired and fielded with supplemental and NGREA funding.

V. FACILITIES

Marine Forces Reserve is comprised of 183 sites in 48 States, the District of Columbia, and Puerto Rico. These facilities consist of 32 owned sites, 151 tenant locations, 3 family housing sites, and a Marine barracks. In contrast to Active Duty installations that are normally closed to the general public, our Reserve sites are openly located within civilian communities. This arrangement requires close partnering with state and local entities nationwide. Thus, the condition and appearance of our facilities may directly influence the American people's perception of the Marine Corps and the Armed Forces.

DOD policy and the use of standardized models for Marine Forces Reserve Facilities Sustainment, Restoration, and Modernization (FSRM) dollars have greatly improved funding profiles for our Reserve Facilities over the last several years. We are experiencing some of the best levels of facility readiness due to increased funding in the last three years, complemented by the addition of $39.9 million in stimulus dollars from the American Recovery and Reinvestment Act of 2009.

We have repaired and upgraded sites across the country with projects continuing to completion in 2011. Between the BRAC 2005 and our normal Military Construction of Naval Reserve (MCNR) Program, we will have replaced over 35 of our 183 Reserve Centers in the next 2 years. This represents the largest movement and upgrade in memory for the Marine Corps Reserve.

MARFORRES research and investment for the last 2 years in energy efficiency, sustainability, and renewable energy is coming to fruition this fiscal year. Every new FSRM renovation project or MILCON is targeted for energy efficiency and sustainability aspects in accordance with policy and Leadership in Energy and Environmental Design (LEED) guidelines. We recently commissioned our first LEED Silver building at Camp Lejeune (the first in the Marine Corps) and are anticipating completion this year of our first LEED Silver rehabilitation project for 4th Combat Engineer Battalion in Baltimore, MD (a potential first for the Marine Corps as well). All of our MILCON projects from fiscal year 2009 on will comply with directives to achieve LEED silver or higher as funding profiles allow. We will be conducting energy assessments of all our 32 owned sites this fiscal year along with preparation of smart metering technology for each to enhance conservation and management. The MARFORRES approach combines efficiency, conservation, and renewable aspects to achieve optimal return on investment. We have six active solar projects underway this year with all coming on line within the next 12 months. Our six wind turbine projects are under suitability and environmental evaluations. If findings support, they will start coming on line within 18 months at an anticipated payback of as little as 8 years. Marine Forces Reserve is working with the National Renewable Energy Lab to produce a sound renewable energy plan for all Marine Forces Reserve locations. Our investment and implementation of these technologies provides energy security, efficiency, and cost avoidance for our dispersed sites. The visibility of our projects in heartland of America and cities across the Nation provides tangible evidence of our commitment to the future.

Marine Forces Reserve Facilities Sustainment, Restoration, and Modernization (FSRM) program funding levels continue to address immediate maintenance requirements and longer-term improvements to our older facilities. Sustainment funding has allowed us to maintain our current level of facility readiness without further facility degradation. Your continued support for both the MCNR program and a strong FSRM program are essential to addressing the aging infrastructure of the Marine Corps Reserve. The MCNR program for exclusive Marine Corps construction must effectively target limited funding to address at least $132 million in deferred construction projects of our aging infrastructure. Increases in our baseline funding over the last 6 years have helped to address these deferred projects substantially. Over 27 percent of the Reserve centers our marines train in are more than 30 years

old and of these, 55 percent are more than 50 years old. Past authorizations have improved the status of facilities in the 30 to 50 year range and continued investment will allow for further modernization. The $35 million in additional MCNR funding this fiscal year has allowed MARFORRES to commence several additional projects.

The Base Realignment and Closure (BRAC) 2005 continues to move forward and the Marine Corps Reserve will relocate 12 units to consolidated Reserve centers this fiscal year. Marine Forces Reserve is executing 25 of the Marines Corps' 47 BRAC directed projects to include the only closure; Mobilization Command in Kansas City, MO, is moving to New Orleans, LA. Of these 25 BRAC actions, 21 are linked to Army and Navy military construction projects. Our BRAC plans are tightly linked to those of other Services and government agencies as we develop cooperative plans to share Reserve centers and coexist in emergent joint bases such as Joint Base Maguire-Dix-Lakehurst. All remaining Marine Corps Reserve BRAC projects are on track for successful completion with the directed timelines for closure.

Of special note is the movement of Headquarters, Marine Forces Reserve and consolidation of its major subordinate commands in New Orleans. This unique BRAC project, integrating State, local, and Federal efforts, is now well underway for the new headquarters compound and tracking for on time completion. The State of Louisiana is providing construction dollars for the new headquarters facility and saving the Federal Government more than $130 million. The Department of the Navy is providing the interior finishings and security infrastructure in accordance with the lease agreement. This building will incorporate multiple energy and environmentally friendly processes to meet LEED certifiable standards. Marine Forces Reserve is working with the Department of Energy's Federal Energy Management Program to maximize the sustainability and energy efficiencies of the buildings and compound. Upon completion and certification, this building and its surrounding acreage will become the newest Marine Corps Installation: Marine Corps Support Facility, New Orleans.

Our Marine Forces Reserve Environmental Program employs the Environmental Management System (EMS), which uses a systematic approach to ensure that environmental activities are well managed and continuously improving. Additionally, Marine Forces Reserve has initiated a nationwide program to reduce hazardous waste production and ensure proper disposal at our centers. Our Green Box Battery Program was responsible in fiscal year 2009 for recycling over 2 tons of various types of batteries alone. MARFORRES Environmental undertook steps to replace the recycling equipment with completely operable, fully recycling systems. Through fiscal year 2009, wash rack recycling systems at 16 Reserve center sites have been replaced. This project has saved over 650,000 gallons of water and cost savings of $500,000, not to mention the enhanced risk avoidance to our national water infrastructure. Marine Forces Reserve is updating all environment baseline surveys of our owned sites to ensure we are current in all aspects of caring for our Nation's resources.

VI. HEALTH SERVICES

The most important part of any Marine organization is of course the marines, sailors, civilian marines, and families who shoulder the burden of defending our country every day. Taking care of them is a sacred trust. This begins with arduous training for combat, and equipping them with the best equipment in the world to do the job once deployed to the fight. It then extends to providing the best health care possible to them and their loved ones. Our routine health services priority is to attain and maintain Individual Medical and Dental Readiness goals as set by DOD. In 2009, individual medical and dental readiness for our marines and sailors was 68 percent and 77 percent respectively. This represents a 5 percent improvement over the previous year.

The Reserve Health Readiness Program (RHRP) is the cornerstone for individual medical readiness. This program funds contracted medical and dental specialists to provide health care services to units specifically to increase individual medical and dental readiness. In the near term Navy medicine supports through various independent contracted programs such as the Post Deployment Health Reassessment (PDHRA), and the Psychological Health Outreach Program. The first identifies health issues with specific emphasis on mental health concerns which may have emerged since returning from deployment, while the Psychological Health Outreach Program addresses post deployment behavioral health concerns through a referral and tracking process. Worthy of mention in the area of mental health is our full participation in a very recent initiative designed and ruthlessly monitored by our Commandant and assistant Commandant, in an effort to get at the tragedy of sui-

cide. Our Warrior Preservation Program, run by senior staff officers and non-commissioned officers has trained 239 instructors who will return to their home units and reinforce the important lessons they received. We conducted training for all of our personnel at each of our units and I have as the Commander, filmed my own message on this topic and prominently displayed it on our public website.

TRICARE remains a key piece of our medical support programs, providing medical, dental and behavioral health services. Members of the Selected Reserve qualify for and may enroll in TRICARE Reserve Select, which provides TRICARE Standard coverage until the member is activated. While on military duty for 30 days or less a reservist who does not choose TRICARE Reserve Select coverage is covered under Line of Duty care. Upon activation, and during any applicable early identification period, the reservist is covered by TRICARE Prime and may choose to enroll eligible family members in TRICARE Prime, Prime Remote or Standard. When deactivated, a reservist who mobilized in support of overseas contingency operations is eligible for 180 days of TRICARE transitional health plan options. With your support these DOD programs will continue to provide reservists and their family members' important medical benefits as they transition on and off active duty status

VII. QUALITY OF LIFE

Our Commandant has affirmed that our Corps' commitment to marines and sailors in harm's way extends to their families at home. As part of Marine Corps reforms to enhance family support, we are placing full-time Family Readiness Officers (FROs), staffed by either civilians or Active Duty marines, at the battalion/squadron level and above to support the Commandant's family readiness mission. As you might imagine an organization spread across the Nation and overseas has unique challenges, but communication technologies, improved procedures and processes have worked to more effectively inform and empower family members including spouses, children and parents who often have little routine contact with the Marine Corps and live far from large military support facilities. The installation of full-time Family Readiness Officers at the battalions and squadrons bridges many gaps and overcomes many challenges unique to the Reserve component. It is a low cost solution with a significant return on investment and I urge the continued support of this critical program.

We fully recognize the strategic role our families have in mission readiness, particularly with mobilization preparedness. We prepare our families for day-to-day military life and the deployment cycle by providing education at unit family days, pre-deployment briefs, return and reunion briefs, and post-deployment briefs. To better prepare our marines and their families for activation, Marine Forces Reserve is fully engaged with OSD to implement the Yellow Ribbon Reintegration Program, much of which we have had in place for quite some time. We are particularly supportive of Military OneSource, which provides our reservists and their families with an around-the-clock information and referral service via toll-free telephone and internet access on subjects such as parenting, childcare, education, finances, legal issues, deployment, crisis support, and relocation.

Through the DOD contract with the Armed Services YMCA, the families of our deployed Reserve marines are enjoying complimentary fitness memberships at participating YMCA's throughout the United States and Puerto Rico. Our Active Duty marines and their families located at Independent Duty Stations have access to these services as well.

The Marine Forces Reserve Lifelong Learning Program continues to provide educational information to servicemembers, families, retirees, and civilian employees. More than 1,100 Marine Forces Reserve personnel (Active and Reserve) enjoyed the benefit of Tuition Assistance, utilizing more than $3 million that funded more than 3,900 courses during fiscal year 2009. The Marine Corps' partnership with the Boys and Girls Clubs of America and the National Association for Child Care Resources and Referral Agencies continues to provide a great resource for servicemembers and their families in accessing affordable child care, before, during, and after a deployment in support of overseas contingency operations. We also partnered with the Early Head Start National Resource Center Zero to Three to expand services for family members of our reservists who reside in isolated and geographically-separated areas.

Managed Health Network is an OSD-contracted support resource that provides surge augmentation counselors for our base counseling centers and primary support at sites around the country to address catastrophic requirements. The Peacetime/Wartime Support Team and the support structure within the Inspector-Instructor staffs at our Reserve sites provide families of activated and deployed marines with

assistance in a number of support areas. Family readiness directly impacts mission readiness and your continued support of these initiatives is deeply appreciated.

VIII. CASUALTY ASSISTANCE AND MILITARY FUNERAL HONORS

Casualty assistance remains a significant responsibility of Active component marines assigned to our Inspector—Instructor and Site Support staffs. Continued operational efforts in Afghanistan and Iraq have required that these marines remain ready at all times to support the families of our marines fallen in combat abroad or in unforeseen circumstances at home. By virtue of our geographic dispersion, Marine Forces Reserve personnel are best positioned to accomplish the vast majority of all Marine Corps casualty assistance calls and are trained to provide assistance to the family. Historically, Marine Forces Reserve personnel have been involved in approximately 90 percent of all Marine Corps casualty notifications and follow-on assistance calls to the next of kin. There is no duty to our families that we treat with more importance, and the responsibilities of our Casualty Assistance Calls Officers (CACOs) continue well beyond notification. We ensure that our CACOs are adequately trained, equipped, and supported by all levels of command. Once a CACO is designated, he or she assists the family members in every possible way, from planning the return of remains and the final rest of their marine to advice and counsel regarding benefits and entitlements. In many cases, our CACOs provide a permanent bridge between the Marine Corps and the family, and assist greatly in the process of grieving. The CACO is the family's central point of contact and support, and is charged to serve as a representative or liaison to the media, funeral home, government agencies, or any other agency that may become involved.

Additionally, Marine Forces Reserve units provide significant support for military funeral honors for our veterans. The active duty site support staff members, with augmentation from their Reserve marines, performed more than 12,700 military funeral honors in 2009 (91 percent of the Marine Corps total.) We anticipate providing funeral honors to more than 13,000 Marine veterans in 2010, even as projected veteran deaths slowly decline. Specific authorizations to fund Reserve marines in the performance of military funeral honors have greatly assisted us at sites such as Bridgeton, MO; Chicago, IL; and Fort Devens, MA, where more than 10 funerals are consistently supported each week. As with Casualty Assistance, we place enormous emphasis on providing timely and professionally executed military funeral honor support.

IX.CONCLUSION

Your Marine Corps Reserve is operational and fully committed to train and execute the Commandant's vision for the Total Force. The momentum gained over the past 9 years, in Iraq, Afghanistan and in support of theater engagements around the globe remains sustainable through coordinated focus, processes, and planning.

In everything we do, we remain focused on the individual marine and sailor in combat. Supporting that individual requires realistic training, proper equipment, the full range of support services and professional opportunities for education, advancement and retention. That is our charge. You should know that the patriots who fill our ranks do so for the myriad reasons familiar to those who wear this uniform and those who sustain us. Yet reservists serve while balancing civilian careers and outside responsibilities, often at significant personal cost. Your continued unwavering support of the Marine Corps Reserve and associated programs is greatly appreciated. Semper Fidelis.

Senator GRAHAM. Okay. Thank you.

General Stenner.

STATEMENT OF LT. GEN. CHARLES E. STENNER, JR., USAF, CHIEF OF AIR FORCE RESERVE; AND COMMANDER, AIR FORCE RESERVE COMMAND

General STENNER. Senator Graham, I am pleased to be here today on behalf of the 70,000 reservists. We are, in fact, I believe, a very strong strategic reserve that we leverage on a daily basis to provide the operational force around the world.

Senator GRAHAM. What percentage of aircrews in the air right now are reservist?

General STENNER. Percentage of aircrews in the——

Senator GRAHAM. The nonfighter force—in transportation, airlift, and refueling.

General STENNER. Yes, sir. I'll get you exact percentages——

[The information referred to follows:]

The percentage of aircrews in the air right now that are reservists in the nonfighter force (transportation, airlift, and refueling) is 22 percent.

General STENNER.—but, we have roughly—between the Guard and Reserve, depending on the actual airframe, whether it's 130s or KC–135s, anywhere from 40 to 60 percent of that capability.

Senator GRAHAM. I hope people understand what you just said. Between 40 and 60 percent of the people flying KC–135s are reservists or Guard members. Is that correct?

General STENNER. I'll get you the exact numbers, sir, but it's a fairly significant——

Senator GRAHAM. Same for the 130 force?

General STENNER. Yes, sir. Actually a little larger in the 130 force.

Senator GRAHAM. Okay. What about the transport side, the C–17s?

General STENNER. Same thing, sir. Part of the Air Force Reserve—we have 43,000 of our 70,000 folks that are associated with the air mobility piece of the house.

Senator GRAHAM. What percentage of the Reserve flying component has reached their 2-year activation limit, but still continue to serve voluntarily? Do you know?

[The information referred to follows:]

11 percent of the officers in the Reserve flying component have reached their 2-year activation limit. Of that number, 95 percent continue to serve voluntarily after demobilization.

17 percent of enlisted aircrew members in the Reserve flying component have reached their 2-year activation limit. Of that number, 95 percent continue to serve voluntarily after demobilization.

General STENNER. Sir, I will get you the exact numbers that have reached the limit, but we are 80 percent volunteers right now. We have 20 percent that we——

Senator GRAHAM. The point I'm trying to make is that we have statutory limitations on how often you can be called up. I think—is that 2 years? Is that right? No?

General STENNER. On a specific mobilization authority, 2 years is the limit.

Senator GRAHAM. Okay. So, at the end of the day, a lot of these people could hold their head up high and walk away, basically say, "I've done my time." They continue to serve voluntarily. Is that correct?

General STENNER. That is absolutely true. We have higher retention on those that have served than we have on those that have not had an opportunity to——

Senator GRAHAM. I just want us to understand, structurally, as a nation, that we have statutes that we've blown by the cap, and people continue to serve, which is a testament to them, but we need to figure out how to address this problem. Okay?

General STENNER. Yes, sir.

Senator GRAHAM. Anything else from the Air Force's point of view, in terms of retention?

General STENNER. Retention is very good, sir; and recruiting is very good. We're growing. We are an Air Force Reserve that's growing in all new mission sets, so we have added a few recruiters, but we have no problem bringing the folks in. They want to serve.

Senator GRAHAM. Are most of your reservists people coming from Active Duty?

General STENNER. No, sir. We're getting—60 percent of our folks are prior service, 40 percent are nonpriors.

Senator GRAHAM. Okay, great.

[The prepared statement of General Stenner follows:]

PREPARED STATEMENT BY LT. GEN. CHARLES E. STENNER, JR., USAF

Mr. Chairman and distinguished members of the committee, I appreciate the opportunity to appear before you today and discuss the state of the Air Force Reserve.

The 21st century security environment requires military services that are flexible—capable of surging, refocusing, and continuously engaging without exhausting their resources and people. Moreover, the 21st century fiscal environment is becoming ever-more constrained as threats by rising nations and pressing national interests compete for limited resources.

In this challenging environment, the Air Force Reserve has never been more relevant. Reserve airmen continue to support our Nation's needs, providing superb operational capability around the globe. We have sustained this operational capability for nearly 20 years—at high operations tempo for the past 9 years. The Air Force Reserve is accomplishing this while still providing a cost-effective Tier 1 ready force to the Nation available for strategic surge or ongoing operations.

Speaking of ongoing operations, U.S. Air Force C–130 aircrews were among the first U.S. military to respond to the earthquake disaster in Haiti, on the ground in Port Au Prince within 24 hours of the earthquake. This quick response was not simply fortuitous, but the result of planning, preparedness, and readiness. This rapid-response capability is available 24/7, 365 days a year through Operation Coronet Oak.[1]

Since 1977, the Operation Coronet Oak mission has been manned primarily by Air Force Reserve and Air National Guard crews who rotate every 2 weeks, year-round. Crews from the Regular Air Force now perform about one-third of the mission. These Operation Coronet Oak crews are postured to respond within 3 hours of notification to any crises requiring airlift support within the U.S. Southern Command area of responsibility.

This predictable-rotational mission allows reservists to perform real-world operational missions and still meet their obligations to their full-time civilian employers. Like Air Expeditionary Force (AEF) rotations, this operation leverages the Tier 1 readiness of Air Force Reserve airmen in a way that works for the combatant commander, and the reservist. Equally important, when Air Force Reserve airmen are not training or performing an operational mission—they are not being paid; yet they remain ready to respond to any crisis within 72 hours should they be called upon. In this resource-constrained environment in which manpower costs are placing downward pressure on our budgets, I believe this full-time readiness/part-time cost is a great use of taxpayer dollars.

This next year brings new challenges and opportunities. Air Force Reserve airmen are being integrated into a wider variety of missions across the full spectrum of Air Force operations. Indeed, the Department of Defense (DOD) is considering using reservists from all Services to perform missions utilizing their unique civilian skill sets.

The challenges we face are not unique to the Air Force Reserve or the Air Force as a whole. Each of the Military Services is being asked to shift capability and capacity across the spectrum of conflict—including irregular warfare—and to resource

[1] In addition to Haitian relief support through Operation Coronet Oak, Air Force Reserve ISR personnel provided exploitation support to assess the damage and focus relief while Air Force Reserve airlift crew saved lives with much needed medical, water, and food supplies flown into Haiti. Air Force Reserve members in fact planned, commanded and exploited Global Hawk derived exploitation missions in order to provide situational awareness on infrastructure status and guide relief efforts during one of the worst earthquakes to hit Haiti on over 200 years. The professional expertise and capabilities of these seasoned citizen airmen demonstrates the flexibility and service inherit in the men and women of the Air Force Reserve as they shifted from supporting combat operations to humanitarian relief.

accordingly. Each has been asked to shift focus away from major weapon systems acquisitions and to the current fight.[2]

To do so, all three components of the Air Force must continually strive to improve the capability provided to the warfighter. Each service component must examine its existing business practices and explore new processes to make optimal use of personnel, platforms, and monetary resources. The Air Force Reserve is helping lead the way in improving Air Force capability as we approach fiscal year 2011 and beyond.

As the Nation looks for ways to strengthen its organizations and integrate all of the untapped resources it will need in facing the challenges of the 21st century, we submit that a model by which ordinary people, dedicated to serving their country in ways that meet both their needs and the needs of the Nation, is already manifest in the U.S. Air Force every day—in the extraordinary Americans of the Air Force Reserve.

I'm proud to serve alongside these great airmen and as Chief and Commander of the Air Force Reserve, I have made a promise to them that I will advocate on their behalf for resources and legislation that will allow them to serve more flexibly in peace and war with minimum impact to their civilian careers, their families and their employers. I will work to eliminate barriers to service, so that they can more easily serve in the status that meets their needs and those of the Air Force. I will work to efficiently and effectively manage our Air Force Reserve to meet the requirements of the joint warfighter and the Nation.

RECRUITING AND RETENTION

Over the last 9 years, the Air Force Reserve has exceeded its recruiting goals and is on track to meet fiscal year 2010 recruiting and end-strength goals. Our success in great part has been due to the accessions of experienced Active component members upon completion of their active duty commitments. Indeed, recruiting highly-trained individuals is essential to lowering the training costs for the Air Force Reserve. For some of our most critical specialties, affiliation, and retention bonuses have provided a greater return on investment versus recruiting non-prior service airmen. However, due to lower regular Air Force attrition rates, we no longer have the luxury of large numbers of experienced airmen leaving Active service.

As the Air Force Reserve builds end strength to meet the needs of new and emerging missions, we are facing significant recruiting challenges. Not only will the Air Force Reserve have access to fewer prior-service airmen; but, we will be competing with all other Services for non-prior service (NPS) recruits. In fact, our non-prior service recruiting requirement has nearly doubled since the end of fiscal year 2007. To improve our chances of success, we have increased the number of recruiters over the next 2 years.

