

**DEPARTMENT OF DEFENSE APPROPRIATIONS
FOR FISCAL YEAR 2010**

THURSDAY, JUNE 18, 2009

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:30 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (chairman) presiding.

Present: Senators Inouye and Cochran.

NONDEPARTMENTAL WITNESSES

STATEMENT OF ALEC PETKOFF, DEPUTY DIRECTOR, NATIONAL SECURITY COMMISSION, THE AMERICAN LEGION

OPENING STATEMENT OF SENATOR DANIEL K. INOUE

Chairman INOUE. I'm pleased to welcome all of you to this hearing, where we'll receive public testimony pertaining to various issues related to the fiscal year 2010 Defense appropriations request.

Because we have so many witnesses who wish to present testimony, I'd like to remind each witness that, unfortunately, they'll have to be limited to 3 minutes. Like to have this all day, but I have a supplemental appropriations pending on the floor.

So at this point, I'd like to recognize the first witness, Mr. Alec Petkoff, deputy director of the—national security of The American Legion.

Mr. PETKOFF. Thank you, Mr. Chairman.

Mr. Chairman, I want to thank you for inviting The American Legion to share its views on defense appropriations for fiscal year 2010.

Since its founding in 1919, The American Legion remains steadfast in support of a strong national defense. The United States is a Nation at war, still battling against extremist Islamists all over the world. The United States also must be prepared for any number of threats to our national security, whether they arise from powerful nation states, rogue nation states, nonstate violent extremists, natural disasters, or instability resulting from economic downturns in the world economy.

Our need for a ready and robust military is clear. Now is not the time to slow down or reduce the level of spending required to keep our country safe from this spectrum of threats. From quality-of-life issues, to force structure, to military healthcare, to procurement,

none of these areas should be neglected at the expense of the other. With this in mind, we would like to briefly highlight some vital areas of concern.

The first area of concern is the size of the active duty force. For decades, The American Legion has advocated for an active duty force of at least 2.1 million members. Since September 11, 2001, we have seen the results of having a force that is too small in relation to our national security needs. The results have been dramatically bad for our military servicemembers. These results are multiple deployments without adequate dwell time, straining military servicemembers, and likewise their families, to the breaking point; the required implementation of stop-loss, and the dramatic transformation of the National Guard from a strategic force to an operational force, which has increased our risk and reduced our strategic freedom of action. These results have had negative impacts on readiness and quality of life.

Three years ago, Congress decided to increase the size of the force, adding 65,000 soldiers to the Army. This initiative has been a success. The Army reached its increased recruiting goal earlier this year, 2 years ahead of schedule. The Grow the Force Initiative has been successful, but that does not mean it should end.

This is reinforced by Defense Secretary Robert Gates, who said, in testimony before the Senate Armed Services Committee last month, that despite the success of the Grow the Force Initiative, he remains concerned by the limited dwell time that our soldiers have between deployments. Therefore, The American Legion recommends further funding to significantly increase the size of the force beyond the original Grow the Force Initiative.

The American Legion also has the following recommendations for the subcommittee:

In military personnel, The American Legion supports a military pay raise from the suggested 2.9 percent to 3.9 percent, to help close the civilian-military pay gap, and additional funds for Reserve Officer Training Corps.

In operation and maintenance, with respect to defense health programs, The American Legion supports the full funding of TRICARE for retirees, dependents, and all Reserve forces. The American Legion also supports wounded warrior care improvements, to include outreach and treatment for traumatic brain injury and all mental and combat-stress related illnesses. And finally, funding for a standalone DOD research program into blood cancers, through the congressionally directed medical research program.

In procurement, the Army should obtain necessary equipment to man the full complement of 48 brigade combat teams, as opposed to the proposed cutback to 45, and continue to refit and update the equipment of our Reserve forces, and timely procurement of advanced Air Force and Navy weapons systems, aircraft, and ships.

In research, development, testing and evaluation, increases in missile defense, electronic warfare technology, and weapons technology are needed. Cuts to missile defense seem unwise.

And finally, military construction—construction improvements to base medical facilities, commissaries, exchanges, and other facilities. And we urge that whenever a base realignment and closure

is conducted, that certain base facilities, such as medical facilities, commissaries, exchanges, and other facilities, be preserved for use by active duty, reservists, retired military, veterans, and their families.

The American Legion, again, thanks the chairman for having this important hearing, and for inviting us to present our views. I look forward to continue working with this subcommittee on these important issues of national defense.

Chairman INOUE. Thank you very much. I would welcome any written material you may have.

Mr. PETKOFF. I would like to submit our written testimony for the record at this time, Mr. Chairman.

Chairman INOUE. Thank you.

[The statement follows:]

PREPARED STATEMENT OF ALEC PETKOFF

Mr. Chairman and members of the Subcommittee, thank you for inviting The American Legion to share its views on defense appropriations for fiscal year 2010. Since its founding in 1919, The American Legion remains steadfast in its support of a strong national defense which is reflected in the Preamble to The American Legion Constitution, namely, "To uphold and defend the Constitution of the United States of America," and "to inculcate a sense of individual obligation to the community, state and nation."

The United States is a Nation at war still battling against extremist Islamists all over the world. The United States also must be prepared for any number of threats to our national security whether they arise from powerful nation-states like Russia or China; rogue nation-states like Iran, North Korea or Somalia; natural disasters; or instability resulting from economic downturns in the world economy. Our need for a robust military is clear. Now is not the time to slow down or reduce the level of spending required to keep our country safe. With this in mind, The American Legion offers the following recommendations with a brief summary of explanation followed by a more complete rendering of The American Legion's views and recommendations:

APPROPRIATIONS PROPOSALS FOR SELECTED GENERAL DISCRETIONARY PROGRAMS FOR
DEPARTMENT OF DEFENSE FOR FISCAL YEAR 2010¹

[In Billions]

	Funding for fiscal year 2009	Proposed defense funding for fiscal year 2010	The American Legion's fiscal year 2010 recommendations
Total Defense Spending	\$654.7	\$663.7	\$728.2
Military Personnel	\$142.7	\$149.6	\$150
Operation and Maintenance	\$273.5	\$276.2	\$315.7
Defense Health Programs (Operation and Maintenance)	\$25.7	\$26.9	² \$63.2
Procurement	\$133.2	\$131.2	\$136.2
Research, Development, Test and Evaluation	\$81.7	\$78.9	\$100
Military Construction	\$28	\$22.9	\$26.3

¹ Includes Overseas Contingency Operations or OCO funding.

² Increase already included in Operation and Maintenance.

Military Personnel.—Military pay raise from 2.9 to 3.4 percent to help close the civilian/military pay gap. Additional funds for Reserve Officer Training Corps (ROTC).

Operation and Maintenance.—The Administration's overall modest increase in operations and maintenance is found mostly in the line item, "Administration and Servicewide Activities" while the line item "Operation Forces" actually gets a decrease. While one can only assume the decrease is predicated on a drawdown of forces in Iraq, The American Legion recommends that more funds be allocated in case the plans for withdrawal are found to be premature by either the Iraqi government or more importantly our commanders on the ground.

Defense Health Programs.—Fully fund TRICARE for retirees, dependents and all reserve forces; Stand alone fund for blood cancers; Wounded Warrior Care improvements.

Procurement—Army.—Obtain necessary equipment to man the full complement of 48 BCTs, Navy—Oppose shifting the Navy Aircraft Carrier program to a 5-year build cycle. Longer cycles only mean larger costs and a weakened force. Air Force—Continue to purchase more F-22 Raptors and to hasten purchase and building of the aerial refueling tankers. Reserve Forces—Continue to refit and update equipment.

Research, Development, Test and Evaluation.—Increases in missile defense, electronic warfare technology, and weapons technology needed. Cuts to missile defense are unwise.

Military Construction.—Construction and improvements to base medical facilities, commissaries, exchanges and other facilities.

The American Legion upholds the following national security principles as fundamental to the best interests of the United States:

- The National Security Strategy needs to be reassessed so that missions and resources are more closely aligned, particularly during the upcoming Quadrennial Defense Review.
- The credibility of the United States in an unstable world needs to be maintained by retaining requisite military capabilities to deal with actual and potential threats.
- Such a strategy requires that the Armed Forces be more fully structured, equipped and budgeted to achieve this strategy.
- Active and reserve military end strengths should be increased to an absolute minimum of 2.1 million for the foreseeable future.
- At least 12 full-strength Army Divisions, 11 deployable Navy aircraft carrier battle groups, three or more Marine Corps Expeditionary Forces, and 13 or more active Air Force fighter wing equivalents should be retained, as the minimum needed baseline force.
- Defense budgets should be funded at least 4 percent of Gross Domestic Product (GDP) during time of peace, and at 5 percent or more during time of war to fund both people and weapons requirements.
- The National Guard and Reserves must be realistically manned, structured, equipped, trained, fully deployable and maintained at high readiness levels, and not over-utilized in order to accomplish their increasing and indispensable missions and roles in the national defense.
- Peacetime Selective Service registration should be retained so as to maintain a viable capability to rapidly reconstitute forces in the event of emergencies or war.
- Force modernization for the Armed Forces needs to be realistically funded, and not further delayed, or the United States is likely to unnecessarily risk American lives in the years ahead. Production of airlift and sealift assets needs to be expedited.
- The American people expect that whenever Armed Forces are committed, that they will be committed only when America's vital national interests are threatened and only as a last resort after all reasonable alternatives have been explored and tried.
- Peacekeeping, peace enforcement, peace-making and humanitarian operations detract from military readiness to conduct combat operations across the full spectrum of potential conflicts. Such operations should be limited, congressionally approved and separately appropriated on a case-by-case basis.
- The honorable nature of military service should be upheld, as it not only represents fulfillment of American patriotic obligation, but is also a privilege and responsibility of citizenship that embodies the highest form of service to the Nation.
- The United States Government must honor its obligations to all service members, veterans, military retirees and their families with equitable earned benefits, lasting military retirement compensation and other appropriate incentives, such as timely access to quality health care for all beneficiaries.
- Major incentives for military service should include an enhanced GI Bill for education and training, improved quality-of-life features, and a reduced operational tempo in order to recruit and retain a high-quality and fully manned, professionally led force.
- The United States Government is urged to retain the necessary deployed forces worldwide to accomplish short-term as well as long-term commitments and contingencies.

The American Legion would like to thank Subcommittee Members for their hard work on previous legislation to improve the quality-of-life for America's Total Force military, retirees, and their families.

This portion of the statement will contain issues on the following subject areas:

- Quality-of-Life;
- Force Structure;
- Manpower and Weapons Systems;
- POW/MIA.

QUALITY-OF-LIFE

It is with particular purpose that The American Legion address quality-of-life issues before the issues of "force structure" and "manpower and weapons systems" as concerns our national defense. Maintaining a high quality-of-life for our service members has to be the first priority of any nation that seeks to defend its interests at home or abroad. Whether it be the infantryman, the pilot, the mechanic, or the cook, America needs to be able to attract and retain the best and brightest our Nation has to offer. Without such Americans to answer the call to service, all other money spent on defense will be in vain. And so it is with good reason that The American Legion is first concerned with the enhancement of quality-of-life issues for active-duty service members, Reservists, the wounded and disabled, military retirees, and their families. If we are to win the war on terror, and prepare for the wars of tomorrow—in this decade and beyond—we must take care of the DOD's (Department of Defense) greatest assets; namely, its men and women in uniform.

The United States must honor its obligations to all service members (past, present and future) and their families. The American Legion urges the Congress and DOD to support and fund quality-of-life features for Active-Duty, National Guard and Reservists as well as military retirees, veterans and their dependents, and military survivors. This is including but not limited to, the following:

- Military pay comparability for the Armed Forces and regular increases in the Basic Allowances for Quarters; renovation and construction of military quarters and increased funding for child day care centers are direly needed. Pay raises must be competitive with the private sector;
- Adequate medical, mental and dental health services; morale, welfare and recreational facilities; and non-privatized exchanges and commissary facilities. The Defense Commissary Agency (DECA) and its functions should be retained and not relegated to the military services;
- Preserving an attractive retirement system for the active and Reserve components and annual cost-of-living adjustments (COLAs) paid at the same rate and concurrently with other Federal retiree COLAs; oppose any changes to the military retirement system, whether prospective or retroactive, that would violate contracts made with military retirees and undermine morale and readiness;
- Requiring that the Services perform mandatory physical examinations, without waivers, for all separating veterans;
- Fully funding the concurrent receipt of military retirement pay, military separation pays, and Department of Veterans Affairs (VA) disability compensation as well as Special Compensation pays for disabled military retirees;
- That the Survivor Benefit Plan and Dependency and Indemnity Compensation (SBP/DIC) offset be eliminated;
- TRICARE for Life and the TRICARE Senior Pharmacy program for Medicare-eligible military retirees, their dependents and military survivors, should be adequately funded; and regular cost-of-living adjustments to military retirement deployment pay, capital gains tax exclusions, tax-free and increased death gratuity payments, and combat zone tax exclusions for service in South Korea;
- Congressional re-enactment of Impact Aid to fund the local public school education of military dependents;
- Adequately protecting the American public and the Armed Forces from the actual or potentially harmful effects of friendly and hostile chemical, biological and nuclear agents or munitions;
- Urging the Congress to extend and improve additional quality-of-life benefits, allowances and privileges to the National Guard and Reserves involved in homeland security and other missions so as to more closely approximate those of the active force. Military retirement pay and TRICARE healthcare for members of the Reserve Components should be authorized before age 60. Hazardous duty and incentive pays for Reservists should be the same as active duty; tax credits to private businesses that pay the difference between military and civilian salaries to mobilized Reservists and restore travel exemptions for Reserve and Guard members for expenses associated with attending drills;

- Military health care should also be provided to members of the Reserve Components and their dependents, who become injured while on active duty status regardless of the number of days served on active duty, to the same degree as active duty members under the same circumstances;
- Whenever a Base Realignment and Closure (BRAC) is conducted, The American Legion will urge that certain base facilities such as base medical facilities, commissaries, exchanges and other facilities be preserved for use by active duty and Reservist personnel and military retired veterans and their families;
- Walter Reed Army Medical Center not be closed until after Overseas Contingency Operations have ended;
- That the numerous, recurring and serious pay problems experienced by the Active and Reserve Components be immediately resolved; and
- Traumatic Brain Injury and Combat Stress Disorders be diagnosed and effectively treated in the military.

Wounded Warrior Care

The respective branches of the military often like to pontificate on how they all “take care of their own.” Nowhere is this statement put more to the test than when dealing with the combat and severely wounded. Since the Building 18 episode at Walter Reed Army Medical Center, a well-deserved spotlight was put on the whole transition process for outgoing military personnel. The resulting findings were somewhat surprising in that it was not the quality of medical care that was in question, but rather it was everything else. Some of those issues included electronic transference of medical records; scheduling of appointments; housing; family support issues; the Physical Evaluation Board (PEB) and Medical Evaluation Board (MEB) process; applying for VA benefits and receiving them without a gap in pay upon discharge from the military; endless forms, paperwork and tests.

The American Legion supports many of the reforms, most of which are still in the form of pilot programs, that address these issues. Warrior Transition Units (WTUs) need to be fully funded and fully staffed. PEB/MEB process needs to be overhauled. Great strides have been made since 2007, but the progress made (particularly in the area of the WTUs) not only needs to be maintained but expanded.

The American Legion supports some of the recommendations of the President’s Commission on Care for America’s Returning Wounded Warriors (the Dole/Shalala Commission). Under the Commission’s proposal, service members found unfit for military duty (a determination made by DOD based on a joint VA/DOD collaborative examination process) would be awarded a lifetime annuity payment by DOD based on years of service and rank. The purpose of this annuity is to compensate for the loss of the service member’s military career.

As these reforms are instituted, the new rating system and compensation should be made retroactive to correct those past egregious disability decisions and call for the re-rating and reevaluation of immediate past military disability retired personnel.