Air Force Reserve retention is solid with positive gains in all categories in fiscal year 2009, after rebounding from a slight annual drop from fiscal year 2006–fiscal year 2008. Both officer and enlisted retention are up; enlisted retention has returned to the fiscal year 2006 rate. Career airman retention is at its highest level in the last 5 years.

Some of this success can be attributed to implementing several retention-focused initiatives such as developing a wing retention report card tool and General Officer emphasis on retention during base visits. With Air Force Reserve retention at its best for the last 3 years, this renewed focus on retention is expected to ensure that rates continue on a positive trend.

We can't take all the credit for this success. Congress has generously responded to our requests for assistance with improved benefits such as the Post-9/11 GI Bill, inactive duty training (IDT) travel pay, and affordable TRICARE for members of the Selected Reserve.

To date, under the conditions of the Post-9/11 GI Bill benefit, the Air Force Reserve has processed over 4,400 transferability requests impacting nearly 7,000 dependents. Under the Individual Duty Training travel pay benefit, more than 5,100 Air Force reservists have received this benefit. This has helped us address those critical duty areas where we have staffing shortages.

Since October 2007 when the three-tier TRICARE plan was eliminated, the Air Force Reserve has seen an increase in covered lives from 4,541 to 14,982 through January 31, 2010, equaling a 330 percent increase in program usage. The current

[2] In Operations Enduring and Iraqi Freedom, Reserve C–130 crews flew over 9,800 hours in fiscal year 2009; Reserve F–16 and A–10 crews flew over 5,400 hours. The Air Force Reserve provides 24 crews and 12 fighter aircraft to USCENTCOM in their regularly scheduled rotations for the close air support mission.

coverage plan has made TRICARE more accessible and affordable for members of the Selected Reserve at a critical time when healthcare costs are rising. In addition to these new benefits, the Air Force Reserve has taken advantage of the many tools that you have provided us including the bonus program, the Yellow Ribbon Program, and our Seasoning Training program.

The Bonus program has been pivotal to recruiting and retaining the right people with the right skills to meet combatant commander warfighting requirements. The Air Force Reserve uses the Bonus Program to fill requirements on our "Critical Skills List." Those skills are deemed vital to Air Force Reserve mission capability. Development of these skills usually requires long training courses and members who have these skills are in high demand within the private sector. We are able to offer a wide menu of bonuses for enlistment, reenlistment, affiliation, and health professionals.

Our Yellow Ribbon Reintegration Office is up and running and fully implementing DOD directives. Our program strives to provide guidance and support to the military members and their families at a time when they need it the most, to ease the stress and strain of deployments and reintegration back to family life. Since the standup of our program from August 2008 to December 2009, we have hosted 113 total events across 39 Wings and Groups. 4,515 reservists and 3,735 family members attended these events reflecting a 67 percent program usage rate for members deployed during this timeframe. From event exit surveys and through both formal and informal feedback, attendees indicated positive impressions, expressing comments about feeling "better prepared, (and) confident following events."

Designed to build a "ready force," our Seasoning Training Program allows recent graduates of initial and intermediate level specialty training to voluntarily remain on active duty to complete upgrade training. The results have been a larger pool of deployable reservists at an accelerated rate through this program. As a force multiplier, seasoning training is ensuring the Air Force Reserve maintains its reputation for providing combat-ready airmen for today's joint fight. The Seasoning Training Program is also proving beneficial for recruiting, training, and retaining members in the Air Force Reserve. This program is a success story and one that we will build on in the next year.

The Air Force Reserve is working hard to increase reservists' awareness of benefits and incentives associated with their service. reservists are taking advantage of these programs because they are having their intended effect. These programs are helping to create the sustainable and predictable lifestyle that our members need to continue to serve in the Air Force Reserve.

I am confident that as we act on not only our Air Force Reserve priorities, but also on those of the Air Force and DOD with the continued support of this committee and Congress, we will be able to continue to meet the needs of combatant commanders and the Nation with a viable operational and strategic Air Force Reserve.

MAINTAIN A STRATEGIC RESERVE WHILE PROVIDING AN OPERATIONAL, MISSION READY FORCE

The Air Force Reserve is first and foremost a strategic reserve leveraged to provide an operational, mission ready force in all mission areas.[3] Air Force Reserve air-

[3] Airmen of the Selected Reserve are mission-ready, capable of performing ongoing operations. Collectively, they have met the operational needs of the Air Force for decades—largely through volunteerism, but also through full-time mobilization. Between 1991 and 2003, reservists supported the no-fly areas of Operations Northern and Southern Watch. Since the attacks on 11 Sept 2001, 54,000 reservists have been mobilized to participate in Operations Enduring Freedom, Noble Eagle, and Operation Iraqi Freedom—6,000 remain on active duty status today. It is a fact that the Air Force now, more than any other time, relies on members of the Reserve and Guard to meet its operational requirements around the globe.

The Air Force Reserve maintains 60 percent of the Air Force's total Aeromedical Evacuation (AE) capability. Reserve AE crews and operations teams provide a critical lifeline home for our injured warfighters. Our highly trained AE personnel fill 43 percent of each AEF rotation and augment existing USEUCOM and USPACOM AE forces in conducting 12 Tanker Airlift Control Center tasked AE channel missions each quarter—all on a volunteer basis.

In 2009, the men and women of our Combat Search and Rescue (CSAR) forces have been heavily engaged in life saving operations at home and abroad. Since February, airmen of the 920th Rescue Wing at Patrick Air Force Base (AFB), FL, and their sister units in Arizona and Oregon, flew over 500 hours and saved more than 200 U.S. troops on HH–60 helicopter missions in support of U.S. Army medical evacuation operations in Iraq and Afghanistan. While mobilized for 14 months in support of combat missions abroad, the 920th continued to provide humanitarian relief in response to natural disasters at home, as well as provide search and rescue sup-

Continued

men accomplish this by training to the same standards and currencies as their Regular Air Force counterparts. As indicated at the outset, Air Force Reserve airmen continue to volunteer at high levels and provide superb operational capability around the globe, serving side by side with the joint team. These airmen provide the insurance policy the Air Force and the Nation need: a surge capability in times of national crises. In fact, the Air Force Reserve is currently mobilizing our strategic airlift resources and expeditionary support to assist surge requirements in Afghanistan.[4]

The Air Force Reserve is a repository of experience and expertise for the Air Force. Air Force Reserve airmen are among the most experienced airmen in the Air Force. Air Force Reserve officers average roughly 15 years of experience, and enlisted members average 14 years of experience, compared to 11 years and 9 years for Regular Air Force officers and enlisted, respectively. In fact, roughly 64 percent of Air Force Reserve airmen have prior military experience.

Reserve airmen are a cost-effective force provider, comprising nearly 14 percent of the total Air Force authorized end strength at only 5.3 percent of the military personnel budget. Put differently, Air Force Reserve airmen cost per capita is 27.7 percent of that of Regular Air Force airmen, or roughly 3.5 Reserve airmen to 1 Regular airman.[5]

However, we cannot take for granted the high level of commitment our reservists have thus far demonstrated. We must do our best to ensure their continued service. Accordingly, we are undertaking enterprise-wide actions to make Air Force Reserve service more predictable.

In the Air Force Reserve, we are revising our management structures and practices to eliminate redundancies associated with mobilizing and deploying reservists

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port for NASA shuttle and rocket launches. In addition, the 39th Rescue Squadron (HC–130s), also at Patrick AFB, flew rescue missions in Africa and provided airborne CSAR support during the rescue of the Maersk Alabama's Captain from Somalian pirates.

The Air Force Reserve provides 100 percent of the airborne weather reconnaissance (hurricane hunting) capability for DOD. Throughout the year, the Citizen Airmen of the Air Force Reserve's 53rd Weather Reconnaissance Squadron "Hurricane Hunters", a component of the 403rd Wing located at Keesler AFB in Biloxi, MS, fly over 1,500 operational storm hours. The Hurricane Hunters have 10 WC–130J Super Hercules aircraft that are equipped with palletized meteorological data-gathering instruments. They fly surveillance missions of tropical storms and hurricanes in the Atlantic Ocean, the Caribbean Sea, the Gulf of Mexico and the central Pacific Ocean for the National Hurricane Center in Miami. The unit also flies winter storm missions off both coasts of the United States and is also used to perform advanced weather research missions for the DOD and the National Oceanic and Atmospheric Administration (NOAA). The lifesaving data collected makes possible advance warning of hurricanes and increases the accuracy of hurricane predictions warnings by as much as 30 percent.

In addition to our hurricane mission, the Air Force Reserve provides 100 percent of the aerial spray mission in support of the Federal Emergency Management Agency, the Centers for Disease Control, and state public health officials. Air Force Reserve aircrews and C–130s from the 910th Airlift Wing, Youngstown Air Reserve Station, OH, sprayed more than a million storm ravaged acres of land with pesticides to control the spread of disease.

Our intelligence, surveillance and reconnaissance professionals are providing critical information as they answer the Nation's call to service. Since September 11, 2001, 1,079 intelligence personnel have deployed in support of world-wide contingency missions to include Afghanistan and Iraq. For the foreseeable future, Reserve intelligence professionals will continue to be deployed throughout the combatant command theaters, engaged in operations ranging from intelligence support to fighter, airlift, and tanker missions to ISR operations in Combined Air Operations Centers and Combined/Joint Task Forces as well as support to the National Command Authority, such as, Defense Intelligence Agency, National Security Agency, and National Geospatial-Intelligence Agency.

These are but a few examples of the dedication and contributions our Air Force Reserve airmen have made and will continue to make around the clock, around the world, each and every day.

[4] Our Reserve community continues to answer our Nation's call to duty with large numbers of volunteer reservists providing essential support to combatant commanders. Forty-six percent of the Air Force's strategic airlift mission and 23 percent of its tanker mission capability are provided by Reserve airmen. We currently have over 450 C–17, C–5, KC–135, and KC–10 personnel on active duty orders supporting the air refueling and airlift requirements.

[5] Fiscal year 2008 budget, figures derived from Automated Budget Interactive Data Environment System (ABIDES), the budget system currently in use by the Air Force and recognized as the official Air Force position with respect to the Planning, Programming and Budget Execution (PPBE) system. Inflation data used for any constant dollar calculations were based on average ConsumerPrice Index for All Urban Consumers (CPI–U) rates for the past 10 years: roughly 2.6 percent average annual rate of inflation. Medicare Eligible Retirement Health Care (MERHC) is an accrual account used to pay for health care of Medicare-eligible retirees (age 65 and beyond). Cost per capita figures were derived dividing cost of Selected Reserve program by Selected Reserve end-strength. When MERHC figures are included, the cost of Air Force Reserve airmen to Regular Air Force airmen increases to 30.4 percent.

to meet combatant commanders' requirements. The intent is to create an integrated process that will be more responsive to the needs of reservists, provide them greater predictability, make participation levels more certain, and ultimately provide combatant commanders with a more sustainable operational capability. This is still a work in progress.

At the Pentagon, the Air Force Reserve is examining its processes to improve Reserve interaction among the Air Force Headquarters staff to better support the Chief of Air Force Reserve, the Chief of Staff of the Air Force, and the Secretary of the Air Force in discharging their service responsibilities. Through the Air Reserve Personnel Center, the Air Force Reserve is also taking action to improve Reserve and Air National Guard personnel administrative and management capabilities. Collectively, these actions will contribute to the overall health of the strategic reserve and improve the sustainability of the Air Force Reserve and the Air Force operational capability required by the warfighters in this new century.

PRESERVE THE CARE AND VIABILITY OF THE RESERVE TRIAD

Reservists have relationships with three basic entities: family, civilian employer, and military employer—what I like to call "The Reserve Triad." Helping our airmen preserve these relationships is critical to our sustainability. In this year of the Air Force family, our policies and our actions must support the viability of these relationships—especially the one reservists have with their families. Open communication about expectations, requirements, and opportunities will provide needed predictability and balance among all three commitments.

To that end, we are now consistently and actively surveying Reserve and Regular airmen to better understand why they come to serve and why they stay. We are continually learning and gaining a better understanding of attitudes toward service and issues associated with employers and family. From their feedback, I can better advocate for benefits that help us recruit and retain airmen for the Air Force Reserve.

Military Services must be flexible: capable of surging, refocusing, and continuously engaging without exhausting resources and people. That is sustainability. Approaching fiscal year 2011 and beyond, it is imperative that we preserve the health of our strategic reserve and improve our ability to sustain our operational capability. Going forward, we need to continuously balance capabilities and capacity against both near-term and long-term requirements.

Clearly, in a time of constricted budgets and higher costs, in-depth analysis is required to effectively prioritize our needs. We must understand the role we play in supporting the warfighter and concentrate our resources in areas that will give us the most return on our investment. Optimizing the capability we present to the warfighter is a top priority, but we must simultaneously support our airmen, giving them the opportunity to have a predictable service schedule and not serve more than they can sustain.

BROADEN TOTAL FORCE INITIATIVE OPPORTUNITIES

As weapons systems become increasingly expensive and more capable, their numbers necessarily go down. Aging platforms are being retired and not replaced on a one-for-one basis. The Air Force is required to make the most of its smaller inventory. To this end, the Air Force Reserve, Air National Guard, and Regular Air Force are integrating across the force, exploring associations wherever practical. The Air Force is aggressively examining all Air Force core functions for integration opportunities.[6]

[6] The Air Force uses three types of associations to leverage the combined resources and experience levels of all three components: "Classic Association," "Active Association," and "Air Reserve Component Association."

Under the "Classic" model, so-called because it is the first to be used, a Regular Air Force unit is the host unit and retains primary responsibility for the weapon system, and a Reserve or Guard unit is the tenant. This model has flourished in the Military Airlift and Air Mobility Commands for over 40 years. We are now beginning to use it in the Combat Air Forces (CAF): our first fighter aircraft "Classic" association at Hill AFB, UT, attained Initial Operational Capability in June 2008. This association combined the Regular Air Force's 388th Fighter Wing, the Air Force's largest F–16 fleet, with the Air Force Reserve's 419th Fighter Wing, becoming the benchmark and lens through which the Air Force will look at every new mission. The 477th Fighter Group, an F–22 unit in Elmendorf, AK, continues to mature as the first AFR F–22A associate unit. This unit also achieved Initial Operating Capability in 2008 and will eventually grow into a two-squadron association with the Regular Air Force.

Continued

Over the past 40 years, we have established a wide variety of associate units throughout the Air Force, combining the assets and manpower of all three components to establish units that capitalize on the strengths each component brings to the mix. We recently partnered with Air Mobility Command to create three more active associate flying squadrons in 2010 and beyond. About 500 regular airmen will associate with Air Force Reserve flying units at Keesler AFB, MS (C–130J); March Air Reserve Base, CA (KC–135); and Peterson AFB, CO (C–130H) by 2012.[7]

But associations are not simply about sharing equipment. The goal is to enhance combat capability and increase force-wide efficiency by leveraging the resources and strengths of the Regular Air Force, Air National Guard, and Air Force Reserve while respecting unique component cultures in the process. To better accommodate the Air Force-wide integration effort, the Air Force Reserve has been examining its 4 decades of association experience. With Regular Air Force and Air National Guard assessment teams, we have developed analytical tools to determine the optimal mix of Reserve, Guard, and Regular forces in any given mission. These tools will give the Air Force a solid business case for associating as we go forward.

AIR FORCE RESERVE MANPOWER

The Air Force is balancing Reserve Forces across the full spectrum of conflict. We are leveraging the experience of reservists to alleviate stressed career fields. We are improving our ability to retain experienced airmen by providing them a means to stay in the Service following any life-changing decisions they make regarding full-time participation. Over the next decade, the Air Force Reserve will grow into many new mission areas, including nuclear enterprise, intelligence, surveillance, reconnaissance, unmanned aerial systems, space, and cyberspace.

However, rebalancing a force can take time, and the fight is now. To meet the more pressing needs of the Air Force, such as easing strain on stressed career fields and taking on new mission sets, the Air Force Reserve is growing by 2,100 airmen in fiscal year 2010. This will bring Air Force Reserve authorized end strength to 69,500. By fiscal year 2013, Air Force Reserve end strength is planned to grow to 72,100.

These manpower increases are placing a premium on recruiting highly-qualified and motivated airmen and providing them the necessary training. The Air Force Re-

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The Air Force Reserve Command is establishing its first Intelligence, Surveillance and Reconnaissance Group Association at Langley AFB, VA, this year. This Group and assigned Intelligence Squadrons of Reserve airmen will partner with the Regular Air Force to provide operational command and control of units delivering real time, tailored intelligence to combat forces engaged in missions in Iraq and Afghanistan, with data derived from theater Predator/Reapers, Global Hawks and U–2s, in partnership with the Total Force team. The Air Force has also programmed additional associate intelligence squadrons for Beale and Langley AFBs for distributed support to global ISR operations to include EUCOM, and PACOM theaters. Once these units have reached full operational capability, Air Force Reserve exploitation and analysis surge capacity of Remotely Piloted Aircraft (RPAs) will be approximately 10 percent of the Air Force's capability based on 65 orbits. Additional Command and Control Intelligence, Surveillance, and Reconnaissance capability is being stood up with an AFRC associate Air Force Forces Command unit at Beale AFB, CA, to support PACOM and one at Hurlburt AFB, FL, to support SOCOM global Special Operations Forces. These new capabilities create a strategic reserve force ready to respond to the call of our Nation, capable of being leveraged as operational crews ready and willing to support the Regular Air Force in everyday missions around the world. This model has proven itself and is the basis for the growth of associations over the last 5 years.

[7] Under the "Active" model, the Air Force Reserve or Guard unit is host and has primary responsibility for the weapon system while the Regular Air Force provides additional aircrews to the unit. The 932nd Airlift Wing is the first ever Operational Support Airlift Wing in the Air Force Reserve with three C–9Cs and three C–40s. Additionally, the Air Force Reserve will take delivery of an additional C–40 in fiscal year 2011, appropriated in the fiscal year 2009 Consolidated Security, Disaster Assistance and Continuing Appropriations Act. This additional C–40 will help to replace the three C–9Cs, which are costly to maintain and fly. To better utilize the current fleet of C–40s at the 932nd, the Air Force created an Active Association. We also are benefitting from our first C–130 Active Association with the 440th AW at Pope AFB.

Under the "Air Reserve Component (ARC)" model, now resident at Niagara Falls Air Reserve Station (ARS) in New York, the Air Force Reserve has primary responsibility for the equipment while the Guard shares in the operation of the equipment and works side by side with the Reserve to maintain the equipment. The Air National Guard has transitioned from the KC–135 air refueling tanker to the C–130, associating with the 914th Reserve Airlift Wing. The 914th added 4 additional C–130s, resulting in 12 C–130s at Niagara ARS. This ARC Association model provides a strategic and operational force for the Regular Air Force while capitalizing on the strengths of the Air National Guard and Air Force Reserve. Additionally, in this case it provides the State of New York with the needed capability to respond to State emergencies.

The Air Force Reserve has 9 host units and is the tenant at 53 locations. There are currently more than 100 integration initiatives being undertaken by the Air Force and Air Reserve components.

serve recruiting goal for fiscal year 2010 is 10,500. While we met our goal of 8,800 new airmen for fiscal year 2009 in August, nearly 2 months before the end of the fiscal year, our forecast models indicate we will continue to face challenges in both recruiting and retention.

Each of these measures—Total Force Integration (TFI), expanding into new mission areas, rebalancing of forces, and, where needed, increasing manpower—will help the Air Force more closely align force structure to current and future DOD requirements, as well as provide increased capability to the combatant commanders.

AIR FORCE RESERVE MODERNIZATION

The Air Force Reserve is an organization of extraordinary working people, wedded to the fabric of our great Nation. Our Citizen airmen support all Air Force mission areas in air, space, and cyberspace. They are trained to the same standards and readiness as their Regular component peers and are among the most highly-experienced members of the U.S. Air Force.

A number of trends continue to influence dependence on Air Force Reserve Forces to meet the strategic and operational demands of our Nation's defense: sustaining operations on five continents plus surge efforts in Iraq and Afghanistan and the resulting wear and tear on our aging equipment; increasing competition for defense budget resources; and increasing integration of the three Air Force components.

The Air Force leverages the value of its Reserve components through association constructs in which units of the three components share equipment and facilities around a common mission. Increasing integration of all three Air Force components requires a holistic approach be taken when modernizing. To ensure our integrated units achieve maximum capability, the precision attack and defensive equipment the Air Force Reserve employs must be interoperable not only with the Guard and Regular component, but the joint force as well.

As Chief of the Air Force Reserve, I am dedicated to ensuring that Air Force reservists have the training and equipment available to them required to provide for our Nation's defense. I appreciate the attention and resources provided to the Reserve thus far, and I ask for your continued support.

The National Guard Reserve Equipment Account (NGREA) appropriation has resulted in an increase in readiness and combat capability for both the Reserve and the Guard. For fiscal year 2010, the Air Force Reserve Command received $55 million in NGREA appropriations. This resulted in the ability to purchase critical warfighting requirements for Reserve-owned equipment including critical upgrades to targeting pods, aircraft defense systems for C–5s and C–130s, and personnel protective equipment like security forces tactical weapons. These new capabilities are directly tied to better air support for our soldiers and marines in Iraq and Afghanistan. NGREA funding has helped the Air Force Reserve to remain relevant in today's fight as well as the ability to remain ready and capable in future conflicts. We truly appreciate and thank you for your support with this critical program.

MILITARY CONSTRUCTION AND INFRASTRUCTURE MODERNIZATION

Along with challenges in modernizing our equipment, we face challenges modernizing our infrastructure. During the fiscal year 2011 budget formulation, both the Regular Air Force and the Air Force Reserve took risk in military construction in order to fund higher priorities. Over time, this assumption of additional risk has resulted in a continuing backlog exceeding $1 billion for the Air Force Reserve. I would be remiss if I didn't take this opportunity to sincerely thank you for the $112 million that we received in last fiscal year's military construction appropriation. This allowed us to address some of the most dire needs that exist in our backlog.

We will continue to work within the fiscal constraints and mitigate risk where possible to ensure our facilities are modernized to provide a safe and adequate working environment for all of our airmen.

CONCLUSION

Mr. Chairman and members of this committee, I am excited to have these roles as Chief of the Air Force Reserve and Commander of the Air Force Reserve Command. I take pride in the fact that when our Nation calls on the Air Force Reserve, we are trained and ready to go to the fight. As a strategic reserve, over 68,500 strong, we are a mission-ready Reserve Force serving operationally throughout the world every day with little or no notice.

As we approach fiscal year 2011 and beyond, it is clear the Air Force Reserve will play an increasingly vital role in meeting national security needs. The actions we initiated in 2009 and those we advance in 2010 will preserve the health of the Air

Force Reserve but also help Congress address the more pressing issues we will face as a Nation in the years to come.

I sincerely appreciate the support of this committee for the authorization and legislation it provides to our readiness and combat capability. I desire to continue working with each of you on the challenges facing the Air Force Reserve, the Air Force, and our Nation. Thank you.

Senator GRAHAM. Admiral Stosz.

STATEMENT OF RADM SANDRA L. STOSZ, USCG, ACTING DIRECTOR OF RESERVE AND TRAINING, U.S. COAST GUARD

Admiral STOSZ. Good morning, Senator Graham. On behalf of the 8,000 Coast Guard reservists, I am pleased to have this opportunity to appear before you today to discuss the Coast Guard Reserve, its contribution to national defense and homeland security, and the issues that face the men and women of our Reserve Force.

Thank you for including the Coast Guard Reserve when considering armed service personnel issues, and for your continued support of our military men and women.

Our Reserve component serves as a responsive and flexible force multiplier at home and abroad. In addition to our mobilization capability under title 10, the integration of our Active and Reserve components in the 1990s enables us to respond quickly when and where operational reserve Forces are needed, aided in part by the unique authority vested in the Secretary of Homeland Security under title 14.

Recently, in response to the earthquake in Haiti, the USCGC *Forward* arrived on scene within 24 hours, while Coast Guard reservists prepared to mobilize, pending presidential recall authorization under Title 10. Port Security Unit (PSU) 307 deployed just 48 hours after receiving that recall notification to provide port safety and security in Port-au-Prince and nearby Haitian ports. As a deployable surge capability, the Coast Guard Reserves PSU force package was vital to ensuring the safe passage of relief supplies and shipping commerce.

Senator GRAHAM. Admiral, we have your written statement. To all of you, Haiti was a major effort, and I couldn't be more proud of the Active and Reserve components helping the people of Haiti.

Admiral, from your point of view, what's your biggest challenge to keep these 8,000 people retained, and recruit in the future?

Admiral STOSZ. Senator, I think our biggest challenge is to keep them well-trained and well-equipped. We use operational-unit training and equipping. Our Reserves augment——

Senator GRAHAM. Do you have ships in the Reserve units that are specific to Reserves?

Admiral STOSZ. No, we don't. Except for our PSU force packages, our Reserves are individual augmentees that go out and augment our operational Coast Guard stations. They use the equipment at those stations.

The only problem we have is, Reserves stationed in the Great Lakes in the wintertime, we have to deploy them down somewhere warm to train on the boats that they need to keep their qualifications up. So probably our biggest challenge is keeping that training going with a geographically constrained workforce, when you also have the employment challenges of an employer, where you can't

send them on temporary assigned duty for that long, to get the training somewhere else, outside that geographical area.

Senator GRAHAM. The equipment problems in the Coast Guard seem pretty serious to me. We have an aging fleet.

Admiral STOSZ. Yes, sir, our aging fleet. But, our small boats are much newer, so our capital cutters, the bigger ships that reservists don't serve in, are the aging assets, and our new smaller boats are the boats that our reservists man and deploy.

Senator GRAHAM. But, your recruiting and retention is okay right now?

Admiral STOSZ. Yes, sir. We have 87 percent enlisted and 93 percent officer retention.

Senator GRAHAM. Okay.

[The prepared statement of Admiral Stosz follows:]

PREPARED STATEMENT BY RADM SANDRA STOSZ, USCG

Good afternoon, Chairman Webb, Senator Graham and distinguished members of the Senate Armed Service Subcommittee. It is a pleasure to have this opportunity to appear before you today to discuss the Coast Guard Reserve; its contribution to national defense and homeland security; the issues that face the men and women of our Coast Guard Reserve; and the Coast Guard's ability to sustain our current high quality staffing.

As one of the five Armed Forces of the United States, the Coast Guard has a long and distinguished history of service at home and abroad as a military, maritime, multi-mission service that is always ready for all threats and all hazards. Because of its mix of military and civil law enforcement authorities, the Coast Guard is uniquely positioned to serve as the lead Federal agency for maritime homeland security and response to natural and man-made disasters, while acting as a supporting agency for national defense.

Founded in 1941, the Coast Guard Reserve is the force multiplier for the operational Coast Guard. During the last decade, we have completely integrated our Selected Reserve Force into Active component units. Over 80 percent of our 8,100-member Selected Reserve Force is directly assigned to Active Duty Coast Guard shore units, where reservists hone readiness skills through classroom instruction and on-the-job training side by side with their active duty counterparts. The remainder of our Selected Reserve Force is dedicated primarily to supporting defense operations, the majority of whom are assigned to our eight deployable Port Security Units (PSUs). The principal mission of the PSUs, which are staffed by both Active and Reserve duty personnel, is to support the combatant commanders in strategic ports of debarkation overseas. The remaining personnel are assigned to Department of Defense (DOD) units, such as the Maritime Expeditionary Security Squadrons and combatant commanders' staffs.

OPERATION UNIFIED RESPONSE

Over the past 2 decades the Coast Guard has focused on an integrated workforce with deployable force packages. In support of the recent earthquake recovery efforts in Haiti, the Coast Guard Cutter *Forward* arrived on scene within 24 hours of the earthquake; PSU 307, augmented by individuals with select specialties from several other PSUs, deployed, for approximately 8 weeks, as a unified force to provide port safety and security in Port-Au-Prince and nearby Haitian ports. The Coast Guard Reserve's PSU force package was vital to ensuring the safe passage of relief supplies and shipping commerce in the port and surrounding waters of Haiti.

INTEGRATION

The 8,100 operational reserve personnel act as a surge capability ready and able to respond to any national or domestic contingency. They responded magnificently to the attacks of September 11, 2001, and all contingency operations that have followed. Since 2001, there have been over 6,900 cumulative recalls of Coast Guard reservists under title 10 of the United States Code. Reservists have served at home as part of the Coast Guard's Maritime Homeland Security mission—usually as part of PSUs—and overseas in direct support of the combatant commanders—in early 2003, at the height of Operation Iraqi Freedom, approximately half of Coast Guard personnel deployed overseas were reservists.

POST-SEPTEMBER 11

Since September 2001, when we embarked on the largest mobilization of Coast Guard reservists since World War II, we have redoubled our efforts to ensure a Reserve Force with the right people, skills and training for the missions of the 21st century. We have examined our systems for recruiting, training, mobilizing and demobilizing reservists to identify and close readiness gaps. More significantly, we undertook a comprehensive review of the Coast Guard Reserve; upon completion, our Commandant, Admiral Thad Allen, issued a policy statement that embodies the three core strategic functions of the Reserve Force: maritime homeland security; domestic and expeditionary support to national defense; and domestic man-made or natural disaster response. The Reserve Employment and Analysis Working Group has further developed this policy statement into employment doctrine that will focus on training and augmentation.

TITLE 14

None of this post-September 11 activity represents a radical change for the Coast Guard Reserve, but rather an affirmation of the vital role our reservists play as the Coast Guard's operational surge force. One key component of this ready surge force is availability and accessibility of individuals for mobilization. As with members of the other Reserve components, our men and women are subject to involuntary mobilization under Title 10 for national security contingencies. However, unlike members of the other Reserve components, Coast Guard reservists can also be involuntarily mobilized for up to 60 days at a time for domestic contingencies, including natural and manmade disasters and terrorist attacks. This unique authority provided under title 14 has been used over a dozen times since the 1970s to mobilize Coast Guard reservists for a wide range of emergencies ranging from the 1980 Mariel Boat Lift to floods, hurricanes and other natural disasters.

In 2005, this special authority was used by the Secretary of Homeland Security to allow the Coast Guard to mobilize approximately 700 reservists for Hurricanes Katrina and Rita, providing a ready force for rescue and recovery operations in New Orleans and other stricken areas of the Gulf Coast. It was used again in 2008 for nearly 70 members in response to Hurricanes Gustav and Ike. In all, members of the Coast Guard Reserve mobilized under Title 14 for Hurricanes Katrina and Rita performed nearly 20,000 person-days of duty in support of Coast Guard rescue and recovery operations. Most served alongside their active-duty counterparts as individual augmentees. For instance, several reservists assigned as Coast Guard Investigative Service special agents were mobilized to augment active-duty and civilian agents deployed to New Orleans, Baton Rouge, and Gulfport, where they provided armed security for senior officials and personnel disbursing cash to Coast Guard staff. In addition to individual augmentees, the Coast Guard also activated two PSUs to provide physical security in New Orleans and Gulfport and to aid in the distribution of relief supplies. These activities are a testament to the ability of our reservists to mobilize when and where needed to increase Coast Guard forces responding to an emergency.

The Coast Guard and Maritime Transportation Act of 2006 expanded the Secretary of Homeland Security's Title 14 recall authority to permit mobilization of Coast Guard reservists "to aid in prevention of an imminent serious natural or manmade disaster, accident, catastrophe, or act of terrorism." Other language included in the bill extended the limits on the period of recall to not more than 60 days in any 4-month period and to not more than 120 days in any 2-year period. This significantly enhanced our ability to mitigate major natural disasters and thwart terrorist attacks by enabling us to bring Coast Guard reservists on active duty even before disaster strikes.

ORGANIZATION STRUCTURE

A major component of the Coast Guard's success in responding to disasters is the Coast Guard's decentralized command and control structure. The authority and responsibility to move forces, including reservists, establish response readiness levels, and direct operations is vested in the regional District and Area Commanders. This provides the most direct oversight of operations at the field level and avoids delays in executing our missions. However, the most important factor contributing to the Coast Guard's effectiveness in disaster response is the fact that our forces are engaged in this type of mission on a daily basis. As the Nation's maritime first responder, Coast Guard men and women—Active, Reserve, civilian, and auxiliary—plan for, train, and execute missions every single day.

AN ARMED FORCE

The Coast Guard possesses several unique features that help to integrate its efforts with those of the DOD, other Federal agencies, the National Guard, and State and local authorities. As an Armed Force, our communications systems, planning processes, personnel training and even our command structures have much in common with the DOD Services. Coast Guard commanders can be either supported or supporting commanders for military operations, with extensive experience working in and with DOD Joint Task Force Headquarters. This capability allows for easy integration of forces and unity of effort when working together during major catastrophes. Today, we enjoy our closest relationship with DOD since World War II, with numerous active duty and Reserve personnel assigned at our combatant commands and various other DOD organizations.

JOINT FORCES

The Coast Guard maintains excellent working relationships with all of the Armed Forces, providing support and leveraging expertise through mutual agreements. At Marine Corps Base Camp Lejeune, NC, the Coast Guard has partnered with the Marine Corps to develop the Coast Guard Special Missions Training Center, which is tasked to provide training, doctrine, and testing/evaluation in support of mission requirements of the Coast Guard, Navy, and Marine Corps operational forces. The Special Missions Training Center offers specialized courses for Coast Guard Reserve deployable units, and inclusion of Coast Guard personnel in formal training conducted by the Navy and Marine Corps.

In today's joint environment, the spirit of cooperation and common purpose is exceptionally high. The Coast Guard welcomed the opportunity in February 2010 to participate in Patriot Hook when PSU 312, working jointly with the 452nd Air Lift Control Flight, leveraged the opportunity to complete required underway live-fire, anti-swimmer grenade training, and personnel and equipment movement by land and air. During the 4-day exercise, held at San Clemente Island, CA, the U.S. Air Force transported over one-half million pounds of cargo from various airfields to San Clemente Island.

As I report to you here today, 120 members of PSU 312 are deployed to Southwest Asia as an integral part of the Navy's Maritime Expeditionary Squadron, providing vital water and shore-side security for ports of strategic importance in Kuwait and Iraq.

INTERAGENCY

In addition to our work with DOD, the Coast Guard works on a daily basis with other Federal, State, and local partners. The Coast Guard's port, waterway and coastal security mission requires the Coast Guard to interact daily with State and local law enforcement and emergency response organizations, exercising command structures and building the trust critical to effectively executing an emergency response. Coast Guard Captains of the Port provide a critical link through Local Emergency Planning Committees, Area Maritime Security Committees, Harbor Safety Committees, Area Planning Committees, Regional Response Teams and other venues that allow the Coast Guard to build close relationships with key partners in disaster response. Because of the integrated nature of the Coast Guard, individual reservists play a key role in these efforts. Their dual status as Coast Guard members and residents of their local communities frequently enables them to leverage organizational and personal relationships that yield immeasurable benefits during a crisis situation.

COMMISSION ON THE NATIONAL GUARD AND RESERVE (CNGR)

The Coast Guard has participated from the start of the Commission on the National Guard and Reserve process, providing both a dedicated staff member as well as testimony to the Commission, participating in each of the factfinding sessions. Upon completion of the study, the Coast Guard worked with the Office of the Assistant Secretary of Defense, Reserve Affairs in evaluating the impact of the Commission's 95 recommendations. The Coast Guard continues to participate in follow-on work groups with the other Reserve components as well as the Office of the Assistant Secretary of Defense, Reserve Affairs as the Services work to implement many of the Commission's recommendations.

WORKFORCE

The Coast Guard takes a unique approach to staffing a Reserve Force by performing both Reserve and Active Duty recruiting through a single Recruiting Com-

mand. The Coast Guard Reserve supplements recruiting offices with reservists on Active Duty (Temporary Active Reserve Recruiters) under the concept that reservists are best suited to recruit reservists. In addition to the Reserve recruiters, the Recruiting Command has found success in the use of In Service Transfer Teams to ensure that all Active Duty personnel being released from active duty are briefed on the benefits of the Coast Guard Reserve and offered an opportunity to affiliate with assignment.

IMPROVED BENEFITS

The Post-9/11 GI Bill, implemented in 2009, offers our reservists who have served extensively on active duty since September 11, 2001, an important benefit that will improve the education and professionalism of our already stellar workforce. This benefit has also contributed to current retention rates, which remain high and virtually unchanged from fiscal year 2009.

The 2010 National Defense Authorization Act, along with changes to DOD and Coast Guard policy, provide continued improvements in benefits for members of the Coast Guard Reserve. Authority was extended to the service secretaries to provide our dedicated reservists with legal assistance for an extended period of time following their release from mobilization orders, which will assist them in resolving issues that may have occurred while they were deployed. Early TRICARE benefits increased from 90 days to 180 days, providing early access to TRICARE medical and dental care when members are notified of upcoming mobilizations, and thereby improving reservists' readiness. The new TRICARE Retired Reserve benefit will provide our retirees with health care options during the period where they do not yet qualify for TRICARE Reserve Select or TRICARE Standard at age 60.

The Coast Guard Reserve often operates in a joint environment with its sister Service, the Navy. The two Services are working to implement joint instructions for the Yellow Ribbon Reintegration Program, which will ensure demobilized reservists are properly transitioned to civilian employment.

The 2008 National Defense Authorization Act authorized early retirement benefits for eligible reservists who serve on active duty during a period of war or national emergency, including Active service under various sections of Title 10, and Title 32 in the case of National Guard reservists, for incidents or a National Special Security Event as designated by the Secretary of Homeland Security. Active service under Title 14 was inadvertently omitted as qualifying service supporting the same incidents where National Guard service would qualify.

RETENTION

Retention in the Coast Guard Reserve is at 93 percent for officers and 87 percent for enlisted personnel in fiscal year 2010. These retention rates have held solid for a number of years, indicating that members see the Coast Guard Selected Reserve as an attractive option and, once they join, they want to continue serving.

EMPLOYER SUPPORT/JOB SECURITY

The Coast Guard is actively engaged with Employer Support of the Guard and the Reserve (ESGR). Each year, the Coast Guard Reserve actively encourages reservists to nominate their employers for the Secretary of Defense Freedom Award. These concerted efforts have resulted in a substantial increase in nominees over previous years.

NEXT STEPS

The Coast Guard has demonstrated its ability to prepare for and respond to a wide range of contingencies, including natural disasters and a terrorist attack, while executing more routine missions, such as maritime law enforcement and search and rescue. To continue to meet these challenges, the Coast Guard continuously examines best practices and takes steps to adapt. In 2008, the Coast Guard Reserve Program developed an initiative called the Reserve Force Readiness System, which is aimed at increasing readiness of Coast Guard Reserve Forces. Under the Reserve Force Readiness System, many billets have been realigned at the operational level providing improved oversight, day-to-day management, and readiness of our Reserve Forces. This new organizational construct also provides additional leadership opportunities for senior reservists (officer & enlisted), provides increased mentorship and training for junior personnel, and optimizes the placement of Full Time Support personnel.

The Coast Guard is the Nation's premier maritime law enforcement agency with broad, multi-faceted jurisdictional authority. It is on behalf of the men and women

of the Coast Guard that I thank you for your continued support of the Coast Guard and the Coast Guard Reserve.

Thank you for the opportunity to testify today. I look forward to your questions.

Senator GRAHAM. I have just a few minutes until I have to vote and—we have your written statements. I don't mean to cut this short, but, at the end of the day, we have to find out what the real problems are, how are you doing, why are you doing so well, and what's likely to change.

Mr. Secretary, tell me about the legal structure, in terms of accessing the Guard and Reserves. What does Congress need to do, with the administration, to change that dilemma? Am I right about the 2-year limit? You can be called up for 2 years——

Mr. MCCARTHY. No, sir.

Senator GRAHAM.—involuntarily, right?

Mr. MCCARTHY. No, sir, not exactly.

Senator GRAHAM. How does that work?

Mr. MCCARTHY. There is a 2-year limitation, but it's interpreted to be 2 years of consecutive service. So, you can't involuntarily mobilize a member of the Guard or Reserve for more than 2 years, consecutively, but the interpretation that we are using is that there is no cumulative limit.

But, you're absolutely right that——

Senator GRAHAM. I'm not so sure that's the intent. Maybe not. You could serve for 20 months, 10 times?

Mr. MCCARTHY. I'm sorry, you can serve for——

Senator GRAHAM. Could you call——

Mr. MCCARTHY.—20——

Senator GRAHAM.—could you call somebody up for 20 months and get 2 years—that doesn't count toward the 2 years, right?

Mr. MCCARTHY. 20 months is not——

Senator GRAHAM. Not 24——

Mr. MCCARTHY.—exceed the 2-year——

Senator GRAHAM.—yes.

Mr. MCCARTHY. Not 24.

Senator GRAHAM. Yes.

Mr. MCCARTHY. But, the interpretation that we've used since September 11 has been that the 2-year limit was consecutive rather than cumulative.

Senator GRAHAM. From the military point of view, here, most people understand that? Or do they care? From the Army's point of view.

Admiral DEBBINK. Yes, sir. The Secretary of Defense came out with a policy on the 12-month mobilization, which I think did the most for us, in terms of putting some structure around the question you're asking, because the question was, is the 24 months concurrent, consecutive, or cumulative? I think, Secretary Gates now has said the mobilization period will be 12 months. Then, the goal is to get a 1 to—currently, a 1 to 4 ratio, and eventually a 1 to 5 ratio, so that the soldier would know, 12 months every 4 to 5 years.

Senator WEBB [presiding]. I guess I came in in the middle of this discussion, so I'm not quite sure where it's going.

Let me pick up on a couple of things that I was talking about before, just to begin my questions.

First, Secretary McCarthy, the 2009 National Defense Authorization Act required the Secretary of Defense to submit to Congress a strategic plan to enhance the role of the National Guard and Reserves no later than April 1, 2009. This plan was to include an assessment of the findings of the Commission on the National Guard and Reserves (CNGR), as well as an assessment of certain legislative proposals, particularly the National Guard Empowerment and State National Defense Integration Act of 2008.

On March 25, 2009, your predecessor testified: "A detailed description of the actions being taken by the Department in response to the recommendations made by the Commission is contained in the report required by section 906 of the National Defense Authorization Act for Fiscal Year 2009, which will be submitted to Congress next month."

Despite numerous requests for this report, we still have not received it. This report is considered by many to be critical for Congress to carry out its oversight. Can you tell us where that report is?

Mr. MCCARTHY. Yes, sir. First of all, with regard to the timeliness of the report, I'm absolutely defenseless. I know we are way late. I've signed out a new report, differently, entirely, from the one that was previously prepared, and it is being staffed in the Pentagon right now. I know that sounds exactly like what Tom Hall said a year ago. I will tell you, sir, that the CNGR report is, if not my highest priority, it's one of my highest priorities, in terms of implementing it, and implementing it effectively.

When I looked at the state of our implementation plan, when I arrived in July, I realized that we had not made anywhere near the progress of substantive implementation. We had a lot of process, but we didn't have much substance. We have worked hard on that, and I think that you will see, when we do get this report to you, that there has been substantive progress on many issues, there's hard work on others, and that we are taking the CNGR report with 100 percent seriousness.

Senator WEBB. Do you know when we're going to receive it?

Mr. MCCARTHY. Sir, I would hope that it will be to you within the month. It is a big, thick report. It's staffing around the Pentagon right now. I checked on it, right before I came over here, and I'm hopeful that we will have it to you within the month.

Senator WEBB. Thank you.

For all of the Reserve component heads, the questions that I asked of the people in the Guard, I would like to reiterate, that we'd like to get some demographic data, as well, on the different Reserve components—prior service, percentage over the age of 40, and percentage of those who were in other-than-organizational billets. General Stultz, you and I had a discussion about that yesterday when you visited. Just to get the demographics of the Guard and Reserve down so that we can have a way to understand the population

[The information referred to follows:]

The average age of Reserve component officer servicemembers (all Services) is 40.2 years old (median age is 40.0), while the average enlisted age is 30.8 years old (median 28). The average and median ages for all Reserve component members (all Services) are 32.2 years old (median 30).

Age	ARNG	USAR	USNR	USMCR	ANG	USAFR	USCGR
Approx. Average Age	30.6	32.1	35.1	26	35.1	36.3	34.7
Percent over age 40	23.6	29.5	38.4	0.9	38.0	43.0	34.0

Senator WEBB. General Stultz, what percentage of the Army Reserve has deployed?