Since Operations Enduring Freedom and Iraqi Freedom began, over 5,000 Americans have given their lives in our operations in Iraq and Afghanistan and over 34,000 have been wounded in action. Of those wounded, over 15,700 did not return to duty. Caring for our military and ensuring good quality-of-life for the service member and the family is part of the ongoing cost of war and national security.

The fiscal year 2009 budget has \$3 billion to improve army barracks, military hospitals, and other facilities. The American Legion recommends a minimum of \$3.4 billion for fiscal year 2010 in order to ensure that there are no delays in construction and improvement of living quarters and medical facilities.

The fiscal year 2009 budget has \$25.8 billion, \$2.4 billion above 2008, for medical care. This includes \$300 million for traumatic brain injury (TBI) and psychological health. The American Legion applauds Congress for this increase and recommends that funding for fiscal year 2010 be \$28 billion in order to sustain current costs and to improve treatment for TBI and psychological health professionals, particularly for the Reserve force that may live in rural areas.

Force Health Protection

The American Legion continues to actively monitor the DOD’s implementation of Force Health Protection policies and urges continual congressional oversight to ensure that all Force Health Protection laws and policies, including thorough pre- and post-deployment physical and mental examinations, are being properly implemented in a consistent manner by all military branches.

The American Legion also urges DOD to actively track and follow-up, with proper medical care, adverse reactions to vaccinations as well as any and all health-related complaints associated with the ingestion of controversial drugs such as

pyridostigmine bromide and Lariamand. In addition, The American Legion urges DOD to continually improve its treatment of service personnel who have been diagnosed with post-traumatic stress disorder and/or traumatic brain injury.

Concurrent Receipt of Military Retired and Severance Pays and Disability Compensation and Their Dependents

Military retired pay and disability compensation have been erroneously equated in one form or another for too long. One pay is earned through service and the other is compensation for debilitating injuries that were acquired while in service (on the job, so to speak). To offset one against the other is clearly unfair.

The American Legion expresses its gratitude to the Congress for the authorization of both Combat-Related Special Compensation (CRSC) and partial concurrent receipt for over 200,000 disabled military retirees but urges the Congress to authorize and fund full concurrent receipt for all disabled military retirees to include those rated at 40 percent and below and to authorize the CRSC payment of military disability retiree pay and VA disability compensation for those disabled military retirees.

Additionally, The American Legion urges Congress to eliminate the phase-in of provisions in Public Law 108-136 so as to accelerate restored retired pay in less than 10 years and to authorize the concurrent receipt of military severance pay for less than 30 percent disabled service members and VA disability compensation.

TRICARE

The American Legion has a longstanding position that it should prevail upon any Administration and DOD to reconsider any proposals to implement any increases in the military retirees' TRICARE enrollment fees, deductibles, or premiums. The American Legion urges Congress to fully fund military and VA healthcare programs for beneficiaries as well as a permanent TRICARE program for Guardsmen and Reservists. The American Legion recommends that the following guidelines be incorporated as part of the DOD healthcare package for military retirees, dependents and military survivors:

- Administrative barriers to an effective TRICARE system to include raising TRICARE provider reimbursements; program portability between TRICARE regions; reducing delays in claim payments; and increasing electronic claims processing need to be removed. Improve TRICARE enrollment procedures, beneficiary education, decrease administrative burdens, eliminate non-availability requirements and eliminate unnecessary reporting requirements;
- TRICARE programs to include the TRICARE for Life and the TRICARE Senior Pharmacy programs which are used by 1.3 million Medicare-eligible military retirees and their dependents should be fully funded annually;
- Restore TRICARE reimbursement policy to pay up to what TRICARE would have paid had there been no other health insurance as was the policy before 1993;
- Dual eligible disabled retirees continue to receive health care from both military treatment facilities and VA medical centers. TRICARE Prime Remote should be included for military retirees, dependents and military survivors;
- All military beneficiaries should be authorized to receive dental and visual care at military treatment facilities;
- Retired Reservists and their dependents should be eligible for TRICARE coverage when they become eligible to receive retirement pay; The American Legion urges that all discharging service members, active and Reservists be required to have discharge and retirement physical examinations; physicals should not be optional or abbreviated;
- Adequate military medical personnel, to include graduates of the Uniformed Services University of Health Sciences and members of the Commissioned Officer Corps of the Public Health Service, should be retained on active duty to provide health care for active duty and retired military personnel and their dependents;
- The Federal Employee Health Benefits Plan (FEHBP) should be authorized as an alternative to TRICARE for those military retirees and dependents who can afford such premiums;
- TRICARE fees should not be increased except as authorized by Congress, not by DOD;
- Military construction funding should be authorized for the construction of Walter Reed Military Medical Center and the Fort Belvoir Army Community Center;

- If Congress increases TRICARE fees, the increases should be at a rate no larger than the rate of pay increases for Active, Reserve, National Guard, military and medical retirees, and military survivors.

Quality-of-Life for National Guard and Reserve Forces

The American Legion urges Congress and DOD to pass legislation and create policy that addresses all the needs of the Reserve forces to include:

- Full range of active duty retention bonuses and recruiting incentives, pay promotions and health care quality-of-life be applicably activated to the National Guard and Reserve;
- Qualified Reservists should be authorized to receive Military retirement pay and TRICARE healthcare before age 60;
- Hazardous duty and incentive pays for Reservists set the same as active-duty;
- Creating tax credits to private businesses paying the difference between military and civilian salaries to mobilized Reservists;
- Restoring travel exemptions for Reserve and Guard members for expenses associated with attending drills;
- Military health care provided to members of the Reserve Components and their dependents, who become injured while on active duty status regardless of the number of days served on active duty;
- Retired Reservists and their dependents should be eligible for TRICARE coverage when they become eligible to receive retirement pay;
- All discharging Reservists should be required to have complete discharge and/or retirement physical examinations to the same standard as the active-duty force.

General Quality-of-Life Issues

Armed Forces Retirement Homes

The American Legion urges the Congress to support and fund those measures, to include annual Congressional appropriations, which will provide for the long-term solvency and viability of the Armed Forces Retirement Home—Washington. The American Legion also strongly supports the rebuilding of the Armed Forces Retirement Home at Gulfport, Mississippi.

Support for the Selective Service Registration Program

The American Legion supports the retention of the Selective Service Registration Program as being in the best interests of all Americans, and its maintenance is a proven cost-effective, essential, and rapid means of reconstituting the required forces to protect our national security interests.

Reforming the Military Absentee Voting System

The American Legion urges that appropriate laws and guidelines be developed at Federal, State and local levels with the intent that all military absentee voters and their families will have their votes counted in every election. The American Legion also recommends that the sending and receiving of blank and completed military absentee ballots be accomplished electronically as much as possible.

Military Commissaries

The American Legion urges DOD and the Congress to continue full Federal funding of the military commissary system and to retain this vital non-pay compensation benefit system. This quality-of-life benefit is essential to the morale and readiness of the dedicated men and women who have served, and continue to serve, the national security interests of the United States. The American Legion opposes any efforts to institute “variable pricing” or to privatize the military commissary system or to dismantle or downsize the Defense Commissary Agency.

Military Funeral Honors

The American Legion reaffirms that the Congress should mandate and appropriately fund DOD and the Military Services, to include reimbursing the National Guard, so as to provide military honors upon request at veterans’ funerals in coordination with Veterans’ Service Organizations such as The American Legion at local levels. The Department of Defense should implement equitable and expedient reimbursement procedures for members of the veterans’ service organizations who participate in military funeral honors.

The American Legion also recommends that an action be taken to change the wordage, as currently written in Section 578 Public Law 106–65 to: That any and all funeral directors performing services for any veteran of The United States armed forces shall be required to ask the veteran’s family member or other interested party

if military honors are requested, at no expense to the family, rather than placing the burden upon the veteran's family at this time of bereavement.

FORCE STRUCTURE

The current active-duty personnel level has been funded to maintain just under 1.37 million active-duty service members. Military leaders had been making up manpower shortages by increasing the OPTEMPO, increasing rotations to combat zones, and by over-utilizing the Reserve Components. American military personnel are deployed to over 150 countries worldwide. Many of these personnel are from the Reserve Components. Multiple deployments, particularly to combat zones, are often the core element of the recruitment and retention challenges that have confronted the Army. While all the services have met or exceeded their recruitment goals for 2008, this is due in large part to the uncertainty in the economy and to the great successes our forces are having in Iraq. All of the services could find themselves in recruitment difficulties again if the economy recovers quickly or if casualties begin to rise again either in Iraq, Afghanistan or some other area of the world where our national security is threatened. We applaud Congress for funding the requested end strength increases of 7,000 for the Army, 5,000 for the Marine Corps, and 1,300 for the Army Guard for fiscal year 2009. However, The American Legion insists that these nominal increases are not enough to adequately provide for the needs of a strong national security posture. The active force combined with the reserve force still only totals under 1.75 million. As stated previously, The American Legion urges an active and reserve force of 2.1 million.

Modernization of weapons systems is vital to properly equip the armed forces, but is totally ineffective without adequate personnel to effectively operate state-of-the-art weaponry. No military personnel should go into battle with unarmed or under-armored vehicles or without body armor or with vehicles and helicopters that are approaching or exceeding their service lives. America stands to lose its service members on the battlefield and during training exercises due to aging equipment. The current practice of trading off force structures and active-duty personnel levels to recoup or bolster modernization or transformation resources must be discontinued. The Army and the Marine Corps need to be immediately funded to reset their combat forces so as to maintain their readiness.

The American Legion recommends restoring former military force structures and increasing active-duty end strengths so as to improve military readiness and to more adequately pursue the Overseas Contingency Operations (OCO). The American Legion seeks to improve alignment of service levels with missions to ease deployment rates and improve quality-of-life features. Ensuring readiness also requires retaining the peacetime Selective Service System to register young men for possible military service in case of a national emergency. Military history repeatedly demonstrates that it is far better to err on the side of preserving robust forces to protect America's interests than to suffer the consequences of an inadequate force structure or military non-readiness, especially during time of war.

America needs a more realistic strategy with appropriate force structure, weaponry, and equipment with increased active-duty and Reserve components and readiness levels to achieve its national security objectives.

Other Force Structure Issues and Recommendations

Support for the Non-Federal Roles of the National Guard

The active-duty force must be able to better accomplish its operational objectives around the globe without relying so heavily on the National Guard. The Guard must go back to its primary roles in homeland security and used as a mainly strategic asset and not as an operational one. The American Legion urges the Congress to retain National Guard units at reasonable readiness levels so that in addition to their active duty missions they may continue to provide civil disturbance and natural and man-made disaster assistance; perform civil defense and drug interdictions functions as well as other essential State or Federal roles as required to include border security.

Uniformed Services University of the Health Sciences (USU)

The American Legion urges the Congress to: continue its demonstrated commitment to USU, as a national asset, for the continued provision of uniquely educated and trained uniformed physicians, advanced practice nurses, and scientists dedicated to careers of service in the Army, Navy, Air Force, and the United States Public Health Service; support timely construction at the USU campus during fiscal years 2009-2010; continue funding the University's collaborative effort for sharing its chemical, radiological and biological, nuclear and high yield explosive (CBRNE)

expertise and training; support development of the USU Immersive, Wide Area Virtual Environment (WAVE) Simulation for CBRNE/WMD Medical Readiness Training; support funding for the Graduate School of Nursing Teaching/Educational Programs; and, encourage continued close collaboration and progress towards the OSD-proposed Joint Medical Command and WRNMMC with USU as the core academic health center.

Aeronautical and Space Exploration

The American Legion deems it imperative that the United States, in the face of increasing competition, maintain its hard-won status as the world leader in aeronautics and aircraft production and in space exploration and research. To realize this goal, we urge the Congress to provide:

- Adequate funding for the Nation's civilian and military aerospace research and development programs to maintain U.S. technological leadership.
- Adequate funding to build, upgrade and enhance the Nation's civilian and military aerospace research facilities and wind tunnels.
- A renewed national commitment to education involving academia in aeronautical and aerospace engineering research and technologies insuring a state-of-the art educated work force.
- Over-watch and investigate functions and related activities with respect to the transfer of American aerospace technology abroad.

Combating Cyberspace Threats

The American Legion urges the Congress to appropriate the necessary funding and resources to combat the continuing cyberspace and other threats to the United States in the 21st Century.

National Missile Defense System

The American Legion urges the United States Government to develop and continue to deploy a national missile defense system which is in the national interest of the United States and the American people and an essential ingredient of our homeland security.

Considering the growing threats of rocket and missile attacks by Iran and North Korea, proposed cuts to missile defense seem unwise. Even if cuts are being made in systems that are not deemed successful, those monies should be reallocated to those defense systems that are working.

MANPOWER AND WEAPONS SYSTEMS

The President's fiscal year 2010 Defense budget request should require continued funding to sustain current Overseas Contingency Operations (OCO) while maintaining the war-fighting capabilities of the Armed Forces. For years, the increased Operations Tempo (OPTEMPO), OCO, and budgetary shortfalls have had a devastating impact on military readiness, modernization, and personnel.

The American Legion recommends that the fiscal year 2010 Defense appropriations bill should include higher military pay raises and allowances as well as recruitment bonuses and incentives. The Defense Health Program, to include the TRICARE health care system, needs to be fully funded without new or increased TRICARE fees. Authorizations for continued higher spending on modernization must include: the resetting, repairing and procuring of Army weapons systems and equipment; continued spending for development of, and fielding, Joint Strike Fighters for the Air Force and Navy; and, procurement of more F-22A Raptor fighter jets and aerial refueling tankers for the Air Force.

The American Legion urges Congress to increase defense spending to levels that represent at least 5 percent of GDP. This represents not only ongoing needs, but also the shared burden of the American people during a time of war.

Defense budgets, military manpower and force structures are currently one-third of their 1986 peacetime levels. Military capabilities are at significantly lower levels than the Persian Gulf War in 1991. With only 10 active Army divisions in the inventory, it is little wonder that thousands of Reservists and Guardsmen have been called to active-duty to bolster homeland security and in fighting the wars in Iraq and Afghanistan. The current plan to cap the Brigade Combat Team numbers to 45, as opposed to the recommended 48, is a terrible case of robbing Peter to pay Paul. While the size of the force will still increase, the actual size of combat ready ground forces will still be inadequate. If our national security needs require more administrators and trainers, then so be it, but it should not come at a cost of a reduction in combat ready forces.

The American Legion, along with its previous quality-of-life and force structure recommendations, further recommends the following as regards the purchasing of weapons systems and armaments in general:

Rebuilding America's Defense Industrial Base

The American Legion urges the new administration and the Congress to rebuild America's industrial base by continuing to adequately fund research, development and acquisition budgets to assure that our military production can meet national requirements especially when U.S. military power is committed. Rebuilding America's industrial base could, and perhaps should, be part of the administration's plan to reinvigorate the economy.

We encourage the new Administration and the Congress in the rebuilding of America's defense industrial base by having a proper balance of policies that:

- Increase and then sustain domestic production at levels that maintain a robust and internationally competitive defense industry.
- Keep the arms industry internationally competitive.
- Ensure that the United States is not putting itself at risk by having our armaments produced offshore.

Buy American

The American Legion urges Congress to require Government contractors to utilize American-made components and subsystems in construction of their equipment over those made by foreign subcontractors for use by the United States military services to ensure the defense of the country, as well as the continued employment of Americans and veterans at subcontractor facilities.

Foreign Investments in the American Defense Industry

The American Legion urges the U.S. Government to ensure that foreign entities are not permitted to own critical industries, especially those involved in producing defense items. The American Legion further opposes the transfer and sales of sensitive technologies which may endanger our national security and economic interests.

Commercial Shipbuilding for Defense

The American Legion urges the Congress to vigorously act to stop the further erosion of our vital maritime capability by boosting naval budgets, promoting commercial shipbuilding, expanding the use of U.S. flagships in world commerce, and resisting foreign actions that would further damage America's defense industrial base.

Procurement of Sufficient F-22 Aircraft

The American Legion advocates that the procurement of F-22 Raptor aircraft should be approved and funded by Congress for the stated USAF requirement of 381 and that such procurement be funded through additional appropriations even if that should result in an increase in the overall National Defense Budget.