General STULTZ. Sir, it's somewhat of a moving target, but right now approximately—if you use the latest figures we have, it's around 50 percent. Now, that sounds like we haven't used half the force, so there's this plethora of people out there. When we take the numbers and say, "Okay, let's look at—of the ones that haven't deployed, where are they?" First and foremost, there's about 14,000 to 15,000 that are in initial military training; those are the new recruits. There's another 15,000 to 20,000 that are preparing to deploy; they just haven't gotten there yet. There's another percentage that are in some kind of status, on a medical hold or something else. It gets down to—there's around 52,000 soldiers that I have in my 208,000 right now that are available and have not deployed.

Furthermore, when you break that down—and I don't mean to get into too much detail, but we study this all the time, because the question comes up—of that 52,000, 86 percent are E–5 or below. It's a lot of our young soldiers that are new recruits, and they are dispersed throughout the force, so it's not as if I can assemble an MP company or a transportation company out of this 50,000. Our force is very seasoned and very used.

What we have done is, we've arrayed the Army Reserve across a 5-year model to give our soldiers, number one, predictability, but, number two, to give the Army predictability about what kind of capacity and capability we can give you each year. The problem is, that's a supply-based system; we're reacting to demand right now, where the demand is higher than the supply.

But, we keep very, very tight control over how many of those soldiers are out there that are available that we have not used.

Senator WEBB. Thank you.

General Kelly, would you have a number on that for the Marine Corps?

General KELLY. It's very, very high, sir. First of all, all of the battalions and squadrons have been overseas, 100 percent. Considering turnover and whatnot—in each one of those units today, 70 percent of the marines have deployed overseas. The ones that haven't, simply because they've just joined the unit and they're just forming on the rotation. So, it's very, very, very high.

Majors and above, virtually 100 percent have gone overseas at least once—many, multiple times—either as individual augments or parts of units. What we find is, when another unit—as we get ready to deploy someone, we have a great many volunteers that want to switch units, get into that unit to go back over again. So, it's a very, very high percentage. Frankly, we don't see any strain on the force, the way it's working.

Senator WEBB. Admiral Debbink?

Admiral DEBBINK. Sir, we have approximately 65,671 in the Navy Reserve today. We've deployed over 66,000 mobilizations since September 11. That accounts for about 45,000 sailors. Some have done two, three, and four pumps.

Having said that, with a flow through the force over the last 9 years, we have approximately 26,000 that are available today for mobilization.

Senator WEBB. So, of the total number in the Navy Reserve today, how many have deployed?

Admiral DEBBINK. I'll get back to you on that.

[The information referred to follows:]

26,284 of 54,140 (48 percent) of the current members of the Navy Selected Reserve have deployed in support of the Overseas Contingency Operations.

Senator WEBB. A snapshot.

Admiral DEBBINK. Yes, sir.

Senator WEBB. Okay.

General Stenner?

General STENNER. Sir, I will also get back with you on the exact numbers.

[The information referred to follows:]

The total number of Air Force Reserve members who have deployed is currently 39,351. Approximately 55 percent of our total current force has deployed.

General STENNER. I would like to just put a little bit of a context on this one, as well.

We have, on any given day, roughly 7,000 folks on orders; 2,600 to 3,000 of those are deployed to the AOR. But, when you look at remotely piloted aircraft, when you look at the command-and-control—there's a lot of deployed in place, folks who are on orders, but they're right here in the CONUS. So, folks who have done their job are the folks who are staying with us, the retention piece; and I'll get you the demographics on how that works out.

Senator WEBB. Thank you.

Admiral Stosz?

Admiral STOSZ. Senator, we have augmentees that augment Active Duty Coast Guard units. When they are recalled, they, generally speaking, become part of the total force. Eighty percent of our reservists serve as part of the total force when they're augmented. We do have our PSUs that deploy overseas to serve as part of the Maritime Expeditionary Security Squadron; and those units go one at a time, and there's about 120 people in each of those. I'll have to get you the exact figure, sir, on how many Reserves we've deployed overseas in recent years.

[The information referred to follows:]

31 percent of personnel assigned to the Coast Guard Selected Reserve are mobilized and deployed in support of domestic operations and Overseas Contingency Operations.

Senator WEBB. Recognizing at the outset that each one of these components has its own personality and its own way of conducting operations, it's a question that varies, just in terms of the way people are used, I fully recognize that, going in. But, I'd be curious to see the data on it.

There's been a lot of discussion about the impact of these multiple deployments on employer relations. I know, General Stultz, you and I had a long discussion about some of the innovations that—putting in place in the Army Reserve. I'm curious to hear thoughts on where this issue is in the other components, and what might be done.

General Kelly, I'll start with you.

General KELLY. The first program, the Marine For Life Program, has proven effective, certainly since General Jones implemented it, some years ago. Other aspects of employer engagement have been very positive. In fact, we're all plugging into, now, Jack Stultz's program, in terms of reaching out to employers. So, within the Marine Corps Reserve right now, very little strain, in terms of jobs and employers and that kind of thing.

The one thing that I've learned, that I wasn't aware of before and does concern me, is, as these men and women deploy overseas, the one thing we can't capture—and they don't complain about it, but—is the opportunity lost. They're overseas when an opening comes up that they would normally at least have the opportunity to bid on, that would raise them up in the company. The employers can't wait, in many cases, for them to come back, and they're exactly the kind of an employee they'd want to have advanced. I was not aware of that before. I don't think there's any way to get our arms around that, other than to just hope. I find this is the case, that the employers are doing the best they can to hold these positions open.

Senator WEBB. Very good.

Admiral?

Admiral DEBBINK. Sir, we believe that our employers remain very supportive of our Navy reservists. We know that over 85 percent of those who deploy return back to their jobs. We hear, anecdotally, about issues and problems; but, every time we drill down into it—and I try to make employer visits in all of my travels—I hear nothing but strong support, provided that, when we employ our reservists, that we're validating the billet that we're sending them to, and that we're giving them real and meaningful work to do, so when they come back, they report back to their employer that, "I was well utilized."

The other thing that we're trying very hard to do is to stay to a 1 to 5 dwell, because that's also our promise to the sailor, his or her family—and to the employers.

Senator WEBB. General?

General STENNER. Sir, we have a very strong employer-relations/family-relations program that goes along with all of our units. We have "Boss Lifts." We have a strong relationship with the Employer Support in Guard and Reserve (ESGR) Freedom Awards. The anecdotal evidence that we get is that the employers are doing a fantastic job, making up differences in pay, and, in some cases, full pay and allowances for folks who are on orders. It's part of the fabric of how we're doing this Nation's business.

If I were to suggest anything, though, sir, I'd say that the Uniformed Services Employment and Reemployment Rights Act that was created many years ago wasn't necessarily written for the operational force that we have right now; it was written for that strategic reserve. Some of the numbers in there, and some of the nuances—it might be helpful if we could take a look at that and perhaps help our employers out in that respect—as well as our military members.

Senator WEBB. Admiral?

Admiral STOSZ. Mr. Chairman, when we recall our Reserves, oftentimes it's for shorter periods of time, as they're integrated in for

hurricane relief, or Haiti, or, now, the Deepwater Horizon oil spill. So, it's not much of a time that they're gone from their jobs that—the ones that deploy overseas are a smaller percentage. We haven't had any problems with our employers that have come to my level. We, in fact, had 15 of our reservists put in their employers for the Freedom Award last year. So, we do local outreach in our communities, and our reservists are probably spread far and abroad, more so than most of the other Services, to small towns. We do the small town local outreach, and it seems to be working.

Senator WEBB. General Stultz, I didn't mean to overlook you, since we had a long discussion yesterday. But, you've been something of a groundbreaker in this area.

General STULTZ. Yes, sir. The employer program—we started out—and, as I mentioned earlier, it's kind of snowballed on us, so now we have included all of the Reserve components as part of that—really has been a success story for us, because what we're finding, and what we have raised to the awareness of the business world, is, we have a treasure of talent, a treasure of talent in the Reserve components, that are drug-free, they're physically fit, they're morally fit, they've been given leadership, they've been given responsibility, they've been given self-confidence. It's a tremendous workforce out there, and, in a lot of cases, we've given them skill sets that apply in that civilian sector. So now the civilian business world is waking up to that and saying, "Wow, we really haven't taken advantage of this workforce out there."

For us, in the military, we can translate those civilian skills back into the military, because, in a lot of cases, if that engineer is working in the civilian workforce, he's probably working state-of-the-art, probably levels higher than the Active Army engineer force is working, because they just don't have that same level of technology. Especially, we see that on the medical side.

We're getting that embracing, now, from the civilian workforce of saying, "Let us take advantage of your soldiers. Bring us your talent." We have the partnerships with over 1,000 companies now across America who have said, "We want to use the Reserve components as our force of choice for the workforce."

I am a little concerned that, as General Stenner said, what the employers tell me is, "Okay, we want to partner with you, but we need some predictability to run a business." In today's environment, we have a lot of soldiers who are volunteering for duty. So, those employers say, "You told me he was only calling him up once every 4 years, but he just came back, and now he's gone again. How can I run a business?" So some of those situations, we have to take a look at. As General Kelly said, we're also seeing—I get resignations from officers every month who have completed their mandatory service obligation and have decided to get out. I read each one of those, the individual's statement as to why they're leaving the Service. In a lot of cases, it's family issues, it's other things like that, but, in some cases, they're saying, "I don't think I'm going to have the opportunity to reach the level, in my civilian job, if I stay in the Reserve, because of the commitment. I'm going to be taken away and miss opportunities." So, there are still concerns in that—the employer world, of: Are we, in some cases, not maintaining faith with the employers, in terms of our predictability, be-

cause of our volunteer situation? Then, second, are we not maintaining faith with our soldiers, in terms of, "They're not going to get, necessarily, all the opportunities in their civilian job"? So, it's not a perfect world.

Senator WEBB. Secretary McCarthy, would you have an overarching thought on that?

Mr. MCCARTHY. I'd just second everything that people have said. I congratulate the Chiefs on this initiative; and General Kelly, in particular.

But, I think that the world is changing. The idea of a rotationally available Reserve, whether there is a war on or not, or whether there's a hot war on or not, is going to change the way we relate to employers. Everything that we've done, historically, in ESGR has been about sustaining existing employment relationships. That's very, very important, and it has to continue.

We have to broaden, though, what we do in the ESGR to think about creating employment relationships, as well as sustaining the existing ones. We're focused on that.

As everybody has said, people come back, they have increased skills, they have increased capacity, they have increased confidence, and the job they left may not be the one they want to go back to. Many will come back and take advantage of the GI Bill, improve their education. Again, the job they left may not be the one that they want, because of their new education. We have to figure out a way to accommodate that.

The only other thing I would say is, I think we also have to understand that, if you want to have a career in this new era of Reserve, that's going to have some influence on what kind of employment. In the days when it was 1 weekend a month and 2 weeks in the summer, that could be accommodated to just about any kind of employment. A rotationally available force may have to reshape the way they think about their own personal employment if they want to make a career in that sort of a force. That's going to be a transition force.

Senator GRAHAM. Is there anything—and I don't mean to interrupt, but that's a good thought.

Senator WEBB. No, it's your turn.

Senator GRAHAM. Is there anything, legally, we can do, in terms of if we're going to go to that model, which makes sense to me, quite frankly, given where we're at and the threats we face, then do we need to adjust our laws?

Mr. MCCARTHY. Sir, there are a number of things that are working their way through the Department's legislative generation process. I won't get into details, but I do think that there is an area of opportunity for us, relative to health care.

One of the things that, for many, many years, we've talked about, in terms of this continuum of service—on-again/off-again service—is maintaining the continuity of family health care. If we can figure out a way to combine what we're doing with TRICARE Reserve Select and employer needs with regard to furnishing health care, there may be an opportunity for us to help both employers and Reserve component members. But, the specifics of that are very complicated. There's a lot of people over there working on it. But, I think that, in the not-too-distant future, this may be

something that the Department will want to talk to Congress about.

Senator WEBB. Thank you.

Senator Hagan.

Senator HAGAN. Thank you, Mr. Chairman. Thank you for holding this hearing.

Thanks, all of you.

Under the current law, servicemembers that receive educational assistance in the form of an ROTC scholarship, or that graduate from one of our service academies, are still eligible for full educational benefits under the post-9/11 GI Bill. However, members of the Selected Reserve that received educational assistance under Chapter 1606 of the Montgomery GI Bill prior to receiving a commission and serving on Active Duty are not similarly entitled to 4 years of benefits under the post-9/11 GI Bill.

My question for all of you is, are the Reserve components concerned that the significant disparity in benefits may dissuade college students who are interested in a commission from participating in the Selected Reserves while attending college?

Mr. MCCARTHY. Senator Hagan, I'll just try to take——

Senator HAGAN. Okay.

Mr. MCCARTHY.—just very, very generally, and then let the Chiefs hit the specifics.

I think that we all recognize that, as we work into the post-9/11 GI Bill, there's probably some adjustments that need to be made. I know that a number of them are being looked at. I'm not familiar with the specific one that you've mentioned, but it sounds like something that we should be, and perhaps are, looking at.

I think that, overall, everybody is tremendously pleased with the post-9/11 GI Bill, but we recognize that there are probably some adjustments that need to be made going forward.

General STULTZ. I'd just speak from the Army's perspective. I kind of echo what Secretary McCarthy said. I don't know the specific details of the situation you're explaining. I do know that the post-9/11 GI Bill has been a huge benefit. As we conduct townhall meetings, there are several things soldiers say: the retirement, they're concerned about that; the education benefits now, for their families, so they see this as enabling them to give something to their families; and the continuum of health care. Those are the three big issues that they say—if we can solve those—I think we can pay for a lot of those, because we will not have to pay the retention incentives and some of the other incentives, to the degree that we're paying now, because the incentive for being in the Reserve and staying in the Reserve is going to be education benefits, health care benefits, and retirement benefits.

Senator HAGAN. Anybody else, on that particular issue?

I've actually talked to individuals, and I know that the post-9/11 GI Bill is generous to a vast majority of servicemembers; and I hear from people all the time how pleased they are with the funding that they're getting to go back to school. But, there are certain groups within the armed services that, based upon the programs that they entered through, are not fully served under the legislation as it's currently written, despite providing this—these individuals providing the same military service as their counterparts.

I'm actually looking at introducing a bill on this pretty soon which aims to address, I think, just this act of disparity and this issue. So, hopefully we'll be hearing a little bit more about it.

There's also a tremendous cost associated with recruiting and retaining—recruiting and training our servicemembers, which becomes even more pronounced when replacing midgrade noncommissioned and commissioned officers.

General Stultz, I was wondering, are there statutory or policy changes that can be implemented, with respect to continuum of service, that would make it easier for Reserve component soldiers to voluntarily serve on Active Duty?

General STULTZ. I think most of it is policy, not statute. But, I think the—and General Debbink can—or, Admiral Debbink—I'm promoting him to the Army side——[Laughter.]

Admiral Debbink and I were talking earlier about this, that the Navy, for instance, in the Navy Reserve and the Active naval component, have come much further than we have, in my opinion, on the Army side, in a continuum of service, where we have made it fairly easy for servicemembers to move from Reserve into the Active Force, but we have not made it as easy for the servicemember to move from the Active back into the Reserve Force.

One of the things that we're working with Secretary McCarthy's office, and with the G–1, and other personnel in the leadership of the Army is, we truly have to get a continuum of service, where soldiers can flow from Active into the Reserve, to take a knee into the Individual Ready Reserve (IRR) to further take a knee, if they want to, and then be able to have the confidence to flow back into the Active Force, if the opportunity is there, because in some cases, there's not a need, and the Active Force simply says, "I can't take any more of these." But, if the opportunity is there, to flow back and maintain that continuum of service.

The other thing that we've discussed, and I know I've talked with Senator Graham about, is in the retirement. I would like to see a system where we reward soldiers who are eligible to retire in the Army Reserve—they have their 20 years of service—but we retain them past that 20 years of service by lowering, eventually, their retirement age, because, again, that is a retention tool that doesn't have an immediate cost. It has a long-term cost, but we retain that talent that we've invested so heavily in.

Currently, with the operational tempo, a soldier gets his 20 years of service, he may not be able to draw his retirement for another 25 years, and there's no incentive for him to stay, except that his love of his country and his love of the Service. But, he has to confront that spouse at home and say, "Why are you re-upping when they're not going to give you anything except another deployment?" Somehow, we have to put something out there.

When I talk to soldiers about, "What if we rewarded you for staying beyond 20 by lowering your retirement age?" That rings home to them. Now, the caveat I've put on them is, selective retention that you may not get to stay as long as you want if you haven't served your country and done your education and physically fit and all the other requirements.

Senator HAGAN. Sure.

General STULTZ. So, the fact that we may be able to put a carrot at the end of the table here for you, you're going to have to earn it.

Senator HAGAN. Thank you. I look forward to continuing to work with you as your command is relocated to Fort Bragg.

General STULTZ. Yes, ma'am.

Senator WEBB. Thank you, Senator Hagan.

Senator HAGAN. Thank you.

Senator WEBB. Just let me, as the Chair, make a couple of comments.

First, also, as the person who wrote the GI Bill, and then who worked hard with Senator Graham to put some of these other provisions in that, we know there's places where we need to refine it, there were two original intentions when it came to the Guard and Reserve components. First of all, was to include them for the first time in a GI Bill. It never happened before. We've done that, and then, there was a big discussion with respect to ROTC scholarship programs, service academy programs, where the initial period of service was actually a payback for having received an education. So, the question was, do you double count that first 5 years of Active service for a GI Bill when the education had already been the result of the Federal Treasury? So, that's an issue, it sounds to me, like you were asking a question about here, with the ROTC programs and the Reserve.

Just as a matter of clarification, General Stultz, I've never heard the IRR termed the "Inactive Ready Reserve."

General STULTZ. Individual.

Senator WEBB. Individual Ready Reserve. I mean, it—I hear this a lot, and I think it's important——

General STULTZ. Yes, sir.

Senator WEBB.—to clarify it. That's basically a SELRES without it being in a unit. It led to a question that I wanted to ask both you and General Kelly, and that is, what percentage of today's IRR do you consider to be of the physical quality to be deployed?

General STULTZ. Yes, sir, we have come great strides, in terms of getting our hands around the IRR in the Army. As you may know, the IRR for the Army does not belong to the Army Reserve, it belongs to the Active Army; it's under Human Resources Command for the Army. We help administer the program.

What we started—and it's part of the initiatives that you started, years ago, I think, when you were Secretary of the Navy—is, the muster formations. In the past 2 to 3 years——

Senator WEBB. Actually, when I was Assistant Secretary of Defense, we did——

General STULTZ. Yes, sir.

Senator WEBB.—the first call-up of the IRR—1-day call-ups, just to try to get the addresses down and get a physical and get people 1-day pay, travel, and proceed, find out where they are, see if they're actually a mobilizable asset.

General STULTZ. Yes, sir. We, in the past 2 to 3 years, have really gotten very active in the musters around the country. We've gotten very good results in the muster formations. We have improved our overall accountability and our overall readiness in the IRR, but we've also seen the numbers in the IRR decline significantly as

people elected to get out of the IRR, didn't realize they were in the IRR, because they had not resigned their commissions, in some cases. So, the IRR numbers for the Army Reserve—or, for the Army right now, that we're overseeing, is about 68,000, where it used to be several hundred thousand.

Senator WEBB. Yes.

General STULTZ. So those numbers have gone down. But, the individuals that are there, we feel very confident that they're available for service, if needed.

Senator WEBB. General Kelly?

General KELLY. Yes, sir. Senator, I have 55,000 in the Marine Corps IRR. They essentially belong to me; I manage them. My Mobilization Command is very aggressive in, as you've described, contacting them periodically, bringing them in for a day. Actually, for what we really need them to come in for, it takes about 20 minutes; and that is, to look at them and make sure they haven't grown their hair too long, they haven't grown a beard, and they haven't put on too much weight.

We use the rest of the day, though, actually, to bring an awful lot of agencies in—the VA and people like that—where they weren't so interested in meeting with these folks of various agencies, they would just—when they decided to get out of the Marine Corps—they were just intent on getting out—as young men and women—just wanting to start something new. When we bring them in for these musters, they're very, very interested at that point. As I say, we bring in various job search agencies—the police, recruiters, everybody. We have a very, very high response, and those that come in—the people that do this to—with thousands of these IRR marines every year—as a general rule, they remain in pretty good shape. As I say, an awful lot of them do respond.

During the war, we've involuntarily called up 3,800. I think, as of today, there's probably zero. There were a few residual that were getting off. All of them that we called up, in the period starting about 5 years ago, all came to the colors ready to go, and were in very good shape. Very, very few of them did we have to not bring on. They were all candidates to bring back on. Very few of them had any problems with the police or medical or whatever. So, it's a good program. Another part of the IRR, of course, is when people can't drill anymore, but want to stay associated, affiliated, they'll drop to the IRR; and then periodically we'll go looking for them, and they'll come out of the IRR and either become individual augmentees or start drilling again. So, it's kind of an in-and-out thing. Overall, very successful.

Senator WEBB. Good, thank you.

Senator Graham, do you have any comments?

Senator GRAHAM. Yes. It's been a great hearing. Thank you, Mr. Chairman.

One last thought and then I'm going to have to run. You all have been very informative.

Mr. Secretary, this idea of mobilization and the way the law works, apparently the Coast Guard has a different system. I think we need to look long and hard at finding a way to call people in from the Reserves to Active Duty for limited periods of time without presidential consultation, because we're more in an operational

mode than ever. I would just challenge the Department to sit down with us and find a way to adjust these laws to make it more flexible for our reservists to be able to be utilized, because, as General Stultz said, that they want to be used if they're going to be trained. I want to make sure they can be used in a logical way.

So I look forward to getting your input as to how to change the law, because I think the law needs to be changed, quite frankly.

Mr. MCCARTHY. We're anxious to work with you on that, sir, because getting access under this new paradigm of rotational availability is high on, I think, everybody's priority list.

Senator GRAHAM. Right. Thank you.

Thank you, Mr. Chairman.

Senator WEBB. Good. Thank you, Senator Graham.

I'd like to express my appreciation to all of you for your testimony today, and for the leadership that you are bringing to your different components.