MILITARY CONSTRUCTION

Military Construction is directly related to the quality-of-life of the service member and their dependants. As such, Military Construction must be funded to a level that meets the immediate and future needs of DOD. The cornerstone to a strong national defense is not based on weapon systems purchased or the way the force structure is organized, but rather, the way military service members and their families are treated and cared for on military installations within the continental United States and overseas. In today's All-Volunteer Armed Forces, maintaining the highest quality-of-life standards is the least we should do in the interest of national security and as the thanks of a grateful Nation to those who serve.

Military Construction

The \$26.3 billion recommendation is based of the current force structure of 1.75 million. This recommendation also accounts for the modest upcoming authorized increases in the sizes of the Army and Marine Corps.

In fiscal year 2009, \$25 billion, (\$4.4 billion above fiscal year 2008) was appropriated for Military Construction. The large increase is mostly due to the costs of implementing Base Realignment and Closure (BRAC) and plans to increase the size of the Army and Marine Corps. It should be noted that The American Legion recommends a 2.1 million man force structure as opposed to the current force size. As such, if authorization and funding for the expansion of the active-duty and reserve force increased by an additional 50,000 service members for fiscal year 2010 (in order to get closer to The American Legion's recommended force structure level),

The American Legion would recommend \$31.3 billion for Military Construction funding for the construction associated with such an expansion of forces.

Quality-of-Life and BRAC

A quality-of-life concern that must be considered is the welfare of our retired military. Often, when a service member retires from service, whether medically or by longevity, they choose to live in close proximity to a military installation. They choose this in order to have access to the benefits they earned from honorable service. Those benefits include access to base medical facilities, commissaries, exchanges and other facilities.

Whenever a Base Realignment and Closure (BRAC) is conducted, The American Legion will urge that certain base facilities (such as base medical facilities, commissaries, exchanges and other facilities) be preserved for use by active-duty and Reservist personnel and military retired veterans and their families.

One key element of quality of life for service members and their families is the quality of their housing, whether it is supplied by the military in the form of on-base housing, or the availability and quality of off-base housing. Long standing policy of DOD has been to rely on local community housing. This policy comes into conflict with reality where there is a localized influx of military families, whether from BRAC or "Grow the Army"-like programs.

Currently, roughly 63 percent of all military families reside in off-base, private sector housing. A further 26 percent reside in residences built under the Military Housing Privatization authorities. Of the remaining 11 percent, 8 percent live in Government-owned housing and 3 percent in (primarily overseas) leased housing. However, the transience of forces may cause localized market problems in the coming years, as changes occur resulting from BRAC, Grow the Force initiatives, global re-posturing and joint basing. Some installations may suddenly find they have a surplus of housing as a result, while in other areas housing availability may be in deficit. Ensuring that service members and their families have access to safe, affordable and sufficient housing must remain a priority in order to address the quality of life for these families.

One initiative which has received excellent reviews from the services has been the Military Housing Privatization Initiative (MHPI) which encourages high quality construction, sustainment, and renovation of military housing by leveraging capital and expertise from the private sector. Under this initiative, 94 projects have been awarded, allowing the DOD to eliminate nearly all inadequate domestic family housing. This program should be continued and expanded with additional resources.

Numerous media reports surfaced last year of troops returning from OCO to barracks that were unsatisfactory. In one case, a distraught father of a soldier with the 82nd Airborne at Fort Bragg, NC went so far as film the living conditions and to publicize it through social networking sites. Following this renewed interest, the Army in particular began a sweeping inspection of all its living facilities and barracks to ascertain the level of need that many of them required in terms of maintenance and repair. The reforms resulted in the First Sergeants Barracks Initiative (FSBI) where the barracks are continually monitored for needed repairs, and "ownership" of barracks for deployed troops is transferred to post control for the duration of the deployment. This successful innovation should be adequately funded to accomplish these needed renovations.

In October of 2007, Secretary of the Army Pete Geren initiated a program entitled the "Army Family Covenant." At the time he stated:

The Health of our all-volunteer force, our Soldier-volunteers, our Family-volunteers, depends on the health of the Family. The readiness of our all-volunteer force depends on the health of the Families. I can assure you that your Army leadership understands the important contribution each and every one of you makes. We need to make sure we step up and provide the support families need so the army stays healthy and ready.

This covenant addressed various ways to improve family readiness by:

- Standardizing and funding existing family programs and services;
- Increasing accessibility and quality of healthcare;
- Improving Soldier and Family Housing;
- Ensuring excellence in schools, youth services, and child care; and
- Expanding education and employment opportunities for family members.

While we enlist soldiers, airmen, marines and navy personnel, we also re-enlist families. Issues of the covenant from which funding comes under the rubric of the Military Construction appropriations should be funded fully to ensure that we maintain a high level of quality of life, and thereby ensure a higher rate of reenlistment for the Armed Forces.

The commitment to this program by the Army was demonstrated by the testimony of Keith Easton, Assistant Secretary of the Army for Installations on March 12. He noted that the Army Family Covenant Program has shown significant progress in meeting its' goals since it came into existence. The program itself shows a commitment and understanding of the importance of family in our force structure and maintaining readiness and force levels. This program is another which should be expanded through adequate funding, to ensure the well being of service members and demonstrate the national commitment towards helping them individually and collectively prosper and reach their potential.

Increased spending in the area of military construction not only serves the strategic needs of the armed forces but also the needs of the service members. It takes approximately 8 years to build a senior Non-Commissioned Officer. To lose a member of the armed forces like that to the civilian world, because they feel they can have a better quality of life for them and their family outside of the services, is a cost that can not be recouped.

The American Legion fully supports the Army Family Covenant Program and engages all of its 14,000+ local American Legion posts to become involved.

Wounded Warrior Care

All branches of the armed forces ascribe to the ethic that they "take care of their own." Nowhere is this statement put more to the test than when dealing with the combat and severely wounded. Since the Building 18 episode at Walter Reed Army Medical Center, a well-deserved spotlight was put on the whole transition process for outgoing military personnel. The fiscal year 2009 budget has \$3 billion to improve army barracks, military hospitals, and other facilities. The American Legion recommends a minimum of \$3.4 billion for fiscal year 2010 in order to ensure that there are no delays in construction and improvement of living quarters and medical facilities.

Further, The American Legion advocates that Walter Reed Army Medical Center should not be closed until after the wars in Iraq and Afghanistan have ended. As such Walter Reed Army Medical Center needs to be funded at levels high enough to meet and exceed the high standards of care our service members deserve.

Uniformed Services University of the Health Sciences

The American Legion has supported the Uniformed Services University of the Health Sciences (USU), since its establishment in 1972 as the Nation's Federal Academic Health Center. USU is dedicated to providing uniquely educated and trained uniformed officers for the United States Army, Navy, Air Force and Public Health Service. USU alumni are currently serving over 20-year careers and thus providing continuity and leadership for the Military Health System (MHS) as physicians, advanced practice nurses and scientists. USU F. Edward Héert School of Medicine has a year-round, 4-year curriculum that is nearly 700 hours longer than found at other U.S. medical schools. These extra hours focus on epidemiology, health promotion, disease prevention, tropical medicine, leadership and field exercises. Doctoral and Masters degrees in the biomedical sciences and public health are awarded by interdisciplinary and department-based graduate programs within the School of Medicine. Programs include infectious disease, neuroscience, and preventive medicine research.

USU Graduate School of Nursing offers a Master of Science in Nursing degree in Nurse Anesthesia, Family Nurse Practitioner, Perioperative Clinical Nursing, Psychiatric Mental Health Nurse Practitioner, and a full and part-time program for a Ph.D. degree in Nursing Science. The university's continuing education program is unique and extensive, serving and sustaining the professional and readiness requirements of the Defense Department's worldwide military healthcare community.

The university's nationally ranked military and civilian faculty conduct cutting edge research in the biomedical sciences and in areas specific to the DOD health care mission such as combat casualty care, infectious diseases and radiation biology. The university specializes in military and public health medicine, focusing on keeping people healthy, disease prevention, and diagnosis and treatment. USU faculty offer significant expertise in tropical medicine and hygiene, parasitology, epidemiologic methods and preventive medicine.

The Department of Defense and the United States Congress have recognized that the extensive military-unique and preventive health care education provided in the multi-service environment of USU ensures Medical Readiness and Force Health Protection for the MHS. USU is recognized as the place where students receive thorough preparation to deal with the medical aspects of Weapons of Mass Destruction, including chemical, radiological and biological, nuclear and high yield explosive (CBRNE) terrorism or other catastrophe. USU has developed similar training for ci-

vilian first responders, medical professionals and emergency planners. USU is also uniquely qualified and experienced in simulation technology, education and training.

With the establishment by the Office of the Secretary of Defense (OSD) of a Joint Medical Command in fiscal year 2008, the role of USU will expand. Plans to establish the Walter Reed National Military Medical Center (WRNMMC) by 2011 has created close collaboration between the Armed Services Flag Officers and the President of USU to create a world-class military academic health center, expanding the role of USU.

As stated previously, The American Legion urges the Subcommittee to: continue its demonstrated commitment to USU, as a national asset, for the continued provision of uniquely educated and trained uniformed physicians, advanced practice nurses, and scientists dedicated to careers of service in the Army, Navy, Air Force, and the United States Public Health Service; support timely construction at the USU campus during fiscal years 2009–2010; continue funding the University's collaborative effort for sharing its chemical, radiological and biological, nuclear and high yield explosive (CBRNE) expertise and training; support development of the USU Immersive, Wide Area Virtual Environment (WAVE) Simulation for CBRNE/WMD Medical Readiness Training; support funding for the Graduate School of Nursing Teaching/Educational Programs; and, encourage continued close collaboration and progress towards the OSD-proposed Joint Medical Command and WRNMMC with USU as the core academic health center.

Armed Forces Retirement Homes

The United States Soldiers' and Airmen's Home (USSAH) and the United States Naval Home (USNH), jointly called the Armed Forces Retirement Home (AFRH), are continuing care facilities which were created more than 150 years ago to offer retirement homes for distinguished veterans who had served as soldiers, sailors, airmen and Marines in our Nation's conflicts. The AFRH system, which is available to retiree veterans from all the Armed Services whose active duty was at least 50 percent enlisted or warrant officer, has been supported by a trust fund resourced by 50 cents a month withheld from active duty enlisted and warrant officer paychecks as well as from fines and forfeitures from disciplinary actions, resident fees and interest income. The extensive downsizing of the Armed Forces has resulted in a 39 percent decrease in that revenue and, coupled with rising nursing home care costs, the Homes have been operating at an \$8–10 million annual deficit which would reportedly require both Homes to close their doors.

The American Legion urges the Subcommittee to support measures which will provide for the long-term solvency and viability of the Armed Forces Retirement Home—Washington, DC. The American Legion also strongly supports the rebuilding of the Armed Forces Retirement Home at Gulfport, Mississippi which was destroyed by Hurricane Katrina.

American Battle Monuments Commission

The American Battle Monuments Commission (ABMC) was established by law in 1923, as an independent agency of the Executive Branch of the United States Government. The Commission's commemorative mission includes:

- Designing, constructing, operating and maintaining permanent American cemeteries in foreign countries.
- Establishing and maintaining U.S. military memorials, monuments and markers where American armed forces have served overseas since April 6, 1917, and within the United States when directed by public law.
- Controlling the design and construction of permanent U.S. military monuments and markers by other U.S. citizens and organizations, both public and private, and encouraging their maintenance.

The resulting United States Military Cemeteries have been established throughout the world and are hallowed grounds for America's war dead. United States Military Cemeteries existing in foreign countries today are in need of adequate funding for repair, maintenance, additional manpower and other necessities to preserve the integrity of all monuments and cemeteries which are realizing increased numbers of visitors annually.

Adequate funding and human resources to the American Battle Monuments Commission must be provided in order to properly maintain and preserve these hallowed, final resting places for America's war dead located on foreign soil. In fiscal year 2009, \$59.5 million, \$15 million above fiscal year 2008 was provided for the care and operation of our military monuments and cemeteries around the world. The American Legion applauded this increased funding and supports the continued full funding for the needs of the American Battle Monuments Commission.

Funding for Joint POW/MIA Accounting Command

The American Legion has long been deeply committed to achieving the fullest possible accounting for U.S. personnel still held captive, missing and unaccounted for from all of our Nation's wars. The level of personnel and funding for the Joint POW/MIA Accounting Command (JPAC) has not been increased at a level commensurate with the expanded requirement to obtain answers on Americans unaccounted for from wars and conflicts prior to the Vietnam War. It is the responsibility of the U.S. Government to account as fully as possible for America's missing veterans, including—if confirmed deceased—the recovery of their remains when possible. The Congress has a duty and obligation to appropriate funds necessary for all Government agencies involved in carrying out strategies, programs and operations to solve this issue and obtain answers for the POW/MIA families and our Nation's veterans. This accounting effort should not be considered complete until all reasonable actions have been taken to achieve the fullest possible accounting. The American Legion calls on Congress to provide increases in personnel and full funding for the efforts of JPAC, the Defense POW/Missing Personnel Office (DPMO), the Life Sciences Equipment Laboratory, and the Armed Forces DNA Laboratory, including specific authorization to augment assigned personnel when additional assets and resources are necessary. The American Legion remains steadfast in our commitment to the goal of achieving the fullest possible accounting for all U.S. military and designated civilian personnel missing from our Nation's wars.

JPAC was forced to reduce field operations in pursuit of missing U.S. personnel in early 2006 due to a failure of DOD to provide adequate funding. The mission of JPAC has been expanded by Congress to include investigation and recovery operations dating back to and including unaccounted for WWII personnel, while funding levels have not increased to meet this requirement. The headquarters currently utilized by JPAC is no longer capable of housing neither the expanded command nor the expanded laboratory requirements for forensic identifications. The American Legion calls on the Congress to ensure that JPAC has at least \$62 million per year in operation funds and an additional \$64 million per year for fiscal year 2010 through fiscal year 2011 for JPAC military construction funds as part of the budget for the Department of Defense in connection with JPAC. The American Legion calls on the Congress to ensure that such funds be approved and restricted for use for no purpose other than those included in the mission statement of the Joint POW/MIA Accounting Command, Hickam AFB, Hawaii.

The American Legion commends Admiral Timothy Keating, Commander, U.S. Pacific Command, for his commitment to seek U.S. Navy funding in the amount of \$105 million to begin construction of a new JPAC headquarters, including a state-of-the-art laboratory in fiscal year 2010, to be completed in fiscal year 2011. Furthermore, The American Legion urges the Congress to fully fund this U.S. Navy military construction project to ensure that those who serve our Nation—past, present, and future—are returned and accounted for as fully as possible.

CONCLUSION

The United States continues to fight in OCO and defend our vital national interests. While America may be safer and has not suffered another tragic event on our soil since the tragic day of 9/11/01, the world is still not a safe place. The American Legion thanks the Subcommittee for inviting The American Legion to this hearing and looks forward to working with Congress and the administration on the many issues in National Defense facing our country.

Chairman INOUE. And now the deputy director of the National Military Family Association, Ms. Kelly Hruska.

STATEMENT OF KELLY B. HRUSKA, GOVERNMENT RELATIONS, DEPUTY DIRECTOR, NATIONAL MILITARY FAMILY ASSOCIATION

Ms. HRUSKA. Thank you, Mr. Chairman, for the opportunity to highlight the National Military Family Association's belief that 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, not merely added on as a part of supplemental funding. Programs must 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 your help over the past years in addressing many of these important issues.

The increased access to resources and programs by the Joint Family Support Assistance Program, now offered in all States and territories, allows families to receive added help when they need it, during all cycles of deployment. The Military Family Readiness Council held its first informal meeting in December. We feel this will be an effective tool in identifying programs that work, and in helping to eliminate overlapping or redundant programs, as the council reviews existing resources for military families. In an effort to make their efforts more credible, our association would like to see more funding set aside to be used for pilot programs that may come out of the council's recommendations, or allows DOD to replicate best practices, as necessary. This seed funding would streamline the bureaucracy and get the pilot programs out to families faster.