We will have follow-on questions. The hearing record will be kept open until close of business tomorrow, in case other Senators have questions for the record.

I appreciate your testimony and also having had to wait for us today.

We are adjourned.

[Questions for the record with answers supplied follow:]

QUESTION SUBMITTED BY SENATOR JIM WEBB

RESERVE DEMOGRAPHIC

1. Senator WEBB. General McKinley, General Wyatt, General Carpenter, General Stultz, Admiral Debbink, General Kelly, General Stenner, and Admiral Stosz, please provide demographic data on the actual numbers of Guard and Reserve members in your Service that are prior service, the number that are more than 40 years of age, and the number of those who are assigned to an organizational billet. The numbers should include Individual Mobilization Augmentees (IMAs).

General MCKINLEY. Of the 363,357 soldiers in the Army National Guard, 154,287 (43 percent) came to us with prior service backgrounds. There are 77,213 (21 percent) soldiers over the age of 40. Currently, 321,750 (89 percent) soldiers are assigned to MTOE units.

Of the 108,386 airmen in the Air National Guard (ANG), 43,858 (40.5 percent) came to us with prior service backgrounds. There are 70,419 (65.0 percent) airmen over the age of 40. Currently 108,836 (100 percent) airmen are assigned to an organizational billet.

General WYATT and General STENNER. The requested Air Force Reserve (AFR) demographic data is as follows: There are 41,827 Air Force reservists that are prior service. Included in this number are 7,041 reservists who are IMAs. There are 27,846 Air Force reservists over 40 years of age. Included in this number are 4,731 reservists who are IMAs. All Air Force reservists are assigned to an organizational billet.

General CARPENTER and General STULTZ. All members in the Army Reserve (USAR) Selected Reserve (SELRES) are assigned against organizational billets. The USAR does not have an "assigned not joined" category, and does not command the Individual Ready Reserve.

	Assigned	Percent of Assigned
Total SELRES	207,660	
Age 40 & Over	56,013	27
Prior Service	69,967	34

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Of the 108,386 airmen in the ANG, 43,858 (40.5 percent) came to us with prior service backgrounds. There are 70,419 (65.0 percent) airmen over the age of 40. Currently 108,836 (100 percent) airmen are assigned to an organizational billet.

Admiral DEBBINK.

(a) 72 percent (46,964 of 65,671) of the Navy Reserve had prior service in the Armed Forces when they affiliated with the Reserves.

(b) 27 percent (17,431 of 65,671) of the Navy Reserve is older than 40 years of age.

(c) 82 percent (42,717 of 53,542) of Navy Selected reservists are assigned to an organizational billet.

General KELLY. 3,186 officers and 6,704 enlisted SELRES members have previously served in the Active component.

2,812 members are more than 40 years of age.

33,298 members are assigned to an organizational (Selected Marine Corps Reserve unit or IMA) billet. An additional 2,282 are assigned to the AR program.

Admiral STOSZ. Currently, 31 percent of personnel assigned to the Coast Guard SELRES are mobilized and deployed in support of domestic operations and Overseas Contingency Operations (OCO).

QUESTIONS SUBMITTED BY SENATOR ROLAND W. BURRIS

DIVERSITY

2. Senator BURRIS. General McKinley, the National Guard is the largest Reserve component force in our military, but its diversity has the worst actual numbers and percentages of minorities and women in the colonel and general officer ranks. Particularly the Army National Guard and the fills in the full-time positions are much worse. Explain to me why this situation exists?

General MCKINLEY. I share your concern in ensuring our military, in particular the National Guard, has representation in our senior ranks that reflects the diversity of the population we serve. The conflicts we are currently facing, as well as the environments that our men and women in uniform will face in the future, clearly indicate that diversity in thought, in perspective, and in experience is and will remain critical for success in conflict prevention and on the battlefield.

In the past fiscal year, minority membership in the National Guard stood at over a quarter of our assigned strength. Seven percent of National Guard General Officers (GOs) are women, 5 percent are Black/African American, and 3 percent are Hispanic. In regards to colonels, nearly 10 percent of National Guard colonels are women, 5 percent are Black/African American, and 5 percent are Hispanic.

The National Guard leadership is committed to increasing the diversity across our entire force, and will continue to focus efforts on recruiting, retaining, mentoring, and promoting up through the ranks a sufficiently diverse pool of officers from which to select our most senior leaders.

3. Senator BURRIS. General McKinley, what are your plans to increase diversity within the senior ranks of the National Guard?

General MCKINLEY. The National Guard has taken several major steps to ensure that diversity is an active and critical component of the culture of the Guard. I have created the office of the Special Assistant for Diversity to provide oversight and guidance to National Guard leaders, at all levels, to aid in the creation and implementation of diversity strategies. In addition, I have formed the Joint Diversity Advisory Council (JDAC) made up of TAGs, ATAGs, Senior Enlisted, Junior Enlisted, both Army Guard and Air Guard. The National Guard Bureau's Joint Diversity Advisory Council's mission is to initiate and support those activities that increase diversity and promote cultural competency among all members of the National Guard by fostering a learning environment that accepts and bridges the gaps between persons of all cultures, genders, and religious differences in today's multicultural world.

JOINT QUALIFIED

4. Senator BURRIS. General McKinley, General Stultz, Admiral Debbink, and General Kelly, there has been a lot of emphasis on joint operations, and the Reserve components are far behind the Active components in getting their officers joint qualified. Current statistics show that the Reserve components only have 1.1 percent of their eligible officers qualified in joint operations, whereas the Active components sit at almost 47 percent. This is largely due to the fact that the Reserve components only began participating in the Joint Qualification System in October 2007.

However, some emphasis on getting officers joint qualified is clearly needed. Explain your plan for getting officers in your Service joint qualified.

General MCKINLEY. We agree with your assessment of the importance of getting National Guard Officer Joint qualified. There are several factors that impact joint qualification opportunities for National Guard officers. A significant factor is the limited number of joint positions available for assignment of National Guard officers in which to earn the joint credit. Presently, there are 124 Joint Duty Assignment List (JDAL) positions designated for National Guard officers. Other opportunities exist in the form of mobilization tours and perhaps limited Active Duty tours for our officers to be assigned against Active component positions.

There is an additional piece of the equation for obtaining joint qualification, and that piece is education. In order to enhance our ability to attain joint qualification for our officers we need an increase in the availability of the Joint Professional Military Education II (JPME) awarding courses. With the completion of the JDAL assignment and JPME I and II, we can ostensibly produce 41 joint qualified officers per year though the Standard-JDAL Path.

Once we have established Joint Force Headquarters (JFHQs) on the Joint Manning Documents a few Traditional/M-Day State positions may become JDAL billets. Incumbents of these positions would need to serve in these JDAL positions for a total of 6 years in order to earn the required points to become joint qualified. We are working with the Chairman of the Joint Chiefs of Staff and his staff to expand our opportunities for fully developing joint qualified officers. For example, the Reserve officer timeline is being reviewed to determine if there is a way to reduce the timeline without diminishing the integrity of "joint qualification". Furthermore, we're seeking increased educational opportunities in order for National Guard officers to participate in programs along side of our Active component counterparts.

Through a combination of joint duty assignments, mobilizations, and utilization of limited existing educational opportunities, we have managed to improve our joint qualification status over the past 3 years. Over 114 National Guard officers have been granted some experience points through the self-nomination process. Also 35 members have been granted Level II Joint Qualification and 25 members have been awarded the Joint Qualification Officer Designation. With the increase of additional JDAL positions and JPME II awarding school quotas, we can improve these numbers.

General STULTZ. Although much still needs to be completed to significantly increase the joint qualification rates for USAR officers, some important steps have been taken towards that goal.

In March 2008, the Reserve Component Officer Joint Qualification Program Guidance was published. This established two paths for traditional Reserve officers to become qualified in joint operations. Through this program, Reserve officers can accumulate joint credit via a Standard Duty Assignment (S–JDA) path or the Experience Joint Duty Assignment (E–JDA) path. The S–JDA credit comes from assignments on the Joint Duty Assignment List (JDAL), while the E–JDA credit comes from joint experience gained while in positions not on the JDAL or from appropriate civilian experience. The E–JDA path is critical for traditional reservists, who typically gain joint experience from periodic or temporary joint assignments.

The importance of joint qualification is being communicated by several methods. We have delivered several strategic communications to all USAR officers explaining the process to apply for joint credit, and promotion boards are being instructed to consider joint qualification in determining the best-qualified officers.

One of the challenges to increasing joint qualification across the USAR is the current lack of Troop Program Unit (TPU) positions on the JDAL. Additionally, a final determination has not been made on the tour length requirement for TPU soldiers to receive S–JDA credit. Finally, the USAR is attempting to identify TPU positions eligible for E–JDA that are not associated with deployments.

Joint qualification ensures that leadership has the critical thinking skills and experience to conceive and apply joint solutions to the 21st century battlefield. We will continue to take the necessary steps to increase the number of USAR officers qualified in joint operations.

Admiral DEBBINK. JPME education is the foundation of the Joint Qualification System and Navy Reserve has funded 100 percent of our in-residence quotas (70 total for JPME I/II enrollment) in fiscal year 2010. Additionally, we have funded distance learning courses (~500 personnel) for JPME phases I and II annually. Of note, we also seek out and regularly fill unfilled Active component quotas in the various JPME phase I and II courses. In fiscal year 2011, we requested and received 10 additional in-residence quotas per year and will continue to offer these joint education opportunities and others to our sailors in the future.

OCO over the past several years have given Reserve officers, both full-time support (FTS) and SELRES, more opportunities to become a Joint Qualified Officer (JQO) through experience tours. With the implementation of the Joint Qualification System Experience Review Process, Reserve officers have been able to gain parity with Active officers in receiving credit for their joint experiences while on Active Duty. Since October 2007, the approval ratings for joint credit submitted for panel review for Navy Active and Reserve officers is at 85.7 percent and 85.2 percent, respectively. Of the total 39 Navy Active and Reserve officers who have attained JQO status via the Experience Review Process, 22 (56.4 percent) are from the Active component and 17 (43.6 percent) are from the Reserve.

For SELRES, joint qualification is more challenging because of the present requirement to serve for 72 months in a Standard Joint Duty Assignment (S–JDA) position. The Navy Reserve is working with the Office of the Secretary of Defense (OSD), the Joint Staff and the other Services to develop policies that will enable SELRES officers to attain joint qualifications within the construct of their existing annual service requirements. One of the recommended policy changes is to decrease S–JDA tour lengths for drilling reservists to provide members with increased flexibility. However, this will require SELRES officers to serve in more than one joint assignment to meet JQO requirements.

Today, most SELRES officers are achieving JQO through experience credit for qualifying joint experiences. However, as operational requirements change or are reduced, this will impact our members' ability to achieve the requirements of JQO Levels II, III, and IV through the experience track. Because of this, it is imperative more SELRES Joint Duty Assignment List (JDAL) billets are identified to enable Reserve officers to qualify via the standard path. The Services are expecting the next JDAL, scheduled for release in late summer, will contain many Joint Staff headquarters SELRES positions. These positions will aid in providing SELRES officers with opportunities to qualify for JQO designation through the S–JDA process in the future, but more Reserve component JDAL billets are still necessary to provide a viable part time path to JQO for Reserve component officers.

General KELLY. We continue to emphasize the importance of having our Reserve officers become joint qualified. The first step in our plan is for all field grade Reserve officers to complete Phase I of JPME qualification. We ensure our Reserve officers have several opportunities to complete JPME I by offering both resident and non-resident courses. Resident courses provide the opportunity for the individual reservist to participate in the full-length 10 months of course work. Resident courses are challenging for the Reserve component officers to attend. We currently receive 16 school seats from the four Service Command and Staff colleges; however, the limiting factor is the ability of the Reserve officer to be able to take 9 to 10 months off from civilian employment to attend a full-length school. While use of resident courses has been challenging, we have seen success in increasing the rate of JPME I qualified Reserve officers through our non-resident weekend seminar program. This fully funded program offers Reserve officers an opportunity to attend monthly seminars at one of 16 different locations across the country.

While not in great number, we also receive school seats and encourage attendance at JPME II accredited resident programs at the Service War Colleges and combined (JPME I & II) programs at the National War College, Industrial College of the Armed Forces, and the Joint Advanced Warfighting School. Again, the issue is more of time for the Reserve officer. We will need to explore additional opportunities for our Reserve officers to receive JPME II as the Marine Corps currently does not have a seminar program for JPME II.

The most challenging issue with Reserve officers obtaining the Joint Qualification is finding the billets and the time to serve either 2 years in a full time or a cumulative 3 years in a Joint Duty Assignment—Reserve. Without a change to this requirement for Reserve officers, we do not foresee our rate of fully joint qualified officers increasing dramatically.

5. Senator BURRIS. General McKinley, General Stultz, Admiral Debbink, and General Kelly, have you budgeted for joint qualified in the Program Objectives Memorandum?

General MCKINLEY. Yes, we have budgeted for Joint qualified courses. There are a number of courses in the Army National Guard (ARNG) program which provide joint certification or credit. Seat allocations for joint courses are determined at an annual Structure and Manning Decision Review. The joint courses for professional education (JPME) are the following:

- Resident Intermediate Level Education Course (JPME level I)—~40 seats/year
- Resident Army War College (JPME level II)—~17 seats/year

- Joint Advanced Warfighting School (JPME level II)—one seat every other year
- Reserve Component National Security Issues Seminar (2 Joint Qualification Points)—25 seats/year
- Reserve Component National Security Course (2 Joint Qualification Points)—25 seats/year

The ARNG does not program for, or receive seat allocations for Advanced JPME; we receive limited seats from Human Resources Command during the current year.

General STULTZ. Yes, the USAR has programmed the school seats necessary to support the educational requirements for the joint qualified designation.

Admiral DEBBINK. Yes; the joint education programs are high on our priority list, and we have budgeted for the JPME quotas as part of our RPN discretionary funds. Additionally, we have funded and budgeted for the Naval War College distance learning materials from OMNR funds.

General KELLY. Joint qualified can be achieved in two different ways: (1) through attendance at a formal PME school and PCS to a 3-year joint billet; or (2) attendance at a formal PME school plus 3 years cumulative time in joint billets. COMMARFORRES does not have any direct resourcing responsibilities with regard to the joint qualification of the Reserve component. Conversely, TECOM budgets/programs for all joint PME formal schooling to include associated temporary assigned duty and M&RA budgets/programs for all associated PCS to joint billets.

6. Senator BURRIS. Secretary McCarthy, General McKinley, General Wyatt, General Carpenter, General Stultz, Admiral Debbink, General Kelly, and General Stenner, in 2001, OSD, Reserve Affairs, in a report for the 2001 Quadrennial Defense Review, outlined a new approach to military service as a continuum between full-time duty and service for only a few days a year. The report suggested "a new availability and service paradigm—referred to here as a continuum of service (COS)—that provides individual servicemembers greater flexibility in becoming involved in and supporting the Department's mission. In turn, the Department would have greater flexibility in accessing the variety of skills required to meet its evolving requirements." What are your thoughts on the COS initiative?

Secretary MCCARTHY. The Department of Defense (DOD) is committed to an effective COS. Faced with the competing demands of providing an affordable national defense and maintaining the all-volunteer character of the military, we must find an approach that facilitates the maintenance of a balanced Total Force. The Reserve components must provide a trained and cost-effective expansion force, ready to augment and reinforce the Active component, in time of war and in support of other contingencies.

Statutory policies and directives, as well as cultural, financial, and technological factors, often impede the seamless movement of Total Force members between components. In combination, these factors can constitute barriers that seriously diminish the capacity of the Department to acquire and retain the personnel and skills needed today and in the future.

The goal of the COS is to dissolve the lines between Active component and Reserve component duty so movement from one to the other status offers optimum operational flexibility. The COS also facilitates different levels of part-time affiliation that are more consistent with how Guard and Reserve members are currently being utilized.

General MCKINLEY. In many ways, both the COS and the Operationalization of the Reserve Component concepts are essentially a reflection of the modern reality in the National Guard. These concepts help the National Guard Bureau shape our strategic planning, particularly in terms of utilization and development of our human capital, our soldiers and airmen. In the National Guard, our principal effort related to the COS is an initiative focused on Senior Leader Development. Key leaders from both the Army and ANG from across the Nation have been helping to generate new policy initiatives to ensure that our assignment, education, and promotion policies all facilitate the repeated changes in duty status—from traditional guardsman to mobilized soldier or airman to Active Guard and Reserve (AGR) and back—that are required in order to sustain our support of OCOs. These initiatives both touch every member of the National Guard, but not in a negative way. Every Guard soldier or airman in our all-volunteer organizations has either joined the Service or made a decision to reenlist or extend at some point following September 11. Our force consists of soldiers and airmen who have chosen to be a part of an operational force. The policy initiatives aren't intended to ask more of them, but rather will ensure that we maximize opportunities for their growth and development in support of operational requirements. The COS ready set for the National Guard means that members of the National Guard have a broader exposure to point qualification train-

ing, assignments, and immersion in positions of increased exposure and familiarization of multiple service duties (both Title 10 and Title 32). Additionally, the alignment of authorities for call to duty are broader with a range of purposes. Today the National Guard has 27 duty statuses that require new orders for the specific purpose of duty. Each of these purposes must be aligned with either title 10 or 32 and we propose that once a member is called to duty in either title 10 or title 32 status that a range of purposes could be proposed with one single call to duty order thus reducing the complexity of systems of record and cascading pay and entitlement changes. While the COS initiative could remove barriers, we must continue to balance the demands of our soldiers and airmen in relationship to their time away from employers and family. Both of these are absolutely critical so they must be carefully considered when reviewing readiness training and further development of our force. We will carefully consider this stewardship and fragile balance of demands.

General WYATT and General STENNER. The COS initiative is an initiative we support, and we have to get it right. Moving between total force components can be difficult. Airmen often encounter barriers when transitioning between the AFR, ANG, and the regular Air Force. The depth and breadth of the skills of our highly trained, ready force means nothing if our airmen are not accessible.

The COS initiative is our consolidated, Total Force effort to increase that accessibility by eliminating barriers to participation and exploring creative, innovative paths to service. Through this initiative, the AFR seeks to remove the barriers to service which encumber the seamless movement between duty statuses required to support total force operations. Two examples of barriers that the COS initiative is working to address include streamlining the accession process from military to civilian government employment and easing a member's transition between components without jeopardizing pay or medical care.

With the removal of barriers like these, the COS initiative can promote the development of a total force human resource management system that retains highly skilled airmen for a lifetime of service. This also means making sure people who leave the Active component have an option to continue serving in the AFR as part of a COS.

The AFR is 100 percent behind each Total Force initiative and is an active team member at the COS table. We are diligently working to continue to identify the existing barriers so we can eliminate those we can and minimize the rest.

General CARPENTER. In many ways, both the COS and the Operationalization of the Reserve Component concepts are essentially a reflection of the modern reality in the National Guard. These concepts help us to shape our strategic planning, particularly in terms of utilization and development of our human capital, our soldiers and airmen. In the National Guard, our principal effort related to the COS is an initiative focused on Senior Leader Development. Key leaders from both the Army and ANG from across the Nation have been helping to generate new policy initiatives to ensure that our assignment, education, and promotion policies all facilitate the repeated changes in duty status—-from traditional guardsman to mobilized soldier or airman to Active Guard and Reserve (AGR) and back—that are required in order to sustain our support of OCOs. Frankly, these initiatives both touch every member of the National Guard, but not in a negative way. Every Guard soldier or airman in our all-volunteer organizations has either joined the Service or made a decision to reenlist or extend at some point following September 11. Our force consists of soldiers and airmen who have chosen to be a part of an operational force. The policy initiatives aren't intended to ask more of them, but rather will ensure that we maximize opportunities for their growth and development.

General STULTZ. Ensuring a COS is a human capital objective seeking to inspire soldiers to a lifetime of service. An effective COS would allow an individual to serve a career seamlessly transitioning between Active (full-time), Reserve (part-time), or civilian status based on both the needs of the Army and the needs of the individual. As national security demands and personal circumstances change, the soldier's status could change without severing his or her military affiliation. A COS would provide the Army's personnel management system maximum flexibility allowing the Army to leverage talent, military and civilian skills, experience and expertise at the right place and time for maximum impact. A fully functioning continuum would be cost effective, reducing recruiting, retention, transition and training costs. Establishing a truly functional COS requires modifying policies, processes, and some statutes to define training and professional development, career benefits (compensation, entitlements), transition requirements, and management procedures. The Army currently is moving incrementally toward a COS. The end-state is to maintain a comprehensive system of human capital management (COS) utilizing the best talent

available to ensure national security. Achieving the end-state will require the cooperative efforts of the Army, DOD, and Congress.

Admiral DEBBINK. The Chief of Naval Operations, Admiral Roughead, has described COS as a strategic imperative. Navy's vision is a personnel management system that allows us to recruit sailors once and retain them for life through variable and flexible service options providing a career continuum of meaningful and valued work. COS allows the ability to change lanes easily from Active to Reserve and back again which will pay significant dividends for both our people and the Navy. COS will: help improve life-work balance and flexibility for our military personnel; improve retention and fit; and decrease recruiting costs by allowing recruiters to focus on people joining the Navy for the first time, instead of re-recruiting our veterans. The COS value proposition is a ready, relevant, and cost-effective workforce that provides both operational flexibility and strategic depth at the most value to the Navy.

General KELLY. MARFORRES generally supports efforts to improve the COS, but believes these efforts need to be tailored to each Service's unique requirement. Currently (as provided by RA) the Marine Corps has no official position regarding this question.

7. Senator BURRIS. Secretary McCarthy, General McKinley, General Wyatt, General Carpenter, General Stultz, Admiral Debbink, General Kelly, and General Stenner, how many Reserve component personnel are affected by this policy and what are the projected costs?

Secretary MCCARTHY. The COS concept applies to all military servicemembers in the Active component (1.4 million) and the Reserve components (851,000 Selected reservists and 218,000 Individual Ready reservists).

A comprehensive cost analysis of this policy has not been completed. Individual legislative proposals supporting this initiative are forthcoming and will include cost estimates when applicable. The remaining issue is access to servicemembers and reducing the barriers that impede the seamless movement of Total Force members between components. The COS capitalizes on the operational experience of the Active Guard and Reserve components and enhances a return on our training and education investment. Making the best use of our military talent pool, particularly in an era of increasingly constrained resources, translates to a more capable force at a lower cost.