Huge strides have been made in the building of brick-and-mortar child development centers on military installations. Within the next year or two, thousands of spaces will become available for our military families. But, the need for more spaces will still exist. Innovative strategies are needed to address the non-availability of after-hours childcare and respite care. We applaud the partnership between the services and the National Association of Childcare Resources and Referral Agencies that provides subsidized childcare to families who cannot access installation-base child development centers. Including National Guard and Reserve families. 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 piloted 24/7 programs. 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 the Army Family Covenant, has rolled out more resources for respite care of families of deployed services. Respite care is needed across the board for 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 appreciate the recent increase to the special survivor indemnity allowance, for surviving spouses, but the elimination of the dependency and indemnity compensation offset to the survivor benefit plan annuity should still remain a high priority.

Our association recognizes and appreciates the many resources and programs that support our military families during this time of war. The need will not go away the day the war ends. We believe it is imperative these programs be included in the regular budget process.

In our written statement we have identified other ways to assist military families, and will be glad to expand on those suggestions, should you have any questions.

Military families—one size does not fit all, but they are united in their sacrifices in support of their servicemembers and our Nation. We ask you to help the Nation sustain and support them.

Thank you, sir.

Chairman INOUE. I thank you very much, Ms. Hruska.

And to all the witnesses, if you have supporting documents and memos, please feel free to submit them, because I can assure you we'll read them.

[The statement follows:]

PREPARED STATEMENT OF KELLY B. HRUSKA

Chairman Inouye and Distinguished Members of this 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. You recognize the sacrifices made by today's service members and their families by focusing on the many elements of their quality of life package: access to quality health care, robust military pay and benefits, support for families dealing with deployment, and special care for the families of the wounded, ill and injured and those who have made the greatest sacrifice.

In this statement, our Association will expand on several issues of importance to military families: Family Readiness; Family Health; Family Transitions.

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 of the past several years that recognized many of these important issues. The increased access to resources and programs provided by the Joint Family Support Assistance Program (JFSAP), now offered in all States and territories, allows families to receive added help when they need it during all cycles of deployment. The Military Family Readiness Council held its first informal meeting in December. We feel this will be an effective tool in identifying programs that work and in helping to eliminate overlapping or redundant programs as the Council reviews existing resources for military families. Our Association is proud to represent military families as a member of the Council.

Our Association believes that it is imperative full funding for family readiness programs be included in the regular budget process and not merely added on as part of supplemental funding.

Child Care

The Services—and families—continue to tell us more child care is needed to fill the ever growing demand, including hourly, drop-in, respite, and after-hour child care. We've heard stories like this:

Child care facilities on base are beyond compare—for spouses and military members who work nine to five. In our increasingly service-oriented economy, the job I have has me working until at least seven most days, and usually as late as midnight 1 to 2 days a week. When my husband deploys or has a stint on second shift, I run out of options quickly. I have been unable to get another, more conventional job in the 2 years I have been in this area . . . there are minimum requirements as to what shifts I need to work to maintain full-time employment at my current workplace, and I cannot have those waived for an entire deployment.

Innovative strategies are needed to address the non-availability of after-hour 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 (NACCRRA) that provides subsidized childcare to families who cannot access installation based child development centers. 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 that 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.

At our Operation Purple® Healing Adventures camp for families of the wounded, ill and injured, we were told 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 for families of deployed service members and the wounded, ill and injured.

Working with Youth

Older children and teens must not be overlooked. School personnel need to be educated on issues affecting military students and 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. However, 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, Operation Purple provides a safe and fun environment in which military children feel immediately supported and understood. Last year, with the support of private donors, we achieved our goal of sending 10,000 military children to camp. We also were successful in expanding the camp experience to families of the wounded and bereaved. This year, we expect to maintain those numbers by offering 95 weeks of camp in 37 States and territories, as well as conducting several pilot family reintegration retreats in the National Parks.

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 contracted with the RAND Corporation in 2007 to conduct a pilot study aimed at the current functioning and wellness of military children attending Operation Purple camps and assessing the potential benefits of the OPC program in this environment of multiple and extended deployments. The results of the pilot study were published last spring and confirmed much of what we have heard from individual families. They also highlighted gaps in our current knowledge, including how family relationships are affected by deployment and reintegration. The study looked at differences in child and caregiver experiences based on Service component, such as how life is different during deployment for families from the Active Component compared to those in the Guard or Reserve.

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 is following these families for 1 year, and interviewing the non-deployed caregiver/parent and one child per family between 11 and 17 years of age at three time points over that year. Recruitment of participants

has been extremely successful because families are eager to share their experiences. RAND is currently gathering information from these families for the 6-month follow-up survey. Preliminary findings from the first round of surveys provide additional support for the pilot study results and identify new areas to investigate. This includes examining the relationship between the total months of deployment that a family experiences and its association with non-deployed caregiver's mental health and child's well-being at school and at home. In addition, RAND is assessing the impact of reintegration on the families and how this varies by a service member's rank and Service component.

This study will provide valuable data to inform the future creation and implementation of services for children and families. More specifically, we hope this study will provide more detailed and clearer understanding of the impact of multiple and extended deployments on military children and their families. We expect to present the final study results in Spring 2010.

National Guard and Reserve

Our Association would like to thank Congress for authorizing many provisions that affect our Reserve Component families, who have sacrificed greatly in support of our Nation. We continue to ask Congress to fully fund these programs so vital to the quality of life of our National Guard and Reserve families.

The National Military Family Association has long realized the unique challenges our Reserve Component families face and their need for additional support. This need was highlighted in the final report from the Commission on the National Guard and Reserves, which confirmed what we had always asserted: "Reserve Component family members 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." While citing a robust volunteer network as crucial, the report also stated that family readiness suffers when there are too few paid staff professionals supporting the volunteers.

Our Association would also like to thank Congress for the provisions which allowed for the implementation of the Yellow Ribbon Reintegration program which is so crucial to the well-being of our Reserve Component families. We urge Congress to make the funding for this program permanent. We also believe that family members should be paid a travel allowance to attend these important reintegration programs. Furthermore, DOD and service providers need to move away from the one-size fits all approach to reintegration which does not work for all the Reserve Components due to the specific nature of each mission and the varying length of deployments.

Our Association asks Congress to fully fund the Yellow Ribbon Reintegration program and other provisions affecting our Reserve Component families and to move away from the one-size fits all approach to reintegration.

Military Housing

Privatized housing is a welcome change for military families and we are pleased the fiscal year 2009 NDAA called for an annual report that addresses the best practices for executing privatized housing contracts. With our depressed economy, increased oversight is critical to ensure timely completion of these important projects. Project delays negatively impact the quality of life of our families.

Commanders must be held accountable for the quality of housing and customer service in privatized communities. Housing areas remain the responsibility of the installation Commander even when managed by a private company. Services members who are wounded and must move to a handicap accessible home or break their lease provisions due to short-notice PCS orders should not be penalized. Service members should not languish on wait lists while civilians occupy housing. While privatization contracts permit other non-military occupants for vacant units, Commanders must ensure that privatized housing is first and foremost meeting the needs of the active duty population of the installation. In some cases, this will require modification or renegotiation of contracts.

Our Association feels there needs to be a review of BAH standards. While families who live on the installation are better off, families living off the installation are forced to absorb more out-of-pocket expenses in order to live in a home that will meet their needs. BAH standards are based on an outdated concept of what would constitute a reasonable dwelling. For example, in order to receive BAH for a single family dwelling a service member must be an E9. However, if that same service member lived in military housing, he or she would likely have a single family home at the rank of E6 or E7. BAH standards should mirror the type of dwelling a service member would occupy if government quarters were available.

Our Association believes that BAH standards should be reviewed and should better reflect the type of dwelling the service member would occupy if government quarters were available.

Commissaries and Exchanges

The commissary is a key element of the total compensation package for service members and retirees and is valued by them, their families, and survivors. Not only do our surveys indicate that military families consider the commissary one of their most important benefits, during this economic downturn, many families are returning to the commissary to help them reduce their grocery budget. In addition to providing average savings of more than 30 percent over local supermarkets, commissaries provide an important tie to the military community. Commissary shoppers get more than groceries at the commissary. They gain an opportunity to connect with other military family members and to get information on installation programs and activities through bulletin boards and installation publications. Finally, commissary shoppers receive nutrition information and education through commissary promotions and educational campaigns contributing to the overall health of the entire beneficiary population.

Our Association appreciates the provision included in the fiscal year 2009 NDAA allowing the use of proceeds from surcharges collected at remote case lot sales for Reserve Component members to help defray the cost of those case lot sales. This inclusion helps family members, not located near an installation partake in the valuable commissary benefit.

Our Association is concerned there will not be enough commissaries to serve areas experiencing substantial growth, including those locations with service members 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.

The military exchange system serves as a community hub, in addition to providing valuable cost savings to members of the military community. Equally important is the fact that exchange system profits are reinvested in important Morale, Welfare and Recreation (MWR) programs, resulting in quality of life improvements for the entire community. We believe 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. Exchanges must also continue to be responsive to the needs of deployed service members in combat zones and have the right mix of goods at the right prices for the full range of beneficiaries.

Family Care Plans

We have heard from single parent and dual military families about the expenses incurred when they have to relocate their children to another location when they are activated for deployment. This issue was raised within the Army Family Action Plan process. Service members requiring activation of Family Care Plans are not compensated for the travel of dependents and shipment of the dependent's household goods. Some items such as infant equipment, computers and toys are necessary for the emotional and physical well-being of the children in their new environment during an already stressful time. Implementation of the Family Care Plan should not create additional financial hardship and emotional stress on the service member and family.

We recommend that changes be made to the DOD Joint Travel Regulations to provide for travel and shipment of household goods to fulfill the needs of a deploying service member's Family Care Plan.

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 (MTF) 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 an interview with syndicated Military Update columnist Tom Philpott in December of 2008, MG (Dr.) Elder Granger, deputy director of TRICARE, gave the Military Health System (MHS) an overall grade of “C-plus or B-minus”. His 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. In previous testimony before this subcommittee we have noted the failure of MTFs to meet TRICARE Prime access standards and to be held accountable in the same way as the TRICARE contractors are for meeting those standards in the purchased care arena.

In discussions with families the main issues are: access to their Primary Care Managers (PCM); getting appointments; 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. Families familiar with how the MHS referral system works seem better able to navigate the system. Those families who are unfamiliar experienced delays in receiving treatment or decide to give up on the referral process and never obtain a specialty appointment.

Case management for military beneficiaries with special needs is not consistent across the MHS, whether within the MTFs or in the purchased care arena. Thus, military families end up managing their own care. The shortage of available health care providers only adds to the dilemma. 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. Meanwhile, the coordination of the military family’s care is being done by a non-synergistic health care system. Incongruence in the case management process becomes more apparent when military family members transfer from one TRICARE region to another and is further exasperated when a special needs family member is involved. Each TRICARE Managed Care Contractor has created different case management processes. There needs to be a seamless transition and a warm handoff between TRICARE regions for these families and the establishment of a universal case management process across the MHS.

Our 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, each branch of Service, TBI care coordinators, VA liaisons, etc. The goal is for a seamless transition of care between and within the two governmental agencies: DOD and the VA. However, with so many to choose from, families often wonder which one is the “right” case manager. We often hear from families, some who have long since been medically retired with a 100 percent disability rating or others with less than 1 year out 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 these families alone trying to navigate a variety of complex health care systems trying to find the right combination of care. Many qualify for and use Medicare, VA, DOD’s TRICARE direct and purchased care, private health insurance, and State agencies. Does this population really need all of these different systems of receiving health care? Why can’t the process be streamlined?

TRICARE

While Congress temporarily forestalled increases over the past 2 years, we believe DOD officials will continue to support large increased retiree enrollment fees for TRICARE Prime combined with a tiered system of enrollment fees, the institution of a TRICARE standard enrollment fee and increased TRICARE Standard deductibles. Two reports, the Task Force on the Future of the Military Health Care and The Tenth Quadrennial Review of Military Compensation Volume II, recently recommended the same.

We acknowledge the annual Prime enrollment fee has not increased in more than 10 years and that it may be reasonable to have a mechanism to increase fees. With this in mind, we have presented an alternative to DOD’s proposal should Congress deem some cost increase necessary. The most important feature of our proposal is that any fee increase be no greater than the percentage increase in the retiree cost of living adjustment (COLA). If DOD thought \$230/\$460 was a fair fee for all in 1995, then it would appear that raising the fees simply by the percentage increase

in retiree pay is also fair. We also suggest it would be reasonable to adjust the TRICARE Standard deductibles by tying increases to the percentage of the retiree annual COLA. We stand ready to provide more information on this issue if needed.

Support for Special Needs Families

We applaud Congress and DOD's desire to create a robust health care and educational service 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.

There was discussion last year by Congress and military families regarding the ECHO program. The fiscal year 2009 NDAA included a provision to increase the cap on certain benefits under the ECHO program to \$36,000 per year for training, rehabilitation, special education, assistive technology devices, institutional care and under certain circumstances, transportation to and from institutions or facilities, because certain beneficiaries bump up against it. 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 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.

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 may prove to be more cost-effective for the government than subsidizing 72 percent of the costs of TRICARE Reserve Select for National Guard or Reserve members not on active duty.

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 access to mental health services.

National provider shortages in the psychological 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 psychological 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.

We have heard the main reason for the VA not providing health care and psychological health care services is because they cannot be reimbursed for care rendered to a family member. However, the VA is a qualified TRICARE provider. This allows the VA to bill for services rendered in their facilities to a TRICARE beneficiary. There may be a way to bill other health insurance companies as well. The VA needs to look at the possibility for other methods of payments.

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 fiscal year 2008 NDAA. However, we 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 the overall negotiation of future drug prices by Medicare and civilian private insurance programs.

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 OTC drugs be a covered pharmacy benefit and there be a zero co-pay for TMOP Tier 1 medications.

National Health Care Proposal

Our Association is cautious about current rhetoric by the Administration and Congress regarding the establishment of a National health care insurance program. As the 111th Congress takes up a National health care insurance proposal, we request consideration of how this legislation will also impact TRICARE, military families' access to health care, and especially recruitment and retention of our service members at a time of war.

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.

Our Association does not support the recommendation of the Task Force on the Future of Military Health Care to carve out one regional TRICARE contractor to provide both the pharmacy and health care benefit. We agree a link between pharmacy and disease management is necessary, but feel this pilot would only further erode DOD's ability to maximize potential savings through TMOP. We were also disappointed to find no mention of disease management or a requirement for coordination between the pharmacy contractor and Managed Care Support Contractors in the Request for Proposals for the new TRICARE pharmacy contract. The ability certainly exists for them to share information bi-directionally and should be established.

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.

Our Association suggests this Subcommittee DOD reassess the resource sharing program used prior to the implementation of the T-Nex contracts and take the steps necessary to ensure Military Treatment Facilities (MTF) meet access standards with high quality health care providers.

We also suggest this Subcommittee direct the Department to make case management services more consistent across the direct and purchased care segments of the MHS.

Our Association recommends a 1-year transitional active duty ECHO benefit for the family members of service members who retire.

We believe tying increases in TRICARE enrollment fees to the percentage increase in the Retiree Cost of Living Adjustment (COLA) is a fair way to increase beneficiary cost shares should Congress deem an increase necessary.

We oppose DOD's proposal to institute a TRICARE Standard enrollment fee and believe Congress should reject this proposal because it changes beneficiaries' entitlement to health care under TRICARE Standard to just another insurance plan.

Our Association strongly believes an enrollment fee for TFL is not appropriate. 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 aftermaths 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 to stress reduction techniques, to individual or family counseling, to 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 also remain high for some time even after military operations scale down.

Access to Behavioral Health Care

Our Association is concerned about the overall shortage of psychological 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. While families are pleased more psychological 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 compassion fatigue, creating burnout and exacerbating the provider shortage problem.

We have seen an increase in the number of psychological 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 psychological health provider list on the contractor's websites that the provider is full and no longer taking patients. The list must be up-to-date in order to handle real time demands by families. We need to continue to recruit more psychological 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. 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. Families want to be able to access care with a psychological health provider who understands or is sympathetic to the issues they face.

Frequent and lengthy deployments create a sharp need in psychological 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 psychological 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. 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.

Availability of Treatment

Do DOD, VA and State agencies have adequate psychological 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. 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 service member's separation, the families find themselves ineligible for TRICARE, and are very rarely eligible for healthcare through the VA. Many will choose to locate in rural areas lacking available psychological health providers. We need to address the distance issues families face in finding psychological 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; and
- educating civilian network psychological health providers about our military culture as the VA incorporates Project Hero.

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 as well as service members who leave the military following the end of their enlistment. They 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 no 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.

Wounded, Ill, and Injured Families

When designing support for the wounded, ill, and injured in today's conflict, our Association believes the government, especially DOD, VA, and State agencies, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded service member must also consider the needs of the spouse, children, parents of single service members, siblings, and other caregivers. Family members are an integral part of the health care team and recovery process.

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 services 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 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 restrict 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. 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, or 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); and sponsor a longitudinal study, similar to DOD's Millennium Cohort Study, in order to get a better understanding of the long-term effects of war on our military families.

Children

Our Association is concerned about the impact deployment and/or the injury of the service member is having on our most vulnerable population, children of our military and veterans. Multiple 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.

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 Military Treatment Facility (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 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.

Caregivers

In the 7th year of the Global War on Terror, care for the caregivers must become a priority. 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 mTBI and PTSD 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.

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.

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 is piloting two family retreats in the National Parks to promote 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; perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members); and sponsor a longitudinal study, similar to DOD's Millennium Cohort Study, in order to get a better understanding of the long-term effects of war on our military families.

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. We appreciate the inclusion in the fiscal year 2008 NDAA Wounded Warrior provision for health care services to be provided by the DOD and VA for family members. 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. In the spring of 2008, our Association held a focus group composed of wounded service members and their families to learn more about issues affecting them. 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 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. We piloted a Operation Purple® Healing Adventures camp to help wounded service members and their families learn to play again as a family and plan one more in the summer of 2009.

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 pro-

grams like BAMC's which has found a way to embrace the family unit during this difficult time.

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 3 years following medical retirement. This proposal will allow the family not to pay premiums and be eligible for certain programs offered to active duty, such as ECHO for 3 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 1 year as active duty for TRICARE and then start 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. The VA has made a strong effort in supporting veterans' caregivers. The DOD should follow suit and expand their definition. Caregivers of the severely wounded, ill, and injured services members have a long road ahead of them. In order to perform their job well, they must be given the skills to be successful. This will require the caregiver to be trained through a standardized, certified program, and appropriately compensated for the care they provide. The time to implement these programs is while the service member is still on active duty status.

Our Association proposes that new types of financial compensation be established for caregivers of injured service members and veterans that could begin while the hospitalized service member is still on active duty and continue throughout the transition to care under the VA. This compensation should recognize the types of medical and non-medical care services provided by the caregiver, travel to appointments and coordinating with providers, and the severity of injury. It should also take into account the changing levels of service provided by the caregiver as the veteran's condition improves or diminishes or needs for medical treatment changes. These needs would have to be assessed quickly with little time delay in order to provide the correct amount of compensation. The caregiver should be paid directly for their services, but the compensation should be linked to training and certification paid for by the VA and transferable to employment in the civilian sector if the care is no longer needed by the service member. Our Association looks forward to discussing details of implementing such a plan with Members of this Subcommittee.

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. Perhaps, caregivers of severely injured service members or veterans can be given the option of buying health insurance through the Federal Employees Health Benefit Program or through enrollment in CHAMPVA. A mechanism should also be established to assist caregivers who are forced out of the work force to save for their retirements, for example, through the Federal Thrift Savings Plan.

There must be a provision for transition 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.

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 themselves. Caregivers' responsibilities start while the service member is still on active duty.

Relocation Allowance

Active Duty service members and their spouses qualify through the DOD for military orders to move their household goods (known as a Permanent Change of Station (PCS)) 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.

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 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 transitioning wounded, ill and injured service members and their families a bridge of extended active duty TRICARE eligibility for 3 years, comparable to the benefit for surviving spouses.

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.

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

Senior Oversight Committee

Our Association is appreciative of the provision in the fiscal year 2009 NDAA continuing the DOD/VA Senior Oversight Committee (SOC) for an additional year. We understand a permanent structure is in the process of being established and manned. We urge Congress to put a mechanism in place to continue 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 Armed Service Committee along with the Veterans' Affairs Committee to talk on these important issues. We can no longer 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.

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.

FAMILY TRANSITIONS

Our Association will promote policies and access to programs providing training and support for families during the many transitions they experience.

Survivors

In the past year, the Services have been focusing on 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 ask that the active duty TRICARE Dental benefit be extended to surviving children to mirror the active duty TRICARE medical benefit to which they are now eligible. We also ask that eligibility be expanded to those Reserve Component family members who had not been enrolled in the active duty TRICARE Dental benefit prior to the service member's death.

Our Association recommends that surviving children be allowed to remain in the TRICARE Dental Program until they age out of TRICARE eligibility and that eligibility be expanded to those Reserve Component survivors who had not been enrolled prior to the service member'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 service member'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 service member was alive and on active duty. The percentage of loss is even greater for survivors whose service members served longer. Those who give their lives for their country deserve more fair compensation for their surviving spouses.

We appreciate the establishment of a special survivor indemnity allowance as a first step in the process to eliminate the DIC offset to SBP.

We believe several other adjustments could be made to the Survivor Benefit Plan. 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 ask the DIC offset to SBP be eliminated to recognize the length of commitment and service of the career service member and spouse. We also request that SBP benefits be allowed to be paid to a Special Needs Trust in cases of disabled family members.

Spouse Employment, Unemployment

Our Association appreciates the expansion of the Military Spouse Career Advancement Accounts. We look forward to the rollout and full implementation of the expanded program and hope that the definition of "portable careers" is broad enough to support the diverse military spouse population. 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 service members, and to provide tax credits to military spouses to offset the expense in ob-

taining career licenses and certifications when service members are relocated to a new duty station within a different State.

Families on the Move

Our Association is concerned about the timely implementation of the Defense Personal Property Program, formerly titled "Families First." Worldwide rollout is still incomplete and it is unclear if customer satisfaction surveys are incorporated into the carrier ranking process. Full Replacement Value has been rolled out, but is handled differently by each carrier. Families are confused about how and where to file claims. Congressional oversight is needed to press for implementation of this program and deliver the best possible service to our families.

Our Association is grateful for the addition of the weight allowance for spousal professional materials. We ask that Congress broaden the language to require the Service Secretaries to implement this much needed benefit.

A PCS move to an overseas location can be especially stressful. Military families are faced with the prospect of being thousands of miles from extended family and living in a foreign culture. At many overseas locations, there are insufficient numbers of government quarters resulting in the requirement to live on the local economy away from the installation. Family members in these situations can feel extremely isolated; for some the only connection to anything familiar is the local military installation. Unfortunately, current law permits the shipment of only one vehicle to an overseas location, including Alaska and Hawaii. Since most families today have two vehicles, they sell one of the vehicles.

Upon arriving at the new duty station, the service member requires transportation to and from the place of duty leaving the military spouse and family members at home without transportation. This lack of transportation limits the ability of spouses to secure employment and the ability of children to participate in extra curricular activities. While the purchase of a second vehicle alleviates these issues, it also results in significant expense while the family is already absorbing other costs associated with a move. Simply permitting the shipment of a second vehicle at government expense could alleviate this expense and acknowledge the needs of today's military family.

Our Association requests that Congress ease the burden of military PCS moves on military families by pressing for the full implementation of the Defense Personal Property Program and by authorizing the shipment of a second vehicle for families assigned to an overseas location on accompanied tours.

Education of Military Children

While our Association remains appreciative for the additional funding you provide to civilian school districts educating large numbers of military children, DOD Impact Aid still remains under-funded. We urge Congress to increase funding for schools educating large numbers of military children to \$60 million for fiscal year 2010. We also encourage you to make the additional funding for school districts experiencing growth available to all school districts experiencing significant enrollment increases and not just to those districts meeting the current 20 percent enrollment threshold. The arrival of several hundred military students can be financially devastating to any school district, regardless of how many of those students the district already serves. This supplement to Impact Aid is vital to school districts that have shouldered the burden of ensuring military children receive a quality education despite the stresses of military life.

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. With over 70,000 military families returning to the United States, at the same time the Army is moving over one third of its soldiers within the United States, we urge Congress to authorize an increase in this level of funding until BRAC and Global Rebasing moves are completed.

Although it does not fall under the purview of this Subcommittee, 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 service members and their families. Under this provision, colleges and universities receiving Federal funding under the act will be required to offer in-State tuition rates for active duty service members and their families and provide continuity of in-State rates if the service member receives orders for an assignment 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.

Our Association congratulates the DOD Office of Personnel and Readiness and the Council of State Governments (CSG) for drafting the Interstate Compact on Educational Opportunity for Military Children and for spearheading the adoption of this important legislation. Designed to alleviate many of the transition issues facing military children, the Compact has now been adopted in 20 States. In addition, Hawaii has a Compact bill awaiting their Governor's signature, and 11 other States are working active legislation this year. With 10 States needed to enact the Compact, the first meeting of the Interstate Commission on Educational Opportunity for Military Children met in October 2008. Our Association is pleased to have been a member of both the Advisory Group and Drafting Team, and has been working actively to support the adoption of this Compact, which will greatly enhance the quality of life of our military children and families.

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 to allow all school districts experiencing a significant growth in their military student population due to BRAC, Global Rebasing, or installation housing changes to be eligible for the additional funding currently available only to districts with an enrollment of at least 20 percent military children.

Spouse Education

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. In 2007, we published *Education and the Military Spouse: The Long Road to Success*, based on spouse scholarship applicant survey responses, identifying education issues and barriers specific to military spouses. The entire report may be found at www.nmfa.org/education.

The survey found military spouses, like their service members and the military as a whole, value education and set education goals for themselves. Yet, military spouses often feel their options are limited. Deployments, the shortage of affordable and quality child care, frequent moves, the lack of educational benefits and tuition assistance for tuition are discouraging. For military spouses, the total cost of obtaining a degree can be significantly higher than the cost for civilian students. The unique circumstances that accompany the military lifestyle have significant negative impacts upon a spouse's ability to remain continuously enrolled in an educational program. Military spouses often take longer than the expected time to complete their degrees. More than one-third of those surveyed have been working toward their goal for 5 years or more. The report offers recommendations for solutions that Congress could provide:

- Ensuring installation education centers have the funding necessary to support spouse education programs and initiatives;
- Providing additional child care funding to support child care needs of military spouse-scholars;
- Helping to defray additional costs incurred by military spouses who ultimately spend more than civilian counterparts to obtain a degree.

Our Association wishes to thank Congress for passing the Post 9/11 G.I. Bill for service members and for including transferability of the benefit to spouses and children. We will continue to monitor the implementation of this benefit, and hope to see the regulations posted soon.

Military Families—Our Nation's Families

We thank you for your support of our service members 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 service members 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 population. Working together, we can improve the quality of life for all these families.

Chairman INOUE. Our next witness represents the Fleet Reserve Association: Mr. John Davis, director of legislative programs. Mr. Davis.

**STATEMENT OF JOHN R. DAVIS, DIRECTOR, LEGISLATIVE PROGRAMS,
FLEET RESERVE ASSOCIATION**

Mr. DAVIS. Good morning, Chairman Inouye. My name is John Davis, and I want to thank you for the opportunity to express FRA's views today.

The association also wants to thank the Obama administration for adequately funding healthcare without a proposed TRICARE fee increase.

FRA believes that raising TRICARE fees during the war on terror would send the wrong message, and that could impact recruitment and retention. A recent FRA survey indicates that more than 90 percent of all active duty, retired, and veteran respondents cited healthcare as their top quality-of-life benefit. That is why FRA supports the Military Retirees Health Care Protection Act, H.R. 816, that would prohibit increasing TRICARE fees unless approved by Congress.

FRA welcomes the 10-percent increase in funding to provide case managers and mental health counselors to heal and rehabilitate our wounded warriors. Adequate funding is necessary for a seamless transition and quality services for wounded warriors, especially those with traumatic brain injury (TBI) and post traumatic stress disorder (PTSD).

FRA is also grateful for the administration calling for improvements to concurrent receipt. And it's also mentioned in the budget resolution.

The offset for chapter 61 retirees would be phased out over 5 years. FRA supports legislation authorizing the immediate payment of concurrent receipt of full military retired pay and veterans disability compensation for all disabled retirees. And this improvement is a big step toward achieving that goal. And if authorized, we urge the subcommittee to provide funding.

FRA strongly supports the funding of the 3.4 percent pay increase for active duty pay, which is one-half of 1 percent above the administration's request. Pay increases, in recent years, have contributed to improved morale, readiness, and retention. Better pay reduces family stress, especially for junior enlisted. Military pay and benefits must reflect the fact that military service is very different from work in the private sector. FRA strongly supports the fully funded family readiness program and stands foursquare in support of our Nation's reservists. Due to the demands of the war on terror, Reserve units are now increasingly being mobilized to augment active duty components. As a result of these operational demands, the Reserve component is no longer a strategic reserve, but is now an operational reserve. And that is an integral part of the total force. That is why, if authorized, FRA supports funding for retroactive eligibility for early retirement benefit, to include reservists who have supported contingency operations since September 11, 2001.

The 2008 Defense Authorization Act reduced the Reserve retirement age by 3 months for every 90 days of active duty, but this

only applies to the service after the effective date of the legislation, which is January 28, 2008, and leaves out more than 600,000 reservists mobilized since 9/11.

Thank you again for giving me this opportunity to speak.
Chairman INOUE. Thank you very much, Mr. Davis.
[The statement follows:]

PREPARED STATEMENT OF JOHN R. DAVIS

OVERVIEW

Mr. Chairman, ensuring that wounded troops, their families and the survivors of those killed in action are cared for by a grateful Nation remains an overriding priority for the Fleet Reserve Association (FRA). The Association thanks you and the entire Subcommittee for your strong and continuing support of funding for the Department of Defense (DOD) portion of the Wounded Warrior Assistance Program. Another top FRA priority is full funding of the Defense Health Program (DHP) to ensure quality care for active duty, retirees, Reservists, and their families.

THE FISCAL YEAR 2010 BUDGET

The DOD request totals \$663.8 billion for fiscal year 2010, which is a base budget increase of \$20.5 billion representing a 4-percent increase over fiscal year 2009 (2.1 percent in real growth). It is noteworthy that for the first time in 4 years, the proposed budget fully funds military health care programs without calling for a TRICARE fee increase. FRA appreciates the reluctance of the new administration to shift health care costs to beneficiaries, and the inclusion of additional money to make improvements in current receipt to expand the number of disabled military retirees receiving both their full military retired pay and VA disability compensation. The budget also calls for a 2.9-percent active duty pay increase that equals the Employment Cost Index (ECI), \$1.1 billion to fund military housing and support programs for service members and their families, and \$3.3 billion to support injured service members in their recovery, rehabilitation, and reintegration.

As Operation Iraqi Freedom ends and troops depart from Iraq, some will be urging reductions in spending, despite the need to bolster efforts in Afghanistan and other operational commitments around the world. FRA understands the budgetary concerns generated by the current economic slowdown but advocates that cutting the DOD budget during the Global War on Terror would be short sighted and that America needs a Defense budget that will provide adequate spending levels for both "benefits and bullets."

This statement lists the concerns of our members, keeping in mind that the Association's primary goal is to endorse any positive safety programs, rewards, quality of life improvements that support members of the Uniform Services, particularly those serving in hostile areas, and their families, and survivors.

WOUNDED WARRIORS

A two-front war, a lengthy occupation and repeated deployments for many service members has put a strain on the DOD/VA medical system that treats our wounded warriors. The system is impacted not only by volume but by the complexity of injuries and the military has shown that it is woefully inadequate in recognizing and treating cases of Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).