General MCKINLEY. The COS is a human capital strategy rather than a program or policy, as a result the National Guard Bureau cannot at this time provide the number of Reserve component personnel that would be affected or a projected cost. However, this strategy would impact the majority of Reserve component personnel. For example, there are multiple barriers that cause interruptions in pay, benefits, and entitlements when Reserve component members transition the continuum of Active, Reserve, civilian, and inactive service. Removing these barriers would go a long way toward achieving the goal of retaining and effectively employing highly qualified military members throughout their careers.

General WYATT and General STENNER. Since 2007, the Air Reserve Personnel Center (ARPC) has processed approximately 583 joint applications (480 in the Joint Management Information System and 103 in the legacy system). Of the 583, only 13 officers are fully Joint Officer qualified (level III) while 34 are level IIs. Our numbers are low because all eligible Reserve officers have not yet applied. We are diligently communicating joint requirements and application processes.

We are focusing our efforts on increasing the number of AFR positions on the Joint Duty Assignment Listing (JDAL) as well as slots in joint education schools. We are reviewing AFR billets (Active Guard and Reserve, IMA, and traditional reservists) that the joint matters definition and collaborating with combatant commanders' (COCOM) staffs to address those eligible for JDAL inclusion. This allows us to make the best use of existing resources and appropriately acknowledge the individuals working in those positions doing joint work. This effort is accompanied by pursuit of the training slots which must/should go with the JDAL billets in order to get our officers formal joint qualifications. Lastly, we have a deliberate methodology to move our younger officers—in particular our developmental education graduates—into joint experiences early in preparation for future opportunities as senior officers.

To date, the costs have been negligible. We are working with the COCOMs to redesignate already funded full-time and part-time billets into the JDAL. The only other costs at this time have been the manpower costs associated with administering this program, which equates to approximately three full-time equivalents. These costs have been absorbed into executing our existing personnel programs.

General CARPENTER and General STULTZ. The COS is a human capital strategy rather than a program or policy, as a result the National Guard Bureau cannot at this time provide the number of Reserve component personnel that would be affected or a projected cost. However, this strategy would impact the majority of Reserve component personnel. For example, there are multiple barriers that cause interruptions in pay, benefits, and entitlements when Reserve component members transition the continuum of Active, Reserve, civilian, and inactive service. Removing these barriers would go a long way toward achieving the goal of retaining and effectively employing highly qualified military members throughout their careers.

Admiral DEBBINK. Because the COS is a key element of a comprehensive personnel management strategy that provides service options to both Active and Reserve component sailors, every sailor in the Navy Total Force is affected by COS initiatives. COS is not a Reserve-centric imperative.

Although initially there are costs associated with realignment of personnel and programs to support COS efforts, it is anticipated that the benefits of these initiatives when realized will be fiscally positive. Specifically, the COS value proposition benefits recruiting and training efforts, reducing costs as sailors are afforded flexible service options to seamlessly transition between Active component and Reserve component. COS will help our Navy more efficiently retain the talents of a skilled and ready workforce and provide a career continuum of meaningful and valued work. COS will ultimately allow an individual to have the option to serve over the course of a lifetime.

General KELLY. We are unable to provide an accurate answer to this question within the allotted timeframe. This question will require detailed analysis by the Service Level Headquarters.

8. Senator BURRIS. Secretary McCarthy and General McKinley, how does DOD plan to implement the COS policy?

Secretary MCCARTHY. The Report of the Commission on the Guard and Reserve included 14 recommendations on the COS. In responding to these recommendations, the Department has made significant progress on the establishment of a joint duty career path for Reserve officers and enlisted members. The Department is developing a civilian skills data base to allow Reserve component members to enter and receive credit for civilian training and skills.

Additionally, a Joint Service COS Working Group was established to identify and eliminate barriers to fielding capabilities by providing seamless transition between Total Force components (Active component, Reserve component, and civilians) to fill the Nation's requirements. Coordinated actions between Services result in retention of experienced and trained individuals and eliminate barriers that prevent transition between differing service commitments and between military and civilian service.

The Working Group is addressing the reform of military personnel records information management, to include a review of the types of information (such as waivers and law enforcement infractions) that should be maintained throughout servicemembers' careers. It is also addressing the life cycle management of medical records. The Working Group continues to work with the Services on improving the seamless transition between the Active and Reserve components. As an example, Navy's Perform to Serve Program now has a SELRES option, whereby a member being released from Active Duty can affiliate into the Reserve component without having to process through recruiting.

General MCKINLEY. At the National Guard Bureau we will continue to work with DOD to implement a COS policy. Current ongoing initiatives supporting the COS strategy would significantly improve smooth integration of the Reserve component into the Total Force and enhance unity of effort thus improving overall military readiness. Several legislative or policy changes are under consideration that would better enable the Reserve component to serve as an operational force.

9. Senator BURRIS. Secretary McCarthy and General McKinley, how does policy support the plan to operationalize the Reserve component?

Secretary MCCARTHY. The DOD Directive 1200.17, published in October 2008, established the overarching set of principles and policies to promote and support the management of the Reserve components as an operational force. It outlines the major stakeholders' responsibilities and defines terms of reference necessary to accomplish those responsibilities. The current policy based on this directive defines the duration and frequency for orders to Active Duty and implements the train, mobilize, deploy model that ensures our servicemembers are mission ready yet able to balance the needs of their families, civilian careers, and periodic military service.

General McKINLEY. While the COS strategy is a broad concept under development rather than a policy per se, the strategy is critically important to continued success in operationalizing the Reserve component. Current ongoing initiatives supporting the COS strategy would significantly improve smooth integration of the Reserve component into the Total Force and enhance unity of effort thus improving overall military readiness.

QUESTIONS SUBMITTED BY SENATOR JOHN MCCAIN

FORCE STRUCTURE FOR THE AIR NATIONAL GUARD

10. Senator McCAIN. General Wyatt, on June 26, 2009, the Air Force formally announced force structure realignments for fiscal year 2010, including the following for the Arizona ANG at Davis-Monthan Air Force Base: "The 214th Reconnaissance Group has an increase of 217 drill positions to meet validated MQ–1 shortfalls. Total impact is an increase of 217 drill positions." From this statement, the Air Force clearly identified a need to meet validated MQ–1 (also known as the Predator) mission shortfalls. What is the current status of the increase of 217 positions for the 214th?

General WYATT. The original Air Force fiscal year 2010 Force Structure Announcement (FSA) that went public on 26 Jun 09, errantly reflected a +217 drill positions for the 214th Reconnaissance Group (RG). These were holdover positions that were the result of attempting to place manpower back into Arizona when the fiscal year 2010 Combat Air Forces (CAF) Redux was going to result in the loss of 30 F–16s from the 162 Fighter Wing in Tucson. When that force structure reduction for Tucson was later reversed by OSD, the 217 drill positions added to the 214 RG Unit Manning Document were placed back at Tucson. This correction was made and reflected in the 21 Sep 09 version of the FSA. The increase of 217 positions at the 214 RG was to increase their capability beyond the one Combat Air Patrol (CAP) they currently fly. The 214 RG is sufficiently manned to fly their current Unit Type Code (UTC) tasking of one steady state MQ–1 CAP. No additional manpower resources are currently scheduled to be added to the 214 RG.

11. Senator McCAIN. General Wyatt, is the ANG taking part in an Air Force study to determine the objective manning authorizations for an MQ–1 squadron? If so, can you give me an update on this action?

General WYATT. The NGB is in the process of developing a manpower study plan to validate the MQ–1 manpower requirement with the goal of completing the study by end of fiscal year 2010. Additionally, we have developed a "model" Unit Manning Document (UMD) for implementation at each of our MQ–1 units, incorporating distilled lessons learned from over 4 years of MQ–1 operations. Our goal is to standardize each of our existing units to this model, as well as ensure that each new unit is designed in accordance with the model UMD. This will ensure that units are manned efficiently and able to meet sustained operational demands.

12. Senator McCAIN. General Wyatt, when will a final determination be made on the number of positions to be added to the 214th?

General WYATT. While the Air Force would like to increase the capacity at the 214th beyond their current 1 CAP UTC, fiscal constraints on manpower resources have prohibited an increase in capacity at the 214 RG without offsetting ANG manpower from other valid mission sets in the State of Arizona.

FACILITIES AND INFRASTRUCTURE FOR THE NATIONAL GUARD

13. Senator McCAIN. General McKinley, I am aware that over half of the 3,300 readiness centers (formerly known as armories), across the country needed to train 358,000 ARNG members are rated as inadequate to support their assigned mission by the Adjutant Generals in each State. The substandard conditions of these facilities, as well as locations that do not reflect current demographic trends, impact the ability to train and quickly respond to State requirements as well as Federal missions. Are you comfortable that the amounts proposed in the current Future Years Defense Plan to invest in readiness centers?

General McKINLEY. The current Future Years Defense Program contains only a fraction of what is necessary in both military construction (MILCON) and Operations and Maintenance Restoration and Modernization to appropriately locate and adequately refurbish ARNG readiness centers to a standard that enables a 21st century Army National Guard operational reserve. The ARNG has a 14.2 million

square foot shortfall in Readiness Centers. If the current level of funding in the Future Years Defense Program is sustained over the next decade, the average age of readiness centers will increase from 40 years to 50 years and will not address the current square footage shortfall. These readiness centers do not support training an operational force because they were designed and built prior to 1960, with lower training requirements, fewer personnel, and less equipment.

14. Senator MCCAIN. General McKinley, what is the National Guard Bureau doing to address this issue?

General MCKINLEY. The National Guard Bureau works with all 54 States and Territories to work around solutions to its operational challenges. Facilities are being refurbished with modest migrations from ARNG Operations and Maintenance, Facilities Sustainment funds focused on those facilities that are most at need. An analytical process is used to identify the most pressing MILCON requirement, which determines the distribution of funding. We coordinate our requirements with the Army and Secretary of Defense and communicate the impacts of lack of funding.

15. Senator MCCAIN. General McKinley, how would you assess the risk to the mission from the conditions of readiness centers?

General MCKINLEY. I would characterize the risk as moderate and increasingly dire as the MILCON investment is redirected to other priorities. Buildings are brick and mortar, and unlike the soldier that adapts to adversity, will fail if not adequately cared for. Recruiting is adversely effected because most our facilities were built in 1960 and earlier, and American demographics shifted the recruiting base away from those facilities. These older facilities do not have the infrastructure or size to accommodate today's training simulators and equipment to train an operational force.

16. Senator MCCAIN. General McKinley, what can be done to improve the usefulness of readiness centers to meet the needs of the Guard and each State?

General MCKINLEY. ARNG Readiness Centers provide unique capabilities to the State and community. With approximately 3,000 Readiness Centers in virtually every community across the Nation, the ARNG provides not only a place for soldiers to drill but also a facility that often hosts events for soldiers and their families as well as other community activities. Many can serve as a shelter to large numbers of civilians in the event of natural or man-made disasters. Furthermore, since Readiness Centers are traditionally located in the heart of the community, they allow a location for National Guard soldiers to quickly assemble and draw equipment in order to support domestic support operations. Readiness Centers can also serve as logistics centers and resource distribution points for interagency crisis response.

The age of current National Guard facilities threatens rapid response capability. The average age of a Readiness Center is 41 years old. Forty percent of all Readiness Centers are over 50 years old and don't meet space standards for administration, classrooms, supply, and maintenance.

The ARNG needs significant investment in Readiness Centers in terms of both MILCON and O&M Restoration and Modernization funding. Worn out or obsolete Readiness Centers need to be replaced, and in many cases, new facilities should be opened near population centers that can support the authorized force structure. Other Readiness Centers can be refurbished and continue to be used for a few more decades. Building new facilities and refurbishing existing facilities, especially with energy saving features, will result in a more efficient, more prepared force that will support the mission as well as the local communities.

Many Readiness Centers lack the space and quality currently authorized. This limits multi-agency operations and impacts organizational capabilities and effectiveness, specifically the ability to store equipment on site and allow rapid response to incidents. As a result, many do not meet existing requirements for storage space. In cases where facilities do not meet code requirements (Americans with Disabilities Act, restrooms for females, and sufficient parking), this reduces their ability to serve as community-based shelters. Many Readiness Centers are not optimally sited for emergency response, due to population shifts since the buildings were constructed.

Many ARNG Training Sites rely on World War II wood barracks for billeting and lack authorized administrative/classroom facilities that would allow training on homeland defense and OCO tasks. Many of these facilities lack proper support for the IT requirements of today's technologically-oriented military. Also, many of these facilities have not kept pace with an evolving Army and do not have adequate administrative spaces for current manning/staffing requirements, or classroom space to efficiently train soldiers.

Many of the older vehicle maintenance facilities do not have the capacity to adequately service today's inventory of vehicles, resulting in lower vehicle operational readiness rates that degrades collective training and vehicle availability in the event of an emergency. Maintenance bays are too small to accommodate larger vehicles. Cranes and lifting devices do not have the capacity to lift larger motors. Storage is inadequate to hold the size and quantity of spare parts required to maintain these vehicles. Parking surfaces around the maintenance facilities are too small to store all of the assigned vehicles. Also, new ARNG equipment has increased demand for space to store vehicles and parts.

The ARNG has recently taken up the challenge to bring the older facilities "up to code" and make them energy efficient. Also, when the ARNG builds a new facility, the goal is to use innovative and sustainable building strategies. Recent "green" accomplishments include energy saving initiatives along with the reduction of hazardous waste.

The Arizona Guard is using the Earth's natural insulation to heat and cool their 5,200 square-foot ECO-building. The building is burrowed into the ground within walls of recycled tires filled with compacted earth. The building also has an atrium that is designed to provide abundant natural light. The roof has cisterns that collect rain water-runoff. On the grounds the facility has 18-kilowatt photovoltaic wind turbines. The State has a central energy control system that controls the indoor climate of the ECO building as well as many other public buildings across the State.

The Michigan Guard revamped their re-painting facility to use non-toxic paints and paint stripping processes. They switched from a solvent-based paint to a water-based paint and shifted from a hazardous working environment to one that is virtually pollution free for the environment and for the workers. They also shifted from a toxic paint stripping process to a water-based solution using high-pressure water jets. By filtering and regenerating waste water, they reduced waste to about 2 to 3 pounds per vehicle.

The Colorado Guard has a new Army Aviation Support Facility constructed primarily from recycled and locally-made materials. The facility is lighted almost entirely by sunlight during day time operations. The facility uses roof runoff to irrigate drought-resistant plants. The facility also has a unique modular design that accommodates a full-time staff of 70 and "expands" to handle the drill weekend staff of 350 soldiers.

The Minnesota Guard has a new model for readiness centers with Federal, State, and community missions. Ten of Minnesota's 63 readiness centers are designed as "hybrid" training and community centers. These hybrid centers have amenities such as ice rinks, gyms, banquet halls, and exhibition space.

The Hawaii Guard has taken an interagency approach breaking ground with a new facility they will share with the USAR and the Hawaii Office of Veterans Services. This facility will make use of photovoltaic panels to help reduce energy usage and costs.

The New Mexico Guard is building a 30-module 54-kilowatt photovoltaic solar farm. This solar project will not only reduce the amount of electricity bought from the service provider but will also reduce the amount of greenhouse gases generated by the consumption. The New Jersey Guard recently completed a 170-kilowatt photovoltaic car port. This car port takes underutilized space to provide shelter for parked vehicles and generates electricity for some of Sea Girt training site facilities. The renewable energy produced will reduce approximately 165 tons of greenhouse gas emissions annually.

Projects include the construction of a new Readiness Center in Owensboro, KY, to replace a building whose foundation is in danger of failing due to severe long-term ground water infiltration. The construction of the second and final phase of a Regional Training Institute in Bangor, ME, is currently using inadequate World War II era facilities. A new construction project supplies potable water to the Mead, NE, training site because existing water supply infrastructure is outdated and undersized for demand. Infrastructure site work to stops the erosion caused by the rising level of an adjacent lake at Camp Grafton in North Dakota.

In light of the critical importance of our Readiness Centers, the ARNG plans to conduct a nationwide assessment of our facilities so that we can prioritize our efforts in terms of current infrastructure conditions and mission requirements. The results of this planned study should ensure optimal return on the investment made in these installations.

PROPOSED FUNDING FOR FACILITIES FOR THE AIR FORCE RESERVES

17. Senator MCCAIN. General Stenner, the AFR has almost 3,000 facilities at 63 locations supporting 71,000 personnel and 348 aircraft. With all these facilities and operations, the President's budget for fiscal year 2011 proposes only one MILCON project for the AFR, a $3.4 million maintenance facility at Patrick Air Force Base, FL, at a cost of $3.4 million buried in the total amount of $1.5 billion requested for Air Force MILCON. Why is there only one MILCON project in the President's budget request?

General STENNER. During fiscal year 2011 budget formulation, the three components of the Air Force (Active Duty, AFR, and ANG) took risk in current mission MILCON to fund other essential priorities. The Air Force decision was to fund the top current mission priority for each Major Command plus new mission requirements. The AFR top current mission priority is included in the budget request, and there were no new mission requirements for this year which resulted in the one MILCON project for the AFR.

18. Senator MCCAIN. General Stenner, is this a fair and accurate reflection of your requirements?

General STENNER. One current mission MILCON project per year beyond this budget year will not allow the AFR to recapitalize our infrastructure at an acceptable rate. The AFR currently has over a $1.2 billion backlog. Reserve component facilities directly correlate to readiness as well as quality of life.

19. Senator MCCAIN. General Stenner, are AFR facilities really in such great shape that practically no MILCON funding is needed to address facility conditions?

General STENNER. No, this level of funding for one project was a risk taken to fund other priorities. One project per year beyond this fiscal year will not allow recapitalization of our aging facilities and will substantially increase our current $1.2 billion backlog.

20. Senator MCCAIN. General Stenner, in your opinion, is the Air Force taking steps to correct this disparity?

General STENNER. The Air Force plans to look much more closely at the distribution of MILCON funding in the upcoming Program Objective Memorandum (POM) to ensure that all three components' requirements are equitably addressed.

BASE REALIGNMENT AND CLOSURE IMPLEMENTATION PROGRESS

21. Senator MCCAIN. General Kelly, Base Realignment and Closure (BRAC) 2005 created many challenges for our Reserve Forces. How would you assess your Service's progress in implementing BRAC requirements?

General KELLY. Marine Forces Reserve is executing 25 of the 47 Marine Corps BRAC Projects. MARFORRES is currently planning for successful completion of all BRAC closures and moves by BRAC deadline of September 15, 2011. All projects have final siting approval with majority under construction. Of special note are the closure of Mobilization Command in Kansas City and consolidation with other headquarters elements of MARFORRES at the Federal City Project in New Orleans. The Marine Compound in New Orleans has recently been designated as Marine Corps Support Facility, New Orleans and the project is currently ahead of schedule with opening planned for June 2011. Currently, 3 of the 25 projects (Akron, OH; Lehigh Valley, PA; and Brunswick, ME) are being tracked for completion in fourth quarter of 2011. These three projects are being managed closely by MARFORRES, Navy BRAC Program Managers, and HQMC to seek on-time execution, but mitigation plans are be developed for any further slippage to accommodate closure and movement into alternate facilities if required. Funding tails for operations and maintenance post BRAC are being refined and updated for inclusion in future budget submissions.

22. Senator MCCAIN. General Kelly, as the Commander, Marine Forces Reserve, and Marine Forces North, can you please tell me about the U.S. Marine Corps' long-term commitment to New Orleans and your vision for your headquarters and continued presence there?

General KELLY. New Orleans has long been a Marine Corps town, and we intend to continue this strong relationship with the city and the region. The greater New Orleans area is an important strategic port for the country because of the Mississippi River, so it is imperative we have a strong military presence here. We are proud it is a strong Marine Corps presence.

First, we are constructing the Marine Corps Support Facility, a 411,320-square foot building at the Federal City campus located in Algiers. This $175 million building will house the MARFORRES and MARFORNORTH staffs, and will be a permanent fixture of the Marine Corps' ongoing commitment to the people of New Orleans. We expect to have our troops permanently occupying the facility around June 2011.

Another strong commitment to New Orleans is exemplified by the proposed $1.5 million repair and renovation of Quarters A, located near the Marine Corps Support Facility on the Mississippi River. This will be the permanent home of Commander, Marine Forces Reserve, which is a three-star billet. It has been home to the past two Marine Forces Reserve Commanders, and I intend to continue this tradition.

We have a solid connection with the people of New Orleans, as evidenced by our robust community relations program. My Marines are volunteering their time rebuilding homes in the Ninth Ward, constructing playgrounds for children across town, working in the wetlands, and collecting Christmas toys for the underprivileged. I envision that connection will grow stronger over the years as the Marine Corps continues to call New Orleans home.

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

FORCE STRUCTURE FOR THE AIR NATIONAL GUARD

23. Senator GRAHAM. General Wyatt, on May 11, 2010, the Air Force issued its fiscal year 2011 Force Structure Announcement under which the 169th Fighter Wing at McEntire Joint National Guard Base is scheduled to lose one WC–130H from backup aircraft inventory (BAI) due to mission requirements. I understand that Florida and Louisiana are also scheduled to lose one C–130 each. I am very concerned with this move as South Carolina, Louisiana, and Florida are hurricane States. In addition, these aircraft continue to provide critical support to the Department of Homeland Security, Drug Enforcement Administration, Federal Emergency Management Agency, South Carolina Civil Support Team, National Guard, and the Air Force. Why take away 100 percent of these three hurricane States' airlift capability, by completely removing this capability, does this compromise any facet of their mission?

General WYATT. The decision to move these BAI aircraft to other higher priority mission needs was an Air Force Corporate Process decision in the fiscal year 2011 Adjusted Program Objective Memorandum (APOM). These three aircraft represent 2 percent of the entire ANG C–130 Tactical Airlift fleet and only 1.5 percent of the total ANG airlift capability. We believe our remaining capability will be more than sufficient to respond to the Governor's request for assistance to a State emergency.

The ANG still will continue to have enormous airlift capacity in the south to support natural or man-made disasters:

- 8 C–130s each at Savannah, GA; Nashville, TN; and Little Rock, AK
- 8 C–5s at Memphis, TN
- 8 C–17s Jackson, MS
- 4 C–27Js at Meridian, MS, with their conversion in fiscal year 2012

24. Senator GRAHAM. General Wyatt, what percentage of all ANG airlift missions did these three aircraft fly in the past year?

General WYATT. In 2009, 12,935.5 Mission Ready Airlift (MRA) hours were flown; the three Fighter Support Aircraft (FSA) flew 275.1 of those hours. Given this data, the Fighter Support Aircraft flew 2.13 percent of the MRA missions. Current 2010 data:

- Total MRA hours flown: 6,296.7
- FSA hours flown: 216.7
- Percent of overall missions for FSA: 3.44

25. Senator GRAHAM. General Wyatt, what percentage of the flying hours flown by these three aircraft in the past year were actual operational missions as opposed to training missions?

General WYATT. All missions flown by these aircraft utilize ANG flight training hours, whether they are supporting a mission or proficiency/training flights. Typically, these missions are broken down into MRA, local training, unit- or State-directed, border patrol, and Hurricane Relief for tracking purposes. In 2010, the three aircraft have flown 357.6 hours, of which, 56 hours were dedicated to local training and aircrew proficiency, with 301.6 hours dedicated to other mission sets.

2009 Data:

- 695.1 hours flown by the three aircraft
- 121.9 hours for training/proficiency
- 573.2 hours for other mission sets

26. Senator GRAHAM. General Wyatt, what savings do these three planes save the American taxpayer in travel and transportation costs for the supported Fighter Wings, the ARNG, and the National Guard Bureau?

General WYATT. The Fighter Support Aircraft represent a very small percentage of overall ANG airlift capacity and MRA hours. We believe our remaining airlift capability will be more than sufficient to meet the Governor's request for assistance to a State emergency. Any realized cost savings lost by the departure of these aircraft, is more than outweighed by the need to realign the tactical airlift fleet of aircraft and retire costly legacy aircraft.

27. Senator GRAHAM. General Wyatt, how many C–130s are there in the BAI? Assuming there are dozens of aircraft in the C–130 BAI, why remove these three planes from performing vital homeland security missions or responding to natural disasters and not utilize three planes from the BAI?

General WYATT. There is currently one C–130 BAI and five WC–130 BAI in the ANG inventory for fiscal year 2011. BAI aircraft are not funded in the budget and are intended to be spare aircraft for regular C–130 units. These six aircraft represent just 4 percent of the entire ANG C–130 Tactical Airlift Fleet. In the event of a homeland security incident or natural disaster, the ANG stands ready to meet any request for assistance that exceeds any impacted State's organic responsibility. The ANG stands ready to respond to any Governor's request for assistance to a State emergency.

Since 2007, the three aircraft have flown a total of 2,803.1 hours under the following mission sets:

Mission Ready Airlift - 1,014.8 hours
Unit/State directed - 1,190.1 hours
Border Patrol - 194.5 hours
Training/proficiency - 404.7 hours
Hurricane Relief - 8.0 hours
NGB Directed - 11.0 hours

ACCESS UNDER EXISTING LAWS TO RESERVE UNITS

28. Senator GRAHAM. Secretary McCarthy, in your written testimony, you state your view that the National Guard and Reserve should be "the force of first choice, for requirements for which they are well suited." We need to know more about the impediments to achieving this goal so that rapid—but equitable—access to the Reserve components can be achieved. Do you think the current mobilization authorities are sufficiently flexible and are changes in legislation needed?

Secretary MCCARTHY. I believe that current mobilization authorities are fairly flexible but may present an impediment to future use of the Reserve component as an operational force in some situations. We are actively studying alternative proposals to either request new legislation or suggest modifications of existing legislation.

29. Senator GRAHAM. Secretary McCarthy, how would you approach the task of creating activation authority, short of a Presidential call up, that balances the need for readiness and response with dwell time and recognition that reservists must be able to stand down?

Secretary MCCARTHY. I agree that any proposed authority needs to provide a balance between the servicemember's need for dwell time, their response and readiness posture, and our Nation's operational requirements.

I support the idea of an access authority to support continued future use of Reserve component capabilities as an operational force. This authority will need to provide assured access that creates confidence with the gaining force commander that the Reserve components are reliable sourcing solutions for predictable missions.

We are exploring the possibility of requesting that Congress create a limited access authority short of a Presidential call up, or, perhaps revising the wording of the existing Presidential call up that facilitates the balanced, judicious, and prudent use of the Reserve components as an operational force in our Nation's future worldwide security strategy.

30. Senator GRAHAM. Secretary McCarthy, is the best approach to do this solely on a voluntary basis, through service agreements or do we need a more flexible involuntary call up?

Secretary MCCARTHY. We believe the best approach is to rely on volunteerism as an effective way to muster certain capabilities on very short timelines. Service agreements are one possible way to increase the effectiveness of volunteer duty over a broader set of capabilities. We want to ensure a commitment to predictable and periodic obligated service as a condition of membership in selected Reserve units. However, when we cannot execute our Nation's security mission solely based on volunteers, we may require some type of mandatory call up.

31. Senator GRAHAM. Secretary McCarthy, what do you see as the most significant obstacle to realizing a truly operational reserve in the post-OCO steady state?

Secretary MCCARTHY. DOD worldwide deployments have forced all of the Services to acknowledge the fact that the Reserve components are an operational force that bring essential capabilities to the battlespace. Even an evolutionary paradigm shift, such as the change in our Reserve component's expectations of utilization, encounters various levels of support. There needs to be a fully embraced cultural shift that recognizes that the Reserves are a force of first choice. To successfully bring about this shift we need assured access to the Reserve units, breeding confidence in the gaining force commander.

RECRUITING AND RETENTION

32. Senator GRAHAM. General McKinley, General Wyatt, and General Carpenter, your written testimony indicates that recruiting and retention in the National Guard is good, but that there are shortfalls in the medical area. Please discuss how each of the Army and ANG are doing in recruiting top quality personnel and retaining soldiers and airmen in the critical skills you need.

General MCKINLEY. The ARNG has initiated a medical recruiting initiative that targets medical professionals. The goal of the program is to initiate a viral marketing effect of recruitment, in which newly accessed medical, dental, and physician assistant students assist in peer-to-peer recruitment. In addition, the ARNG continues to aggressively improve retention of health care professional through programs such as the Health Professional Loan Repayment Plan, and Retention Bonus programs, which provide incentives from $5,000–25,000 depending on the critical health specialty.

The ARNG has also initiated specific programs aimed to address shortages in other critical skills. The Military Intelligence Readiness Improvement Program commenced in 2004 as the cornerstone of the Director of the ARNG's Military Intelligence "Get Well Plan." The success of the Military Intelligence Readiness Improvement Program far surpassed expectations and contributed significantly to the increase in Military Intelligence Personnel Readiness throughout the ARNG.

In addition, the Low Density Recruiting Program was created to address the challenges within other High-Demand/Low-Density Military Occupational Skills (MOS), and to more appropriately define expansion outside of the Military Intelligence Career Management Field. The key component of the program is the ability to facilitate the assignment of duty MOS qualification to soldiers with limited geographical constraints.

The Low Density Recruiting Program also works as a tool to retain critical personnel in qualified positions who would otherwise require training in a different MOS due to the location of their residence in respect to the location of their assigned unit.

General WYATT. The ARNG has initiated a medical recruiting initiative that targets medical professionals. The goal of the program is to initiate a viral marketing effect of recruitment, in which newly accessed medical, dental, and physician assistant students assist in peer-to-peer recruitment. In addition, the ARNG continues to aggressively improve retention of health care professional through programs such as the Health Professional Loan Repayment Plan, and Retention Bonus programs, which provide incentives from $5,000–25,000 depending on the critical health specialty.

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In regards to the ANG, the advertising branch of the ANG, the Recruiting and Retention Directorate, will be launching a precision advertising campaign aimed at generating leads to fill critical Health Professionals vacancies nationwide. The advertising mediums being utilized for this campaign are online search engine marketing and online banner ads. All interested individuals will click through to a newly designed Health Professional specific landing page www.goang.com/hp, providing a single source opportunity sharing platform with tracking on the effectiveness of the ads. The projected launch of this program is July 2010.

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33. Senator GRAHAM. General McKinley, General Wyatt, and General Carpenter, what, specifically, is the National Guard doing to improve its recruiting and retention of health care professionals?

General MCKINLEY. The ARNG has initiated a medical recruiting initiative that targets medical professionals. This program will place newly accessed medical, dental, and physician assistant students on T–32 Additional Duty Operation Support (ADOS) orders to serve as ARNG Medical and Dental Student Recruiters (ASRs) for 1,094 days or the completion of their educational program. These positions will be available on a first-come, first-served basis and students in all States and Territories will be able to participate.

The goal of this program is to initiate a viral marketing effect of recruitment in which the student recruiters assist in peer-to-peer recruitment. All ARNG student recruiters will be missioned, and performance of this mission will impact orders renewal. Newly identified personnel recruited would be afforded the opportunity to participate in the ARNG Student Recruiters Programs. The annual cap of newly appointed members of the ARNG student recruiters force would be 200 accessions, with a total program limit of 600.

The ARNG also continues to aggressively improve the retention of health care professional through its current retention programs. This includes the Health Professional Loan Repayment Plan, and Special Retention Bonuses, where incentives range from $5,000–25,000 depending on the critical health specialty.

The ANG also offers cash bonus, loan repayment, and residency stipend to Health Professionals in order to fill critical wartime specialties. The Recruiting Operations branch of the ANG Recruiting and Retention Directorate has implemented a comprehensive training program to improve the officer recruiting and accession process throughout the ANG. This training is provided to recruiters, retainers, personnel

specialists, medical service corps officers, and all others who have a role in the Health Professional recruiting and accession process.

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RECOMMENDATIONS OF THE COMMISSION ON NATIONAL GUARD AND RESERVES

34. Senator GRAHAM. Secretary McCarthy, you have indicated that implementing the recommendations of the Commission on National Guard and Reserves (CNGR) that have been approved by Secretary Gates is among your highest priorities. We have been visited by some of the commissioners and were glad to see that you have called on them to assist you in this regard. Could you discuss how you plan to go about this task and what you view as the most pressing actions that need to be taken?

Secretary MCCARTHY. The Commission published their final report and there were 53 recommendations in the report that the Secretary of Defense accepted for action. Implementing these approved action plans is among my highest priorities. In order to ensure proper execution of these plans, I have restructured my office and assigned a single point of contact to further the CNGR implementation efforts and related strategic initiatives. Many of the actions called for by the Secretary of Defense have already been completed and others have continued down their multiyear implementation cycles. The Department's major accomplishments include:

- We published DOD Directive 1200.17, Managing the Reserve Components as an Operational Force, providing the basis for initial strategic planning. It was essential in setting the vision and outlining the nine principles to guide the management of the Reserve component as an operational force.
- Reserve units are part of force generation models that will allow more predictability to Reserve component members.

- U.S. Pacific Command, U.S. Northern Command, and The National Guard Bureau have published various Concept of Operations Plans for support to Civil Authorities.
- Early access to TRICARE has been extended up to 180 days prior to activation.
- DOD established the Yellow Ribbon Program office to coordinate post-deployment reintegration efforts with the Guard and Reserve.

We plan to continue to stay in touch with stakeholders who are committed to fully integrating the Reserve components into the Total Force. Future efforts include:

- Identification and elimination of cultural prejudices that stand in the way of continued Total Force integration.
- Ensuring that Reserve component readiness issues are programmed and funded in the future.
- Ensuring adequate support is available to the families and employers of Reserve component members. Longer advance notice for mobilizations will lead to less friction and better preparation for Reserve component members, their families, and employers.

MEDICAL AND DENTAL READINESS OF THE RESERVE COMPONENTS

35. Senator GRAHAM. General Carpenter, we know that historically maintaining medical and dental readiness for the Reserve and Guard has been a significant challenge—especially for the ground forces. DOD reported that for fiscal year 2008, only 60 percent of the ARNG met the Individual Medical Readiness standard. How would you assess the ARNG progress in achieving individual medical readiness goals?

General CARPENTER. To date, 63 percent of the ARNG meets DOD Individual Medical Readiness standards. From fiscal year 2008 to the end of fiscal year 2009, the Army Fully Medically Ready percentage increased from 35 percent to 46 percent. The ARNG Dental Readiness GO rate at the mobilization platforms has increased from 74 percent in fiscal year 2008, to 84 percent in 2010 year to date. The increase can be attributed to early and sustained individual soldier medical readiness screening through the use of annual Soldier Readiness Processing (SRP) events. These SRPs include Periodic Health Assessments, dental screening and identification of all Dental Readiness Class (DRC) 3 soldiers, and their overall Medical Readiness Classification (MRC) 3 issues. MRC 3 issues are documented and aggressively case managed to include correction of identified DRC 3 issues using the Army Selected Reserve Dental Readiness System.

36. Senator GRAHAM. General Carpenter, what percent of ARNG members are currently nondeployable due to medical or dental conditions?

General CARPENTER. Twenty-three percent of ARNG soldiers are medically nondeployable, while 11 percent are nondeployable due to dental conditions. Issues affecting medical readiness are documented and aggressively case managed, including correction of identified dental readiness issues using the Army Selected Reserve Dental Readiness System. A pilot program slated to begin in fiscal year 2011 identifies select deploying Medical Readiness Classification 3 soldiers for correction and treatment of a deployment limiting medical condition.

MENTAL HEALTH OUTREACH FOR MEMBERS OF THE GUARD AND RESERVE AND THEIR FAMILIES

37. Senator GRAHAM. General Carpenter, we know that as many as 15 percent of our servicemembers who have deployed are returning with some kind of mental health need, and that extends to family members as well. In the face of a shortage of mental health providers nationwide, are we able to meet the needs of members of the Reserve and their families in this important area?

General CARPENTER. Yes, currently the ARNG and their families have access to contracted civilian behavioral health providers at no cost through Military Family Life Consultants, Military OneSource, Directors of Psychological Health and various non-profit organizations. The Department of Veterans Affairs and Vet Centers continue to expand their services and outreach. TRICARE has behavioral health providers, which ARNG soldiers can access through the Transitional Assistance Management Program, and their families can access through TRICARE Reserve Select.

38. Senator GRAHAM. General Carpenter, some say that embedding counselors within Reserve and Guard units is an effective approach. Do you agree? What works and what doesn't?

General CARPENTER. The Army continues to improve the equipment on hand (EOH) rates as well as the modernization levels for both the ARNG and the USAR. The Army sees this as critical to the transformation of the Reserve component from a strategic to an operational reserve. The Army Equipping Strategy identifies equipping goals for units as they progress through the Army Force Generation (ARFORGEN) cycle. These equipping goals apply equally across all three components—Active, ARNG, and USAR.

Beginning in fiscal year 2006, the Army significantly increased its investment in ARNG equipment, allocating approximately $28.7 billion for new procurement and recapitalization between fiscal year 2006 and fiscal year 2010. Of particular significance, the ARNG was fully equipped with Single Channel Ground and Airborne Radio System (SINCGARS) radios and UH–60 Blackhawk helicopters in fiscal year 2009 and is on track to complete fielding of M4 rifles by the end of fiscal year 2010. However, the Blackhawk fleet is still only partially modernized and current funding efforts will not produce a modernized fleet until the end of fiscal year 2025. Despite the increased investment since fiscal year 2006, the ARNG still has critical shortfalls and modernization gaps in the truck fleet, helicopter fleet, and digital enablers. In addition to supporting OCO, this equipment is critical to supporting the ARNG's Homeland Defense/Defense Support to Civil Authorities (HLD/DSCA) missions.

Modernization

The Army is committed to equipping soldiers going into harm's way with the most capable systems possible. This equipping strategy applies to Reserve component units as well as Active component units and is designed to modernize the USAR and ARNG on par with the Active component.

Transparency

The "CNGR"—also known as the "Punaro Commission"—provided DOD with a set of recommendations designed to improve the operational readiness of National Guard and Reserve Forces. Two of the recommendations (CNGR #42 and #43) directed DOD to increase the transparency of equipment requirements, funding, procurement, and delivery. Over the past year, the Army has significantly improved transparency within its equipment procurement and distribution processes.

Based on the current Army Equipping Strategy, the Army's commitment to equipping soldiers going into harm's way with the most capable systems possible and the significant increase in transparency, I am confident the ARNG is receiving modern equipment which is compatible with the Active component.

PRIORITY FOR FUNDING OF MEDICAL AND DENTAL READINESS

39. Senator GRAHAM. General Carpenter, despite the importance of medical and dental readiness, at the end of the day, my sense is that funding for medical and dental readiness does not compete well with other priorities, such as training and equipment and that the real solution is day-in, day-out leadership within Reserve and Guard units. What is the best solution to ensure that funding for readiness includes and improves medical and dental readiness?

General CARPENTER. The question can be addressed by increasing funding to the appropriate level at a fixed amount not to be reduced within the fiscal year by internal taxes or external Department of the Army directed bills. The ARNG also needs additional full-time medical personnel at the State level to identify and case manage soldiers considered non-deployable due to medical and dental issues.

ACCESS UNDER EXISTING LAWS TO RESERVE UNITS

40. Senator GRAHAM. General Stultz, Admiral Debbink, General Stenner, and General Kelly, in written testimony, you echo General McCarthy's view that the Reserve should be "the force of first choice, for requirements for which they are well suited." But you note that we need better access to the unique units and capabilities in the Reserve in a timelier manner. Please comment on this and be specific. We need to know what your concerns are and how to address them.

General STULTZ. Yes, I do believe the Nation could and should reap more benefits from increased use of the USAR, specifically in operations requiring extensive CS/CSS capabilities.

Our recent history has shown us that such capabilities are oftentimes required in unexpected places with little or no advanced warning. Our Army's rapid deployment capability is sufficient to show timely responsiveness; but, primarily depending on the Active component to demonstrate national will in such instances puts us at risk of unnecessarily straining the force, especially if such capabilities are required

in multiple places. To provide the Nation (and our Army) with flexibility and accessible depth enables us to maximize the unique capabilities of the USAR to help the combatant commander to build partner nation capacity and/or protect and sustain human life anywhere on the globe. From my perspective, this can be efficiently accomplished through legislation that permits the Secretary of Defense to quickly activate reservists for unexpected or last minute requests for assistance that, if responded to in a timely manner, can go a long way in advancing U.S. interests abroad. This permissive authority would also have to be supported by legislation that results in the provision of supportive services to the soldier and the soldier's family as soon as the soldier is notified of a pending mobilization and deployment.

Admiral DEBBINK. My specific concerns are:

(1) The need to establish the legal authority to most effectively delegate access to the Reserve components.
(2) The need to plan for sustainable funding in a post-OCO environment that will ensure the Services have adequate resources to access the strategic depth and operational capabilities of their Reserve components.

Authorities to access the Reserve component during rapidly emerging situations, (humanitarian assistance, disaster response, as well as other low-intensity crises) should be considered. Amending title 10 to create a new statute that allows the President to delegate authority through the Secretary of Defense to the Secretaries of the Services, the ability to respond to requirements with the most appropriate and accessible Forces from either the Active component or Reserve component, would permit better access allowing the Reserve component to fill the requirements for which they are best suited.

We should review our budgeting practices for operations in a post-OCO environment. While the current budget combined with associated OCO supplementals support the present use of the Navy Reserve, we should plan and budget for the level, sustainable funding of both the required training and operational employment of certain elements of the Navy Reserve.

General STENNER. From a legal perspective, the current proposed legislative change addressing the legal constraints of the use of Air Reserve Technicians (ARTs) will help provide better access to the unique units and capabilities in the Reserve in a timelier manner; specifically, the need for flexibility in ART assignments. We must be able to place/assign ARTs outside of the traditional unit construct at all levels of command and in the IMA program. We also need more flexibility to deploy ARTs.

The second current legislative proposal relating to ART Mandatory Separation Dates (MSD) will also help provide better access to the unique units and capabilities in the Reserve in a timelier manner. Under existing law, the AFR is mandated to extend an ART officer or enlisted member's MSD to age 60 at the election of the ART. This severely limits career advancement in the ART world. We have proposed a change to the law that would give the commander the discretion to extend the MSD.

General KELLY. The Marine Corps has not hesitated to employ the Reserves operationally and we concur with the premise that the Reserves should not be the "force of last resort" as viewed during the Cold War. Predictability is significant to tapping into Reserve capabilities. The Marine Corps Reserve can be the first choice for recurring or predictable missions within their capabilities as we've demonstrated with success over the last 8 years. The Marine Corps has embraced that premise by ensuring that Marine Corps Reserve capabilities are an integral part of the available operating forces through our Force Generation Model. We're really not talking about unique capabilities or units, but the unique nature of combat tested and highly trained Marine reservists who bring with them a wide range of civilian experiences and skills. The Reserve's unique nature makes it a great complement to our Total Force when conducting stability operations in Iraq and Afghanistan as well as performing worldwide theater security cooperation and training commitments.

The current authorities and policies in place for OCO work well and allow the needed predictability we desire. However, authority to access the Reserve for other operational missions is another matter. Concern has been raised within the Defense establishment whether the current authorities can justify involuntary mobilization, the key to predictability, for missions outside of OCO. The Marine Corps, as well as the other Services, are examining the question of access. Without an appropriate authority to maintain non-OCO access to the Reserve component, we will be unable to meet the great demand for the Marine Corps Reserve to meet our training and mentoring capabilities so vital to partner nation engagement. A new authority may be needed which will require a change to our current laws regarding mobilization. Of course, continued use of an operational reserve beyond OCO supplemental fund-

ing will require appropriate programming within the Marine Corps and DOD to ensure adequate funding for the right balance of Active component/Reserve component employment.

41. Senator GRAHAM. General Stultz, Admiral Debbink, General Stenner, and General Kelly, do you think the current mobilization authorities are sufficiently flexible or are changes in legislation needed?

General STULTZ. No, current mobilization authorities are not sufficiently flexible. Legislative changes are needed. The type of changes I envision are those which permit the Army to mobilize the USAR for: domestic emergencies; generating force operations; and overseas contingency missions which provide our soldiers an opportunity to perform security cooperation missions and/or training exercises in a predictable and cyclical manner. Limiting mobilizations to warfighting type situations is a major barrier to our transition from a strategic reserve into an operational force (per one of the CNGR recommendations).