In recent years substantial progress has been made in the treatment of the Nation's wounded warriors. The fiscal year 2010 budget provides \$3.3 billion to support injured service members in their recovery and rehabilitation and FRA appreciates the \$300 million increase over fiscal year 2009 for mental health programs which includes additional case managers, and mental health counselors. The budget also provides for an expedited Disability Evaluation System (DES), and construction of 12 additional wounded warrior transition complexes. The budget also continues implementation of the Walter Reed National Military Medical Center, Bethesda, Maryland, DeWitt Army Community Hospital, Fort Belvoir, Virginia, and BRAC projects within the national capitol region. More than \$400 million is targeted for medical research for Traumatic Brain Injury (TBI) and other casualty treatment issues. FRA advocates for resources to support an effective delivery system between DOD and VA to ensure seamless transition and quality services for wounded personnel, particularly those suffering from PTSD and TBI.

Adequate funding is essential to providing pre- and post-deployment screenings for mental and physical injuries, and if authorized compensation, training, and health care coverage for family members forced into service as full-time caregivers for the severely wounded warriors. Further, the War on Terror has seen an increasing percentage of women serving in the military (15 percent in 2009 as compared to 4.4 percent in 1988) and combined with the asymmetrical nature of the conflict will undoubtedly cause an increasing number of women casualties that will place unique demands upon the military health care system requiring additional associated funding.

HEALTH CARE

Adequately funding health care benefits for all beneficiaries is part of the cost of defending our Nation and a recent FRA survey indicates that more than 90 percent of all active duty, retired, and veteran respondents and most Reserve participants cited health care as their top quality-of-life benefit. Accordingly, protecting and/or enhancing health care access for all beneficiaries is FRA's top 2009 legislative priority.

Health care costs both in the military and throughout society have continued to increase faster than the Consumer Price Index (CPI) making this a prime target for those wanting to cut the DOD budget. Many beneficiaries targeted in recent proposals to drastically increase health care fees are those who served prior to enactment of the recent and significant pay and benefit enhancements and receive significantly less in retired pay than those serving and retiring in the same pay grade with the same years of service today. They clearly recall promises made to them about the benefit of health care for life in return for a career, and many believe they are entitled to "free" health care for life based on the Government's past commitments.

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

DOD must continue to investigate and implement other TRICARE cost-saving options as an alternative to shifting costs to retiree beneficiaries. FRA notes progress in this area in expanding use of the mail order pharmacy program, Federal pricing for prescription drugs and a pilot program of preventative care for TRICARE beneficiaries under age 65, and elimination of co-pays for certain preventative services. The Association believes these efforts will prove beneficial in slowing military health care spending in the coming years.

Our Nation is at war and imposing higher health care costs on retirees would send a powerful negative message not only to retirees, but to those currently serving about the value of their service. The prospect of drastically higher health care fees for retirees is also a morale issue with the senior enlisted communities who view this as an erosion of their career benefits. Unlike private sector employees, military retirees have answered the call to serve, and most have done so under extremely difficult circumstances while separated from their families to defend the freedoms we enjoy today.

CONCURRENT RECEIPT

FRA appreciates a boost in compensation for benefiting disabled retirees in the new Administration's budget. The fiscal year 2010 budget includes funding for expansion of concurrent receipt of military retired pay and VA disability compensation to retirees who were medically retired from service (Chapter 61 Retirees). Under current law these benefits (CRDP) are offset by the amount of VA disability compensation. This offset would be phased-out over 5 years. FRA supports legislation authorizing the immediate payment of concurrent receipt of full military retired pay and veterans' disability compensation for all disabled retirees, and these improvements reflect a big step toward achieving this goal.

PROTECT PERSONNEL PROGRAMS

Active Duty Pay.—FRA strongly supports the authorization and funding of a 3.4 percent fiscal year 2010 pay increase which is consistent with past support of annual active duty pay increases that are at least 0.5 percent above the Employment Cost Index (ECI). The Association also supports targeted increases, as appropriate for mid-career and senior enlisted personnel to help close the remaining 2.9 percent pay gap between active duty and private sector pay.

Adequate and targeted pay increases authorized in recent years, particularly for middle grade and senior petty and noncommissioned officers, have contributed to

improved morale, readiness, and retention. Better pay reduces family stress, especially for junior enlisted and may reduce the need for military personnel use of short-term pay day loans unaware of the ruinous long-term impact of excessive interest rates. Military pay and benefits must reflect the fact that military service is very different from work in the private sector.

End Strength.—Adequate active duty and Reserves end strengths are essential to success in Operations Enduring Freedom (OEF) and Iraqi Freedom, and other commitments around the world. The fiscal year 2010 budget supports additional end strength for the Marine Corps (202,000) and halts Navy end strength reductions. The Association supports funding to support these proposals and also strongly supports funding for bonuses for service members with extended deployments.

FAMILY READINESS

FRA supports a fully funded, robust family readiness program which is 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, and they often are being asked to do without in other important areas.

The availability of child care is especially important when so much of the force is deployed and this program, along with other family readiness programs must be adequately funded in fiscal year 2010 and beyond.

BRAC and Rebasing.—Adequate resources are required to fund essential quality of life programs and services at bases impacted by the Base Realignment and Closure (BRAC) and rebasing initiatives. FRA is concerned about sustaining commissary access, MWR programs and other support for service members and their families particularly at installations most impacted by these actions. These include Guam, where a significant number of Marines and their families are being relocated from Okinawa. The shortage of funds is curtailing or closing some of the activities while the costs of participating in others have recently increased.

Family Housing.—The Association welcomes the \$200 million more for family housing, child care, and other support services over the fiscal year 2009 budget. Adequate military housing that's well maintained is critical to retention and morale.

Child and Youth Programs.—MCPON Rick West testified before the House Appropriations Subcommittee on Military Construction and Veterans Affairs in February 2009 that there is a need for more child care facilities since the Navy currently provides for only 72 percent of capacity while the goal is 80 percent. Access to child care is important and FRA urges Congress to authorize adequate funding for this important program.

RESERVE ISSUES

FRA stands foursquare in support of the Nation's Reservists. Due to the demands of the War on Terror, Reserve units are now increasingly being mobilized to augment active duty components. As a result of these operational demands, Reserve component is no longer a strategic Reserve but is now an operational Reserve that is an integral part of the total force. And because of these increasing demands on Reservists to perform multiple missions abroad over longer periods of time, it's essential to improve compensation and benefits to retain currently serving personnel and attract quality recruits.

Retirement.—If authorized, FRA supports funding retroactive eligibility for the early retirement benefit to include Reservists who have supported contingency operations since 9/11/2001 (S. 831/S. 644). The fiscal year 2008 Defense Authorization Act (H.R. 4986) reduces the Reserve retirement age (age 60) by 3 months for each cumulative 90-days ordered to active duty. The provision however only applies to service after the effective date of the legislation, and leaves out more than 600,000 Reservists mobilized since 9/11 for Afghanistan and Iraq and to respond to natural disasters like Hurricane Katrina. About 142,000 of them have been deployed multiple times in the past 6 years.

Family Support.—FRA supports resources to allow increased outreach to connect Reserve families with support programs. This includes increased funding for family readiness, especially for those geographically dispersed, not readily accessible to military installations, and inexperienced with the military. Unlike active duty families who often live near military facilities and support services, most Reserve families live in civilian communities where information and support is not readily available. Congressional hearing witnesses have indicated that many of the half million mobilized Guard and Reserve personnel have not received transition assistance services they and their families need to make a successful transition back to civilian life.

CONCLUSION

FRA is grateful for the opportunity to present the organization's views to this distinguished Subcommittee. The Association reiterates its profound gratitude for the extraordinary progress this Subcommittee, with outstanding staff support, has made in advancing a wide range of enhanced benefits and quality-of-life programs for all uniformed services personnel, retirees, their families and survivors. Thank you.

Chairman INOUE. I'd like to point out that, at this moment, several subcommittees are having their meetings or conferences. As a result, you can see that they're busy elsewhere. The vice chairman of this subcommittee had to go to the Energy Committee subcommittee, because he is the senior member there.

So, if I may, I'd like to call upon him for any remarks he may have.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Mr. Chairman, thank you very much.

I'm pleased to be able to come by and join you in thanking these witnesses for preparing testimony, and giving us the benefit of your observations and experience and interest as we review the budget for this next fiscal year for the Department of Defense and related agencies.

Because of your experiences and your knowledge, we take what you say very seriously, and we will carefully review your statements and make sure that the subcommittee considers them as we proceed through our appropriations process for this next fiscal year.

Thank you.

Chairman INOUE. Thank you very much.

And next, the Chief Executive Officer of the Air Force Sergeants Association, Command Master Sergeant John McCauslin, of the Air Force.

**STATEMENT OF COMMAND MASTER SERGEANT JOHN R. McCAUSLIN,
UNITED STATES AIR FORCE (RET.), CHIEF EXECUTIVE OFFICER,
AIR FORCE SERGEANTS ASSOCIATION**

Sergeant McCAUSLIN. Good morning, Chairman Inouye, Senator Cochran.

On behalf of the 125,000 members of the Air Force Sergeants Association, I thank you for your continued support of our airmen and their families. I appreciate this opportunity to present our perspective of six important areas of priority for the fiscal year 2010 defense appropriations.

First, Air Force manpower and equipment. AFSA strongly believes the aging fleet of legacy Air Force systems, facilities, and equipment needs to be modernized. However, we also know the truly most valuable weapon that America has are those serving this Nation, especially the men and women wearing chevrons.

Operational demands, including deployments, have greatly increased to include intelligence activity, reconnaissance, and surveillance resources, the newest combatant command in Africa, the new Air Force Cyber Command, increased activity in Afghanistan and elsewhere overseas. Therefore, AFSA supports General Schwartz's request for more F-35 aircraft to do our job of preserving peace through deterrence.

Quality of life. Our Nation's military should not be considered a financial burden, but considered a national treasure, as they pre-

serve our national security for all that live here. If we expect to retain this precious resource, we simply must provide them and their families with decent and safe work centers, family housing and dormitories, healthcare, childcare, physical fitness centers, and recreational programs and facilities. Tremendous strides have been made to improve access to quality childcare and fitness centers on our military installations, and we're grateful to the Department of Defense and Congress for these collective efforts. However, there's still much work to be done. I have personally visited over 125 Air Force installations in the States and overseas these past 3 years, and I can assure you that the demand for adequate childcare and decent, affordable housing is a top priority among our airmen and their families' decision to stay or get out.

Veterans Affairs healthcare funding. AFSA believes that the healthcare portion of Veterans Affairs (VA) funding should be moved to mandatory annual spending. One of the Nation's highest obligations is their willingness to fully fund VA healthcare facilities and other programs for those who have served in the past or are serving today and will serve in the future.

On a positive note, we're particularly pleased by the tremendous support of Congress and this subcommittee to implement and fund wounded warrior programs across America.

The Air Force Sergeants Association applauds the actions of this subcommittee, other committees and subcommittees, to directly address the issue of unique health challenges faced by our women veterans. AFSA urges an increase to the VA budget so that they can appropriately care for these female veterans, now and in the future.

Regarding the educational benefits. The post-9/11 GI bill was a giant step forward, even though there are still some funding shortfalls being currently worked by Senator Webb's office, and we urge your subcommittee's support.

And finally, my final point concerns basic military pay and the tremendous pay gap, for these last 15 years, that you've helped us close. However, we still have serious problems in the junior enlisted. For example, enrollment in food stamps rose 25 percent in the military this last year alone. Our junior enlisted are all volunteers serving our Nation, yet thousands remain on food stamps.

In conclusion, this was a very brief presentation of our perspective for you. Our detailed, typed testimony has been personally delivered to your subcommittee staff for inclusion today.

Thank you very much.

Chairman INOUE. I thank you very much, Command Master Sergeant.

[The statement follows:]

PREPARED STATEMENT OF JOHN R. "DOC" MCCAUSLIN

Mr. Chairman and distinguished committee members, on behalf of the 125,000 members of the Air Force Sergeants Association, (AFSA), I thank you for your continued support of Airmen and their families. I appreciate this opportunity to present our perspective on priorities for the fiscal year 2010 defense appropriations.

The Air Force Sergeants Association (AFSA) represents Air Force Active Duty, Air National Guard, Air Force Reserve Command, including active, retired and veteran enlisted Airmen and their families. We are grateful for this subcommittee's efforts, and I cannot overstate the importance your work is to those serving this Nation.

You certainly have a daunting task before you and shoulder the tremendous responsibility as you wisely appropriate limited resources based on many factors. The degree of difficulty deciding what is funded isn't lost on us. It is significant.

AIR FORCE MANPOWER

AFSA strongly believes the aging fleet of legacy Air Force systems, facilities, and equipment needs to be modernized. However, we also know the truly most valuable weapon America has are those serving this great Nation, especially the men and women wearing chevrons of the enlisted grades.

We are deeply concerned about the recent Air Force drawdown of manpower in order to facilitate funding of system modernization and recapitalization but we greatly appreciate Congressional support that has reinstated some of that lost resource. The impact on Air Force ability to maintain the highest level of readiness was felt throughout the smaller force and it placed even more stress on our maintainers and security forces.

Although well-intended, that drawdown did not appear to have yielded the results envisioned. Some efficiency was gained as Airmen exercised innovation and continuous process improvement in order to accomplish more. The ole adage "do more with less" certainly and quickly became a reality.

Operational demands including deployments have increased over this same time—increased intelligence activity, reconnaissance and surveillance (ISR) resources, supporting the newest combatant command in Africa, the new Air Force Cyber Command based in Louisiana, increased activity in Afghanistan, and elsewhere overseas. The Air Force has increased its capabilities to ward off threats from the cyber domain and accomplishing the expanding workload associated with more inspections and maintenance to keep aging airframes mission ready.

With the appropriate recommendations from the Armed Service committees, we need to continue offering enlistment bonuses for those career fields that are physically demanding and highly skilled hard to fill jobs since 2001. With Congressional assistance, coupled with the hard work of our Air Force recruiters, we can continue to meet the required annual needs of new Combat Controllers, Para-rescue; Tactical Air Control Party; Explosive Ordnance Disposal; Security Forces; Linguist and Survival, Evasion, Resistance, and Escape Instructors. The amount offered at the initial enlistment ranges from \$2,000 to \$13,000, depending on the career specialty and terms of enlistment. These are currently the only fields offering enlistment bonuses for fiscal year 2009. Congress authorized hazardous duty allowance for all DOD firefighters, still today the services have not funded this program. The Air Force has over 3,000 firefighters who have been authorized this allowance by Congress but not funded.

AFSA believes a course correction is needed to avert severe adverse, long-term consequences that have already begun to affect morale, retention and combat readiness. We strongly support increasing and fully funding Air Force end strength to 332,800.

QUALITY OF LIFE

Our Nation's military should not be considered a financial burden but considered a national treasure as they preserve our national security for all that live here. If we expect to retain this precious resource, we must provide them and their families, with decent and safe work centers, family housing and dormitories, health care, child care and physical fitness centers, and recreational programs and facilities. These areas are a prime recruitment and retention incentive for our Airmen and their families. This directly impacts their desire to continue serving through multiple deployments and extended separations from family and friends.

This Nation devotes considerable resources to train and equip America's sons and daughters—a long term investment—and that same level of commitment should be reflected in the facilities and equipment they use and in where they live, work, and play.

We urge extreme caution in deferring these costs, especially at installations impacted by base realignment and closure (BRAC) decisions and mission-related shifts.

We applaud congressional support for military housing privatization initiatives. This has provided housing at a much faster pace than would have been possible through military construction alone.

AFSA urges Congress to fully fund appropriate accounts to ensure our installations eliminate substandard housing and work centers as quickly as possible. Those devoted to serving this Nation deserve better.

Tremendous strides have been made to improve access to quality child care and fitness centers on military installations, and we are grateful to the Department of

Defense and Congress for these collective efforts. However, there is still much more work to be done. I have personally visited over 125 Air Force installations in the states and overseas these past three years and I can assure you that the demand for adequate child care is a top priority among our Airmen and their families. The importance of this is directly reflected in the military members' family decision to remain in the service or exit.

VETERANS AFFAIRS HEALTHCARE FUNDING

AFSA believes that the healthcare portion of Veterans Affairs (VA) funding should be moved to mandatory annual spending. One of this Nation's highest obligations is the willingness to fully fund VA health care, facilities, and other programs for those who have served in the past, are serving today and will serve in the future.

There are many challenges facing veterans and we are encouraged by the initiatives centered on improving access for all veterans regardless of their VA designated category. Much more emphasis has to be focused on continuity of care and addressing the scars of war, some obvious and others not so, such as traumatic brain injuries and post traumatic stress disorders. We are particularly pleased by the tremendous support of Congress and this Committee to implement and fund Wounded Warrior programs across America. The outpouring of support from civilian communities and volunteer support has been truly amazing and very much appreciated.

WOMEN VETERANS HEALTHCARE ISSUES

The Air Force Sergeants Association applauds the actions of this committee, other committees and sub-committees to directly address the issue of the unique health challenges faced by women veterans. Between 1990 and 2000, the women veteran population increased by over 33 percent from 1.2 million to 1.6 million, and women now represent approximately 9 percent of the total veteran population. By next year, the VA estimates women veterans will comprise well over 10 percent of the veteran population. Currently women make up more than 20 percent of the active duty Air Force, Air National Guard 19 percent, and approximately 26 percent of the Air Force Reserves with thousands serving, or having already returned from serving, in Iraq, Afghanistan and other places a long way from our shores. AFSA urges an increase to the VA budget so they can appropriately care for these veterans now and in the future.

IMPACT AID

Military leaders often use the phrase, "we recruit the member, but we retain the family" when talking about quality of life and retention. Impact Aid is a program at the very core of this premise, because it directly affects the quality of educational programs provided to the children of military service members. In the Department of Defense Dependent Schools, there are over 79,000 children of our active duty force scattered all over the globe.

These children lead unique lives, fraught with challenges associated with frequent changes in schools, repeatedly being uprooted and having to readjust to new communities and friends. Many of these school children are in other countries in either the DODDS system or host nation schools that are not affected by Impact Aid funding. Worrying about what resources might or might not be available to school administrators should not be yet another concern heaped upon them and their parents.

The Impact Aid program provides Federal funding to public school districts in the United States with enrollment of students that have a parent who is a member of the Armed Forces, living on and/or assigned to a military installation.

The budget proposed by the administration is identical to the approved funding in 2009 in spite of increased financial obligations by the servicing local school districts. It has a completely detrimental effect on the military member and their decision to take that next assignment or opt to get out for the good of his or her family. The implicit statement in this action is military children are a lower priority than others in our Nation. We ask this committee to take the steps necessary to show our military men and women that the education of their children is as important at the next child.

AFSA is grateful that Congress funded Impact Aid with 1.265.7 million this past fiscal year. We strongly urge increased funding of this important family quality of life area that has a direct bearing on reenlistment rates and military families quality of life. We urge Congress restore this program to its rightful full funding.

BASIC MILITARY PAY

Tremendous progress has been made over the last 15+ years to close the gap between civilian sector and military compensation. AFSA appreciates these steady efforts and we encourage further steps. We believe linking pay raises to the employment cost index (ECI) is essential to recruiting and retaining the very best and brightest volunteers. AFSA urges the formula for determining annual pay increases to be ECI + 0.5 percent until the gap is completely eliminated. If we want to continue having an all volunteer force then we must continue on the path to close the aforementioned pay gap. Enrollment in food stamps rose 25 percent in the military last year. Our junior enlisted are all volunteers serving our Nation, yet they remain on monthly use of food stamps.

TRANSITION ASSISTANCE PROGRAMS

The all-volunteer military force repeatedly answers this Nation's call to duty and at the end of their tours of duty, whether a few years or after decades of service, all transition to civilian life.

Section 502 of the National Defense Authorization Act of Fiscal Year 1991 codified in sections 1141-1143 and 1144-1150 of title 10, United States Code, authorized comprehensive assistance benefits and services for separating service members and their spouses.

From that legislation, grew a valuable partnership between the Department of Labor and the Departments of Defense, Veterans Affairs and Homeland Security to provide Transition Assistance Program (TAP) employment workshops, VA Benefits Briefings and the Disabled Transition Assistance Program (DTAP). These programs and briefings provide service members valuable job placement assistance, training opportunities, and education on veteran benefits so they make informed choices about post-service opportunities.

We urge the committee to continue fully funding transition assistance programs at a level that serves our deserving volunteer veterans.

In addition, we ask you to support the initiatives in this Congress to pass legislation and fund a program that would create hiring preferences across the Federal Government for military spouses. Under current law, veterans of America's Armed Forces are entitled to preferences over others in competitive hiring positions in Federal Government. We believe the sacrifice of family members warrant this consideration as well.

VETERANS EDUCATION BENEFITS

There's no escaping the fact that college costs are rising. As the gap between the cost of an education and value of the MGIB widens, the significance of the benefit becomes less apparent. For that reason, the Post 9-11 GI Bill was a giant step forward. However, we must make sure that the new post 9-11 stays current at all times, so that this benefit will not lose its effectiveness when it comes to recruiting this Nation's finest young men and women into service. As a member of The Military Coalition and the Partnership for Veterans' Education, we strongly recommend you make the technical corrections to the Post 9-11 Veterans GI Bill that need to be done prior to its implementation this August 1st.

When young enlisted men and women opt for military service, they should know that this Nation will provide them with a no-cost, complete education, as do numerous companies in the private industry. We, as a Government, give them a one-time chance to enroll in the MGIB during basic training. The Department of Defense charges them \$1,200 to enroll at a time when they can least afford it. Service-members are even offered an opportunity to increase their education benefit by paying an additional \$600.

Now that the new Post 9-11 GI bill is coming on board for free, those who already paid for but who have not yet utilized the Montgomery GI Bill, will now have to wait until their chapter 33 entitlements are exhausted before they will be allowed to receive a refund on their Montgomery GI bill contributions. Under current law, those who have contributed the additional \$600, will not have that money returned to them at all.

This is unacceptable.

In good faith and trusting their Government-funded education will be provided in their best interest, service-members now find a program that does not require further investment in their education. However the Government will withhold the service-member's Montgomery GI Bill initial investment and not refund it. Our recommendation is that the service-members who chose to enroll in the chapter 33 benefit, and who bought the additional benefit for \$600, should be given their invest-

ment back or granted an additional 2 years of chapter 30 benefits to roll their \$600 education investment into the new education bill. The latest shortfall with the new bill is that all active duty will not receive the \$1,000 book allowance. We urge the appropriate committees to make the necessary corrections to ensure those on active duty receive this allowance.

Mr. Chairman, we appreciate your efforts and thank you for this opportunity to share our perspective. AFSA realizes the many difficult decisions this committee must make and hope the information presented today proves helpful. As always, the Air Force Sergeants Association remains ready to support you in matters of mutual concern.

Chairman INOUE. And our next witness represents the American Psychological Association, Dr. Gavin O'Shea.

STATEMENT OF GAVIN O'SHEA, Ph.D., ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Dr. O'SHEA. Good morning Mr. Chairman and members of the subcommittee. I'm Dr. Gavin O'Shea from HumRRO, the Human Resources Research Organization. I'm submitting testimony on behalf of the American Psychological Association, or APA, a scientific and professional organization of more than 148,000 psychologists.

For decades, clinical and research psychologists have used their unique and critical expertise to meet the needs of our military and its personnel, playing a vital role within the Department of Defense. My own military-oriented research and consulting focuses on organizational commitment, personnel selection, and leadership assessment.

This morning, I focus on APA's request that Congress reverse disturbing administration cuts to DOD's science and technology budget and maintain support for important behavioral sciences research on counterterrorism and counterintelligence operations.

In terms of the overall DOD S&T budget, the President's request for fiscal year 2010 represents a dramatic step backward for defense research. Defense S&T would fall from the current fiscal year 2009 level of \$13.6 billion to \$11.6 billion, with cuts across the board. With very few exceptions, all basic and applied research accounts within military labs would face cuts, some as high as 50 percent.

This is not the time to reduce support for research that is vital to our Nation's continued security in a global atmosphere of uncertainty and asymmetric threats. APA urges the subcommittee to reverse this cut to the critical defense science program by providing \$14 billion for defense S&T in fiscal year 2010.

Finally, APA is also concerned about the potential loss of invaluable human-centered research programs related to counterintelligence and counterterrorism due to the reorganization of the CIFA office into the Defense Intelligence Agency (DIA). APA urges the subcommittee to provide ongoing funding in fiscal year 2010 for DIA's behavioral research programs on cyberdefense, insider threat, credibility assessment, detection of deception, and other operational challenges.

As noted in a recent National Research Council report, "People are the heart of all military efforts. People operate the available weaponry and technology, and they constitute a complex military system composed of teams and groups at multiple levels. Scientific research on human behavior is crucial to the military, because it

provides knowledge about how people work together, and use weapons and technology to extend and amplify their forces.”

The defense research programs need your help more than ever this year, and we look forward to your support.

Thank you.

Chairman INOUE. I thank you very much, Dr. O’Shea.

[The statement follows:]

PREPARED STATEMENT OF GAVAN O’SHEA

The American Psychological Association (APA) is a scientific and professional organization of more than 148,000 psychologists and affiliates.

For decades, psychologists have played vital roles within the Department of Defense (DOD), as providers of clinical services to military personnel and their families, and as scientific researchers investigating mission-targeted issues ranging from airplane cockpit design to human intelligence-gathering. More than ever before, psychologists today bring unique and critical expertise to meeting the needs of our military and its personnel. APA’s testimony will focus on reversing Administration cuts to the overall DOD Science and Technology (S&T) budget and maintaining support for important behavioral sciences research within DOD.

DOD RESEARCH

“People are the heart of all military efforts. People operate the available weaponry and technology, and they constitute a complex military system composed of teams and groups at multiple levels. Scientific research on human behavior is crucial to the military because it provides knowledge about how people work together and use weapons and technology to extend and amplify their forces.”—Human Behavior in Military Contexts, Report of the National Research Council, 2008.

Just as a large number of psychologists provide high-quality clinical services to our military service members stateside and abroad, psychological scientists within DOD conduct cutting-edge, mission-specific research critical to national defense.

In terms of the overall DOD S&T budget, the President’s request for fiscal year 2010 represents a dramatic step backward for defense research. Defense S&T would fall from the estimated fiscal year 2009 level of \$13.6 billion to \$11.6 billion with cuts across the board. With the exception of a less-than-1-percent increase in Air Force basic (6.1) research and an increase in basic research in the Office of the Secretary of Defense, all military labs would see cuts to their 6.1, 6.2 and 6.3 accounts, some as high as 50 percent.

The President’s budget request for basic and applied research at DOD in fiscal year 2010 is \$11.6 billion, which represents a stunning decrease of almost \$2 billion or 15 percent from the enacted fiscal year 2009 level of \$13.6 billion. APA urges the Subcommittee to reverse this cut to the critical defense science program by providing a total of \$14 billion for Defense S&T in fiscal year 2010. This is not the time to cut back on research vital to our Nation’s continued security in a global atmosphere of uncertainty and asymmetric threats.

BEHAVIORAL RESEARCH WITHIN THE MILITARY SERVICE LABS AND DOD

Within DOD, the majority of behavioral, cognitive and social science is funded through the Army Research Institute (ARI) and Army Research Laboratory (ARL); the Office of Naval Research (ONR); and the Air Force Research Laboratory (AFRL), with additional, smaller human systems research programs funded through the Office of the Secretary of Defense, the Defense Advanced Research Projects Agency (DARPA), and DOD’s Defense Intelligence Agency (DIA).

The military service laboratories provide a stable, mission-oriented focus for science, conducting and sponsoring basic (6.1), applied/exploratory development (6.2) and advanced development (6.3) research. These three levels of research are roughly parallel to the military’s need to win a current war (through products in advanced development) while concurrently preparing for the next war (with technology “in the works”) and the war after next (by taking advantage of ideas emerging from basic research). All of the services fund human-related research in the broad categories of personnel, training and leader development; warfighter protection, sustainment and physical performance; and system interfaces and cognitive processing.

National Academies Report Calls for Doubling Behavioral Research

The 2008 National Academies report on Human Behavior in Military Contexts recommended doubling the current budgets for basic and applied behavioral and so-

cial science research “across the U.S. military research agencies.” It specifically called for enhanced research in six areas:

- intercultural competence;
- teams in complex environments;
- technology-based training;
- nonverbal behavior;
- emotion; and
- behavioral neurophysiology.

Behavioral and social science research programs eliminated from the mission labs due to cuts or flat funding are extremely unlikely to be picked up by industry, which focuses on short-term, profit-driven product development. Once the expertise is gone, there is absolutely no way to “catch up” when defense mission needs for critical human-oriented research develop. As DOD noted in its own Report to the Senate Appropriations Committee: “Military knowledge needs are not sufficiently like the needs of the private sector that retooling behavioral, cognitive and social science research carried out for other purposes can be expected to substitute for service-supported research, development, testing, and evaluation . . . our choice, therefore, is between paying for it ourselves and not having it.”

Defense Science Board Calls for Priority Research in Social and Behavioral Sciences: Mapping the Human Terrain

This emphasis on the importance of social and behavioral research within DOD is echoed by the Defense Science Board (DSB), an independent group of scientists and defense industry leaders whose charge is to advise the Secretary of Defense and the Chairman of the Joint Chiefs of Staff on “scientific, technical, manufacturing, acquisition process, and other matters of special interest to the Department of Defense.”

In its 2007 report on 21st Century Strategic Technology Vectors, the DSB identified a set of four operational capabilities and the “enabling technologies” needed to accomplish major future military missions (analogous to winning the Cold War in previous decades). In identifying these capabilities, DSB specifically noted that “the report defined technology broadly, to include tools enabled by the social sciences as well as the physical and life sciences.” Of the four priority capabilities and corresponding areas of research identified by the DSB for priority funding from DOD, the first was defined as “mapping the human terrain.”

MAINTAINING BEHAVIORAL RESEARCH ON COUNTERINTELLIGENCE

In addition to strengthening the DOD S&T account, and behavioral research within the military labs in particular, APA also is concerned with maintaining invaluable human-centered research programs formerly within DOD’s Counterintelligence Field Activity (CIFA) now that staff and programming have been transferred to the Defense Intelligence Agency. Within this DIA program, psychologists lead intramural and extramural research programs on counterintelligence issues ranging from models of “insider threat” to cybersecurity and detection of deception. These psychologists also consult with the three military services to translate findings from behavioral research directly into enhanced counterintelligence operations on the ground.

APA urges the Subcommittee to provide ongoing funding in fiscal year 2010 for counterintelligence behavioral science research programs at DIA in light of their direct support for military intelligence operations.

SUMMARY

On behalf of APA, I would like to express my appreciation for this opportunity to present testimony before the Subcommittee. Clearly, psychological scientists address a broad range of important issues and problems vital to our national security, with expertise in modeling behavior of individuals and groups, understanding and optimizing cognitive functioning, perceptual awareness, complex decision-making, stress resilience, recruitment and retention, and human-systems interactions. We urge you to support the men and women on the front lines by reversing another round of cuts to the overall defense S&T account and the human-oriented research projects within the military laboratories and CIFA.

As our Nation rises to meet the challenges of current engagements in Iraq and Afghanistan as well as other asymmetric threats and increased demand for homeland defense and infrastructure protection, enhanced battlespace awareness and warfighter protection are absolutely critical. Our ability to both foresee and immediately adapt to changing security environments will only become more vital over the next several decades. Accordingly, DOD must support basic Science and Tech-

nology (S&T) research on both the near-term readiness and modernization needs of the department and on the long-term future needs of the warfighter.