Admiral DEBBINK. I believe that the Services need additional authorities delegated to them in order to access their Reserve components during and for operations other than war or national emergencies. A major paradigm shift has taken place with regard to the utilization of our Reserve Forces. Current authorities do not allow us to deploy reservists in the regular, rotational work of the Services. Providing access to the Reserve component to complete these missions will help increase the efficiency and capability of the Total Force, and will enhance the Reserve component's ability to be the force of first choice for DOD requirements around the globe.

General STENNER. From a legal perspective, the current mobilization authorities are sufficiently flexible and no legislative changes are needed at this time. The issue is that historically, the current mobilization process as identified in the Global Force Management Implementation Guides (GFMIG), has not been adhered to resulting in confusion mobilizing Reserve Forces. AFR Command proposes to educate the Regular Air Force (Active component) on the proper authorities and process for mobilizing reservists and require adherence to using the proper authorities and the process requirements.

General KELLY. If we are to truly operationalize our Reserve component to support the combatant commanders within the full range of military operations after the current authority to involuntarily activate has expired, changes to legislation will be required. Current authorities lack the flexibility to employ an operational reserve post-OEF as there is not an authority that permits involuntary activation of units for more than 2 weeks without an authorization from the commander in chief. The Services require the ability to involuntarily activate units in accordance with their Force Generation models in order to provide predictability for the reservist and cohesive capabilities for the Combatant Commanders.

42. Senator GRAHAM. General Stultz, Admiral Debbink, General Stenner, and General Kelly, how would you approach the task of creating activation authority, short of a Presidential call up, that balances the need for readiness and response with dwell time and recognition that reservists must be able to stand down?

General STULTZ. I would identify various categories for which such activations should be appropriate. A few things that come to my mind are: domestic emergencies, augmenting the Army's stateside training support base, and perhaps helping the combatant commands, in coordination with U.S. embassies, strengthen the capacity of partner nation's security forces.

Additionally, I would consult key stakeholders from throughout our Employer-Army Reserve Partnership program to determine the type of conditions that would be favorable to them, as it relates to acceptable frequencies and durations of short-term deployments. I would also attempt to find out from them if there were any feasible incentives that could help mitigate whatever disruptions would result from call-ups that were not of the Presidential call up variety.

Lastly, I would consult with the families of our Force, and the type of information I would seek would be very similar to what I would want from the employers: conditions and possible incentives.

Once complete, I would analyze what's fiscally feasible, and legally practical, and then work through the Army's OCCL to develop a recommendation that had been reconciled with the Army's human capital strategy as it relates to recruiting and retention activities.

Admiral DEBBINK. I would approach this task by amending Title 10 to create a new statute that allows the Secretary of Defense to delegate authority to the Secretary of the Services to recall to Active Duty members of the Ready Reserve for a pre-designated set of specific missions and a period of not more than 365 days

in any 5-year period. Notification requirements would be in accordance with current policies addressed in DOD Instruction 1235.12 "Accessing the Reserve Components."

General STENNER. Although not a legal question, one thought would be to ensure the AFR has input into the assets to be activated prior to activation to adequately assess the balance between the readiness and response and dwell time.

General KELLY. We need to ensure Reserve component force generation models continue to be used as dwell period calculators. When utilized, these models provide predictability for Service headquarters, servicemembers, families, and employers. We also need to ensure that when we recall reservists involuntarily, it is consistent with the Guidance for the Employment of the Force priorities and OSD utilization rules. Furthermore, we must provide meaningful opportunities for the reservist. We view Security Force Assistance and Theater Security Cooperation Phase Zero operations as meaningful and existing within the "full spectrum of conflict." These operations are wholly suitable for mobilizing Reserve capabilities to support, but should not require a Presidential recall.

43. Senator GRAHAM. General Stultz, Admiral Debbink, General Stenner, and General Kelly, is the best approach to do this solely on a voluntary basis, through service agreements or do we need a more flexible involuntary call up?

General STULTZ. I believe an activation authority that's in tune with readiness, response, and stand-down requirements is best achieved through a more flexible involuntary call up process. The myriad of unpredictable challenges to our national interests, should prompt us to realize that the timely and enduring use of our force, both Active and Reserve components, should not be confined to instances warranting a presidential call-up. In light of the far-reaching implications behind future activation of Reserve Forces, and an understanding that the USAR primarily mobilizes units, not individuals, I feel additional volunteer service agreements would be neither mission nor cost effective. Instead, I think Congress should empower the SECDEF with the capability to initiate actions to assemble, and prepare for activation, a relevant and capable force mix to preserve or promote our national interests at home or overseas. The value of such autonomy would be easily validated whenever the United States had to quickly send the proper military capabilities to either prevent or mitigate the effects of a natural disaster in a foreign country.

Admiral DEBBINK. I believe the best approach is to provide the necessary authority for the Services to have routine access to the operational elements of the Reserve components. For many capabilities, the Reserve component complements the capabilities of the Active component, and is the best source for some capabilities. Our reservists are all volunteers. When they choose to affiliate with an operational unit, they expect to perform Active Duty service in support of the country, and they want to be involved in DOD operations globally.

General STENNER. My belief is that a voluntary basis is the best approach. A more flexible involuntary call-up may negatively affect recruitment and retention.

General KELLY. A more flexible involuntary call up should be enacted. To fully recognize the potential of the Reserve component as a non-OCO operational force, involuntary mobilization authority is required to support CCDR requirements across "the full spectrum of conflict." Involuntary mobilization authority is required to preserve the integrity of Reserve component force generation models because when volunteers are cross-leveled between several units, the mission readiness of remain-behind units suffer. When a deploying unit's personnel and equipment do not originate from within, the mission readiness of units that provide volunteers and equipment suffer. This, in turn, jeopardizes the reliability of force generation models and eliminates the predictability they provide to service headquarters, servicemembers, families, and employers.

44. Senator GRAHAM. General Stultz, Admiral Debbink, General Stenner, and General Kelly, we are consistently told the Reserve components are more cost effective than the Active Forces. What funding challenges do you foresee in realizing an operational reserve?

General STULTZ. To fully operationalize, the USAR will increase readiness by reducing the number of post-mobilization training days needed to deploy and therefore, increase the amount of time units spend boots-on-the-ground for a given mission. To accomplish this goal, the USAR foresees the following resourcing challenges in base funding: increases in Operational Tempo (OPTEMPO); military pay associated with increased pre-mobilization training days as a part of the ARFORGEN process; enhancements to the Combat Support Training Centers and Medical Regional Training Sites; and increases in flexible full-time equivalent support.

Admiral DEBBINK. While current budgets and associated OCO supplementals support present use of the Navy Reserve, the future construct we envision will demand

continued sufficient resourcing of Fleet support. Current DOD appropriations are pressurized, and operational support funding is viewed as "discretionary." Maintaining level, sustainable, and adequate funding for the operational elements of the Navy Reserve will be a key component of the successful implementation of this initiative.

General STENNER. The operational reserve concept of operations necessitates a significant investment in readiness assurance training. It's extremely important for Reserve personnel to have ready access to state-of-the-art equipment with which to train, and that adequate funding be made available to ensure optimum levels of readiness for all assigned personnel. One of the largest funding challenges the AFR faces is to ensure training requirements are funded adequately to ensure members are qualified and ready for deployments. We must ensure mission qualified reservists are available and ready for deployment.

As currently appropriated, the Reserve Personnel, Air Force, (RPA) appropriation is for "training" reservists. It is not intended to be used to perform missions tasked by the Active Duty component. Reserve support to the Active Duty component is to be funded through the Military Personnel Appropriation (MPA). We are concerned that as the AFR becomes more "operational", that our increased support activity, and funding requirements, will increase costs in MPA, adding further stress to an already challenged appropriation. Ultimately, either more MPA funding will be needed, or language must be added to clearly and specifically allow supporting the Active Duty component using the RPA.

Finally, the activities associated with an operational reserve require additional funding for manpower and facility space for the Reserve headquarters, including the issuance of MPA days along with travel and per diem supporting the Active Duty taskings.

General KELLY. Unquestionably the Reserve Forces are more cost effective to maintain. This is due primarily to the reduced manpower cost. The Reserve Forces are trained, manned, and equipped to the same standards as the Active component. For the vast majority of Reserve marines, this is accomplished through 48 drills and a 2-week annual training period, equating to a paycheck for 62 days a year. Reserve Operations and Maintenance costs are somewhat reduced, based on supporting the reduced time reservists are actually in a duty status. However, the majority of Reserve operations and maintenance costs are non-discretionary (i.e. utilities, facilities sustainment and maintenance, maintenance of equipment, etc.). Because we train to the same standards as our Active component counterparts, Reserve Forces can be integrated into the Total Force very quickly and with minimal "specialized" training. Once activated to fulfill Active component missions, the Reserve Forces costs are practically the same as the Active component. These are incremental cost in that they are above and beyond what is programmed in the Active Duty appropriations to support the authorized end strength.

However, history has proven there are no significant savings in the Reserve appropriations, due to activations, unless they are activated for an entire year. This is primarily because once notified of the intent to activate, Reserve marines accelerate their drills and annual training periods to prepare for upcoming activations.

45. Senator GRAHAM. General Stultz, Admiral Debbink, General Stenner, and General Kelly, are there any hidden costs that could reduce your Reserve Force's cost effectiveness?

General STULTZ. As a strategic reserve, no. However, there will be some costs associated with an operational reserve. Costs include medical care before and after mobilization; potential increases in Veterans Affairs benefits; post deployment support to soldiers and their families; and increases in the overall equipment level of certain units. Yet, even with these additional costs for an operational reserve, the USAR continues to remain a cost effective force.

Admiral DEBBINK. There are no hidden costs.

General STENNER. Increased readiness ultimately equals increased costs. Expediting the process of fully training, qualifying, and certifying each individual as quickly as possible, as the AFR is determined to do, also increases expenses. The most prominent funding issue is the amount of additional support and "hands on" time required to make sure each reservist is current and fully qualified. Many AFR specialty areas are technologically complex and require demonstrated proficiency in order for the individual to be considered deployment-ready. The legacy missions in the AFR are being supplanted by even more challenging requirements in the Air Force's new array of emerging organizations, and the need for substantial training drives increased costs. Unlike previous eras, Active Duty personnel with the requisite skills are not generally available, so the training requirements are consequently much greater.

Additionally, operating costs for Reserve wings located on Active Duty and joint installations are increasing as the additive support required for reservist qualification and currency training leads to increased charges for common support from the Active Duty hosts. The host installations have placed limits and restrictions on standard services that ultimately increase Reserve expenses and reduce that cost effectiveness.

General KELLY. Major end items are purchased as Total Force requirements from the Procurement Appropriation. Due to lead time for delivery of these items and changing priorities, it is difficult to determine what portion of the Procurement account (outside NGREA), which directly supports the Reserves on an annual basis.

46. Senator GRAHAM. General Stultz, Admiral Debbink, General Stenner, and General Kelly, what do you see as the most significant obstacle to realizing a truly operational reserve in the post-OCO steady state?

General STULTZ. I see funding as the most significant obstacle to realizing a truly operational reserve. I mean, we've been effectively functioning in this capacity for over 8 years and what has enabled us to do all that is required as an operational force: the manning, equipping, and training has been provided through a string of budgetary supplementals. As an active participant in the Army's budget preparation efforts, it is not difficult to see that the Army's base budget has minimal capacity to absorb and sustain the costs associated with fielding a truly operational reserve. Conventional wisdom suggests there is a direct relationship between OCO funding and increased utilization of the Reserve component. It only follows that, if OCO funding is decreased, the operational tempo that we equate to an operational reserve will also decrease. So, I see funding (followed closely by current mobilization authorities) as the most significant obstacle to realizing a truly operational reserve.

Admiral DEBBINK. The most significant obstacle will be ensuring appropriate policies and legislation are in effect to allow the Services to keep faith with the members, families, and employers of the Reserve Forces. Our success in any endeavor, from OCO support to the implementation of an operational reserve in the post-OCO environment, depends on the strength of the support our reservists and their families receive from the military and their civilian employers. By providing predictable rotations of active service and ensuring the assignment of meaningful work for those periods, the Services will be better positioned to maintain readiness and retention levels.

General STENNER. The higher costs in a fiscally constrained environment, ability to recapitalize worn out equipment, and need to mirror Active Duty requirements via acquisition programs are the largest obstacles to a truly operational reserve.

The higher costs associated with operational reserve use, as opposed to use as a strategic reserve, is due to the generally higher rank and experience level of our units. The higher experience and ranks of our units translates into higher pay costs when used in an operational reserve mode.

The higher rates of use of equipment in an operational reserve will lead to a more rapid retirement of older aircraft and equipment. Once again, in a fiscally constrained environment recapitalization may pose challenges.

Active Duty aircraft are updating their equipment with new weapons, defensive systems, and communications gear. As new equipment is outfitted on Active Duty aircraft, the AFR will need to match these improvements to maintain combat readiness and interoperability. This too will pose challenges for the operational reserve Air Force.

General KELLY. Funding an operational reserve from baseline service budgets as OCO supplemental funding diminishes. Operational reserve funding will likely compete with other service programs and requirements, primarily Military Personnel Marine Corps funding as it relates to the Marine Corps' Active component end strength.

MEDICAL READINESS

47. Senator GRAHAM. General Stultz, in a DOD report on the individual medical readiness of Reserve Forces, it stated that only 57 percent of USAR personnel met deployment-ready standards, with mobilization-disqualifying dental conditions being the prime reason for the low percentage. Despite the importance of medical and dental readiness, at the end of the day, my sense is that funding for medical and dental readiness does not compete well with other priorities, such as training and equipment and that the real solution is day-in, day-out leadership within Reserve and Guard units. What is the best solution to ensure that funding for readiness includes and improves medical and dental readiness?

General STULTZ. Command emphasis and adequate funding have improved medical and dental readiness within the USAR.

Dental readiness has historically been one the lagging indicators for overall medical readiness. The Army Selected Reserve Dental Readiness System (ASDRS) is an example of prioritizing the utilization of medical readiness funding. Implementing the ASDRS program increased dental readiness from 52 percent on Oct. 1, 2008 to 63 percent on Oct. 1, 2009 to 70 percent on May 1, 2010.

As far as demonstrating an overall return on investment, medical readiness improved from 24 percent on Oct. 1, 2008 to 45 percent on Oct. 1, 2009 to 58 percent on May 1, 2010. As a result of this demonstrated improvement, funding for USAR medical readiness has competed well in the POM and is expected to be funded to achieve the DOD standard for medical readiness in fiscal year 2012.

QUESTIONS SUBMITTED BY SENATOR SAXBY CHAMBLISS

RETIRED PAY

48. Senator CHAMBLISS. Secretary McCarthy, as you know, I have been a strong supporter of allowing qualifying duty performance since September 11, 2001, to be counted towards early receipt of retired pay. I noticed in your statement that you said "we must recruit and retain prior-service personnel." If we were to pass a provision allowing qualifying duty since September 11, 2001, to be counted towards early receipt of retired pay, what effect do you believe that may have on recruiting and retention of prior-service personnel in the Reserve and what effect might such a provision have on force shaping of the Guard and Reserve in general?

Secretary MCCARTHY. Currently, we have not fully reviewed the impact of early receipt of retired pay on recruiting and retention on prior-service reservists. The 11th Quadrennial Review of Military Compensation will review the retirement system and its force shaping impact as part of its comprehensive analysis of National Guard and Reserve compensation. I am well aware that the Reserve retirement system is a significant issue for the members of the National Guard and Reserve and we are carefully examining this system.

RESERVE READINESS

49. Senator CHAMBLISS. General Carpenter, in terms of training, how are you doing with respect to having up-to-date equipment that you can train on?

General CARPENTER. New equipment is coming to the ARNG today at an unprecedented rate; the fielding of new equipment requires initial user level training. When fielding new equipment, such as a digital command and control system to a unit, the Product Manager is required to conduct training for the unit; usually the training is done through the New Equipment Training (NET) process and is the initial step in fielding equipment. NET provides basic level training for operators, maintainers, and unit leadership, and provides the foundation for further refined collective training at the unit level.

Part of the ARNG's issue with respect to equipping is the timeliness that we receive new equipment. The ARFORGEN cycle is designed for units to progressively build readiness in order to be operationally available to meet the needs of the Nation on a rotational basis. In order to achieve the required readiness levels, unit training is designed to become progressively more complex and intense. Equipment must be programmed and scheduled to be fielded by units early in their respective ARFORGEN cycles in order to facilitate, rather than interrupt, the training plans. If a unit receives equipment late in the ARFORGEN cycle, critical training events are interrupted and may be canceled in order to complete the fielding process. That training must then be made up later, most likely at a mobilization station, resulting in additional post-mobilization training time and less time that the unit will spend deployed in theater.

50. Senator CHAMBLISS. General Carpenter, I know there are efforts to ensure that the Reserve component have access to equipment compatible with the Active component, but are you confident that our soldiers in the National Guard and Reserve are getting these items?

General CARPENTER. The Army continues to improve the EOH rates as well as the modernization levels for both the ARNG and the USAR. The Army sees this as critical to the transformation of the Reserve component from a strategic to an operational reserve. The Army Equipping Strategy identifies equipping goals for units

as they progress through the ARFORGEN cycle. These equipping goals apply equally across all three components—Active, ARNG, and USAR.

Beginning in fiscal year 2006, the Army significantly increased its investment in ARNG equipment, allocating approximately $28.7 billion for new procurement and recapitalization between fiscal year 2006 and fiscal year 2010. Of particular significance, the ARNG was fully equipped with SINCGARS radios and UH–60 Blackhawk helicopters in fiscal year 2009 and is on track to complete fielding of M4 rifles by the end of fiscal year 2010. However, the Blackhawk fleet is still only partially modernized and current funding efforts will not produce a modernized fleet until the end of fiscal year 2025. Despite the increased investment since fiscal year 2006, the ARNG still has critical shortfalls and modernization gaps in the truck fleet, helicopter fleet, and digital enablers. In addition to supporting OCO, this equipment is critical to supporting the ARNG's Homeland Defense/Defense Support to Civil Authorities (HLD/DSCA) missions.

Modernization

The Army is committed to equipping soldiers going into harm's way with the most capable systems possible. This equipping strategy applies to Reserve component units as well as Active component units and is designed to modernize the USAR and ARNG on par with the Active component.

Transparency

The CNGR—also known as the "Punaro Commission"—provided DOD with a set of recommendations designed to improve the operational readiness of National Guard and Reserve Forces. Two of the recommendations (CNGR #42 and #43) directed DOD to increase the transparency of equipment requirements, funding, procurement, and delivery. Over the past year, the Army has significantly improved transparency within its equipment procurement and distribution processes.

Based on the current Army Equipping Strategy, the Army's commitment to equipping soldiers going into harm's way with the most capable systems possible and the significant increase in transparency, I am confident the ARNG is receiving modern equipment which is compatible with the Active component.

51. Senator CHAMBLISS. General Carpenter, are they able to become familiarized with these items at home before they step foot into Iraq or Afghanistan and see them for the first time?

General CARPENTER. ARNG soldiers get the appropriate time to become familiarized with the new equipment, but we don't always get enough time to be proficient enough to realize the full capability of the new system.

Proper training with new equipment has three phases. First, the actual operators of the equipment must be trained in basic operation and maintenance. Second, the squad or section must be trained in integrating the new equipment into the performance of training tasks. Finally, as the unit conducts higher-level collective training, the various pieces of new equipment are integrated into the unit's operations.

The ARFORGEN design includes time for progressive training to ensure that units properly utilize new equipment while deployed. When fielding of new equipment occurs late in the ARFORGEN cycle, or even after mobilization, this progressive building of proficiency on the new equipment is delayed and sometimes lost. Individual operators may have a basic understanding of how to operate their equipment, but the unit is not sufficiently training in employing the equipment's full capability.

QUESTIONS SUBMITTED BY SENATOR GEORGE S. LEMIEUX

RESERVE TRAINING

52. Senator LEMIEUX. Secretary McCarthy, what is the status of the tire removal training project in fiscal year 2010 and what are the plans for this continued training activity in fiscal year 2011?

Secretary MCCARTHY. In October 2009, Dr. Kenneth Banks, Marine Resource Program Manager for Broward County, was notified that the Services did not select the Osbourne Reef Tire project as a training venue for fiscal year 2010. The Services select the projects based on specific training requirements and priorities. None of the Services have selected the reef project as a training project in 2011.

For 3 years, fiscal year 2007 to fiscal year 2009, military dive and boat crews have volunteered to conduct a training mission off the coast of Fort Lauderdale, FL, to assist Broward County with the 1977 failed Osbourne Reef Tire project. During the 3 years that training was conducted, over 40,000 tires of the 2,000,000 dispersed

throughout 36 miles of ocean floor were removed. The Innovative Readiness Training (IRT) has been a very successful program to provide voluntary real world predeployment training venues for military units while benefiting underserved communities throughout the United States.

53. Senator LEMIEUX. Secretary McCarthy, can you provide me with a status report on the IRT program in the fiscal year 2010 and highlight projects in the State of Florida and explain how the fiscal year 2011 budget request and the National Defense Authorization Act dovetail with your plans in Florida for fiscal year 2011?

Secretary MCCARTHY. There are no IRT projects being conducted in Florida during fiscal year 2010. Broward County was the only entity in the State of Florida that submitted a request for military support under the IRT program in fiscal year 2010. Broward County was notified in October 2009 that none of the Services had selected the Osbourne Reef Tire Project as a training venue for fiscal year 2010. IRT is a voluntary program which the Services can use for alternative training; as such, none of the Services have selected the Osbourne Reef Tire project as a training venue for 2011. No other communities or non-profits in the State of Florida requested support in accordance with the IRT program for fiscal year 2011.

Section 2012, title 10 U.S.C., DOD Directive 1100.20 and Service instructions authorize units or individuals to provide support to non-DOD organizations. The Services have the opportunity to review many training venues submitted by communities and determine those that will meet the mission essential task list training requirements of the military personnel. This voluntary training alternative for meeting military mobilization readiness requirements has assisted communities throughout the United States with infrastructure development and medical care.

[Whereupon, at 11:33 a.m., the subcommittee adjourned.]

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