Below is suggested appropriations report language for fiscal year 2010 which would encourage the Department of Defense to fully fund its behavioral research programs within the military laboratories and protect counterintelligence research:

Department of Defense

Research, Development, Test, and Evaluation

Behavioral Research in the Military Service Laboratories.—The Committee notes the increased demands on our military personnel, including high operational tempo, leadership and training challenges, new and ever-changing stresses on decision-making and cognitive readiness, and complex human-technology interactions. To help address these issues vital to our national security, the Committee has provided increased funding to reverse cuts to psychological research through the military research laboratories: the Air Force Office of Scientific Research and Air Force Research Laboratory; the Army Research Institute and Army Research Laboratory; and the Office of Naval Research.

Human-Centered Counterintelligence Research.—The Committee urges the Department of Defense to continue supporting human-centered research, formerly coordinated through the Counterintelligence Field Activity, at the Defense Intelligence Agency.

Chairman INOUE. And now may I call upon the chair of the Extremities War Injuries Project Team of the American Academy of Orthopaedic Surgeons, Dr. Andrew Pollak.

STATEMENT OF ANDREW N. POLLAK, M.D., CHAIR, EXTREMITY WAR INJURIES AND DISASTER PREPAREDNESS PROJECT TEAM, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Dr. POLLAK. Good morning, Senators. I'm Dr. Andy Pollak, and I chair the Extremity War Injuries Project Team for the American Academy of Orthopaedic Surgeons. During the day, I serve as chief of orthopaedic surgery at the Shock Trauma Center at the University of Maryland in Baltimore.

On behalf of military and civilian orthopaedic surgeons and researchers throughout the country, I take this opportunity to urge the subcommittee to continue to provide significant resources for peer-reviewed medical research in the area of extremity war injuries, injuries arising from trauma to the bones, joints, muscles, and tendons of the arms and legs.

We thank you for providing the DOD with the funding for this purpose since fiscal year 2006, including \$117 million total in fiscal year 2009, and we urge you to consider increasing funding for this program, in fiscal year 2010, to \$150 million.

Chairman Inouye, we know of your personal experience involving extremity trauma during war, and appreciate the fact that you have both personal and professional perspectives from which to address this issue.

We're very grateful for the dedicated work of Senators Harkin and Hutchison, both members of the subcommittee. They worked together in support of last year's appropriation, and have both expressed support for growing this program to \$150 million for fiscal year 2010.

Mr. Chairman, I've had the privilege of performing surgery in military facilities in Balad, Iraq, and Landstuhl, Germany. I can assure this subcommittee of the outstanding quality of trauma care being delivered by the military health system there. The problem facing surgeons emanates from limitations in medical knowledge and techniques in the management of these horrific injuries. We

need your help to advance the state of the art. We also need your help to improve our ability to treat consequences of severe injury to the extremities, such as arthritis, nerve damage, infection, and failure of bones to heal properly.

I'll keep the statistics short. Extremity injury is the most common type of injury sustained in battle, affecting over 80 percent of wounded warriors. Extremity wounds are the greatest source of expense related to hospitalization of wounded warriors after combat injury. Extremity war wounds are the greatest source of war-related disability expense for the military, expected to total \$1.8 billion, lifetime, for payments related to injuries sustained to American warriors in Iraq and Afghanistan, exclusive of costs associated with their medical care. And conditions analogous to arthritis were the most common reason for disability-related retirement from the Army in 2008.

The peer-reviewed orthopaedic research programs were designed to help military surgeons find new, limb-sparing techniques, with the goals of avoiding amputations, and preserving and restoring the function of injured extremities, limiting disability and suffering, and, whenever possible, allowing our warriors to return to duty as soon as it's safely possible.

The interest and capacity of the U.S. research community is very strong. This past year, as a result of funding made available in the fiscal year 2008 supplemental appropriation, the DOD accepted applications for development of a consortium of military and civilian trauma centers to begin work on the critically important clinical studies necessary to understand the best ways to treat extremity injuries, and to translate recent scientific advances in bone growth and tissue regeneration to the real world, where these advances can help improve the lives of our injured heroes.

Mr. Chairman, Mr. Vice Chairman, you've recognized the urgent need to finance extremity research over the past 4 years, and we're extremely grateful for that support. Based on the level of scientific need, our goal is to see the Defense Department programs achieve an operating level of \$150 million per year.

Thank you and the entire subcommittee for your vision and leadership in responding to this appeal. We strongly urge your continued action.

Chairman INOUE. All right, thank you very much, Dr. Pollak. [The statement follows:]

PREPARED STATEMENT OF ANDREW N. POLLAK

Chairman Inouye, Vice Chairman Cochran, Members of the Senate Defense Appropriations Subcommittee, thank you for the opportunity to testify today. I am Andrew N. Pollak, M.D., and I speak today on behalf of the American Academy of Orthopaedic Surgeons (AAOS), of which I am an active member, as well as my military and civilian orthopaedic surgery colleagues who are involved in extremity trauma research and care.

I am Chair of the Academy's Extremity War Injuries and Disaster Preparedness Project Team, past-chair of its Board of Specialty Societies, and a subspecialist in orthopaedic traumatology. I am Associate Director of Trauma and Head of the Division of Orthopaedic Traumatology at the R Adams Cowley Shock Trauma Center and the University of Maryland School of Medicine. My Division at Shock Trauma is responsible for providing education and training in orthopaedic traumatology to residents from eight separate training programs nationally, including the Bethesda Naval, Walter Reed Army and Tripler Army military orthopaedic residency programs. In addition, Shock Trauma serves as the home for the Air Force Center for

the Sustainment of Trauma and Readiness Skills (CSTARS) program. I also serve as Second Vice President of the Orthopaedic Trauma Association.

Senators, on behalf of all the military and civilian members of the American Academy of Orthopaedic Surgeons, please allow me to take this opportunity today to thank you both, as well as the Members of this Subcommittee, for your vision and leadership in providing funding in fiscal years 2006 through 2009 for the peer reviewed medical research program on orthopaedic and extremity war injuries. In particular, we thank you for providing \$66 million in your fiscal year 2009 Conference Bill and for creating the Peer Reviewed Orthopedic Research Program to cover the full range of research—from basic to clinical trials.

We also thank you most sincerely for your consideration of providing funding in the fiscal year 2009 Supplemental Appropriations Bill. Your commitment to building this research enterprise and enabling the Department of Defense to pursue answers to its critical medical needs must be recognized. Clearly this effort by the Congress will provide medical benefit through improved treatments and procedures to help our Wounded Warriors heal better and quicker.

We are very grateful for the dedicated work of Senators Tom Harkin and Kay Bailey Hutchison—both Members of this Subcommittee—in sponsoring a “Dear Colleague” letter this year supporting the ultimate goal of achieving an annual operating level of \$150 million per year for this critical peer reviewed research program.

It really cannot be overstated: the level and consistency of appropriations you are providing are “game-changing.” It provides the Department with the ability to move rapidly in developing the full research continuum, especially clinical trials—an essential form of investigation that has not existed in the extremity injury field previously because of a lack of significant and sustained resources. Just last month because of your support the U.S. Army’s Medical Research and Materiel Command accepted applications in response to its first ever call for the formation of network for clinical research into these challenges. In addition because of this critical funding, in April the Command hosted a 2-day scientific conference to further examine needs, and prioritize areas for its broadened research agenda.

Mr. Chairman, our message is straightforward:

- Extremity trauma and its sequelae represent the single most common injury class our wounded warriors suffer, the greatest source of inpatient medical care expense for the DOD, the single greatest source of injury related disability expense for the military, and the most common cause for disability retirement from all branches of the armed services;
- the state of the science must be advanced to provide better treatment options for our wounded service members who suffer extremity trauma and other injuries to their bone and muscles with a goal of limiting the profound long-term disability associated with these injuries;
- the current peer reviewed research program has great potential to address a wide range of bone and muscle injuries and conditions that are sidelining our troops at increasing rates; and
- the Defense Department must be convinced to proactively budget for research on military-related orthopaedic injuries, including extremity trauma, but until that occurs, we believe that the Congress has an obligation to ensure—as you have done—that the necessary resources are appropriated and directed to the task.

As the Iraq and Afghanistan conflicts enter their seventh year, the Nation continues to face a profound need for focused medical research to help military surgeons find new limb-sparing techniques with the goal of avoiding amputations and preserving and restoring the function of injured extremities.

Chairman Inouye, we know of your experience with extremity trauma during war and appreciate the fact that you have both personal and professional perspectives from which to address this issue and we honor your service as well as that of Vice Chairman Cochran.

U.S. military researchers have documented that approximately 82 percent of war injuries suffered fighting the global war on terror involve the extremities—often severe and multiple injuries to the arms and legs.

The evidence is also reflected in legislative documents. House Report 111–105 accompanying the recent fiscal year 2009 Supplemental Appropriations Bill, H.R. 2346, correctly states that “. . . extremity injuries are the most prevalent injury, and amputations following battlefield injury now occur as twice the rate as in past wars. Understanding how to treat and facilitate rapid recovery from orthopedic injuries should be one of the top priorities for the Military Health System.”

The Report accompanying the fiscal year 2009 House Appropriations Bill made similar points and added: “. . . the committee believes that every aspect of research shall be considered during a time when unique and dynamic research and treatment

is necessary to provide the soldiers the greatest ability to recover from injuries sustained on the battlefield.”

House Report 110–279 accompanying the fiscal year 2008 Defense Appropriations Bill stated that “Extremity injuries are the number one battlefield injury . . . dynamic research and treatment is necessary to provide service members the greatest ability to recover from injuries sustained on the battlefield.”

A recent U.S. Army analysis of soldiers injured in Iraq and Afghanistan from 2001 through 2005 shows that extremity injuries account for the greatest proportion of medical resource utilization and cause the greatest number of disabled soldiers. In fact, soldiers with extremity injuries had the longest average inpatient stays, accounted for 65 percent of total inpatient resource utilization and 64 percent of projected disability benefits costs in the future. The projected disability cost for extremity injuries sustained in this conflict to date—exclusive of ANY short or long-term medical costs—is estimated to be approximately \$1.2 billion.

In addition, muscle and bone injuries are sidelining a growing number of troops in our current conflicts. Data from the U.S. Army reported 257,000 acute orthopaedic injuries in 2007—an increase of 10,000 over the previous year. Increasing numbers of troops are listed as “non-deployable” as a result of injuries related to carrying heavy combat gear in repeated deployments, and, in the case of Afghanistan, carrying those loads in high altitude settings.

A February 1, 2009 Washington Post article on this challenge stated that “Army leaders and experts say the injuries—linked to the stress of bearing heavy loads during repeated 12- or 15-month combat tours—have increased the number of soldiers categorized as “non deployable.”

The article goes on to quote General Peter W. Chiarelli, the Army Vice Chief of Staff: “You can’t hump a rucksack at 8,000 to 11,000 feet for 15 months, even at a young age, and not have that have an impact on your body, and we are seeing an increase in muscular-skeletal issues.”

THE PEER REVIEWED ORTHOPAEDIC RESEARCH PROGRAM

Chairman Inouye, the AAOS and military and civilian orthopaedic surgeons and researchers are very grateful for your Subcommittee’s vision in providing support for Peer Reviewed Orthopedic Research. This is the first program created in the Department of Defense dedicated exclusively to funding peer-reviewed intramural and extramural orthopaedic research. Having the program administered on behalf of the Defense Health Program by the U.S. Army Medical Research and Materiel Command, Fort Dietrick, ensures that the funding closely follows the research priorities established by the Armed Forces. With the assistance of the Army’s Institute of Surgical Research, MRMC has extensive experience administering military-related research grant programs. Military orthopaedic surgeons have also had significant input into the creation of this program and fully support its goals.

The design of the program fosters collaboration between civilian and military orthopaedic surgeons and researchers and various facilities. Civilian researchers have the expertise and resources to assist their military colleagues with the growing number of patients and musculoskeletal injuries and war wound challenges in building the military research program. As can be seen in extensive numbers of research applications submitted under each RFP, civilian investigators are extremely interested in advancing this research and have responded enthusiastically to engage in this important work which will also provide wide ranging spin-off benefits to civilian trauma patients.

The program is growing to encompass the full spectrum of research, from basic and translational studies to clinical trials. It focuses on targeted, competitively-awarded research where peer reviewers score proposals on the degree of (1) military relevance, (2) military impact, and (3) scientific merit. Military and civilian orthopaedic surgeons are highly involved in defining the research topics and in evaluating and scoring the proposals. This unique process ensures that projects selected for funding have the highest chance for improving treatment of battlefield injuries and deployment related musculoskeletal injuries.

Significant new funding from the Congress will allow for more robust numbers of grants, a broader scope of work and increased multi-institutional collaboration. As mentioned earlier, clinical trials and more in-depth tracking of long term outcomes are in the planning stages—important components in rapidly advancing the state of the science.

By funding the Peer Reviewed Orthopedic Research Program—operated on behalf of all services by the Army’s Medical Research and Materiel Command—your committee is advancing the state of the science in this field to the benefit of our current servicemen and women—and those who will step forward in the future to defend

our Nation. Your action will directly result in improved treatments for our Wounded Warriors and injured troops now and in future conflicts.

It is important to point out that unique to the current conflicts is a new type of patient, a war fighter with multiple and severely mangled extremities who is otherwise free of life-threatening injury to the torso or whose life-threatening injuries have been successfully addressed because of improvements in protective body armor and the excellent care quickly delivered through the echelon treatment system. Such injuries are rarely seen in civilian surgical hospitals, even in Level 1 trauma centers like my own at Shock Trauma in Baltimore. Current challenges that often compound the battlefield injuries include serious infections due to the nature of the injuries and the environment in which they are sustained, and the need for immediate transport for more complex surgery.

The Academy's interest in this effort began in the very early days of Operation Enduring Freedom when our deployed military Academy members began to report the great clinical needs that were emerging as they went about their work in surgery to save injured servicemen and women. Soon studies on the nature of injuries in Iraq and Afghanistan documented the high proportion of extremity injuries as well as the severity of injuries.

I have been fortunate to travel to and operate in the U.S. Army Hospital in Landstuhl, Germany several times and to the Air Force Theater Hospital in Balad, Iraq to initiate the Academy's Distinguished Visiting Scholars Program. This program is a joint initiative between the AAOS and the Orthopaedic Trauma Association. The activity allows civilian orthopaedic trauma specialists with demonstrated clinical expertise and national recognition for their teaching abilities to volunteer two weeks at a time to be away from their practices performing surgery and teaching at Landstuhl Regional Medical Center. I also had the privilege of operating in Balad, Iraq as part of a request by Air Force Surgeon General James Roudebush to evaluate the trauma care being delivered at the Air Force Theater Hospital and to investigate the feasibility and value of extending the Distinguished Visiting Scholars Program into Iraq and Afghanistan. Based on my experiences in Balad, I can assure this committee of the outstanding quality of trauma care being delivered there by the military health system. I believe the quality of medical care being delivered to our injured warriors in Balad is at or above the care being delivered in our finest trauma centers within the United States.

On January 21-23 of this year, the fourth annual Extremity War Injuries Scientific Symposium was held in Washington, DC, sponsored by our Academy, along with the Society of Military Orthopaedic Surgeons, The Orthopaedic Research Society and the Orthopaedic Trauma Association. This combined effort of three major associations and the United States military began in 2006 in an initiative to examine the nature of extremity injuries sustained during Operation Enduring Freedom and Operation Iraqi Freedom and to plan for advancing the state of the science and treatment of these injuries. Each year the meetings are attended by over 175 military and civilian leaders in orthopaedic and extremity medical research and treatment from around the world. We have been very fortunate to have had many outstanding leaders speak to the conference audiences in the past about their perspectives on injuries being sustained by our armed forces. These speakers have included Joint Chiefs Chairman Adm. Michael Mullen, Senator Tom Harkin, Representatives John Murtha, Dutch Ruppersberger, and Tom Latham, and the previous Assistant Secretary of Defense for Health Affairs, Ward Casscells. This conference series has produced widely referenced scientific publications describing the clinical challenges posed by extremity war injuries, and a research agenda to guide the scientific community and the managers of the Peer Reviewed Orthopedic Research Program in planning and executing the program.

ORTHOPAEDIC TRAUMA FROM OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM

The likelihood of surviving wounds on the battlefield was 69.7 percent in WWII and 76.4 percent in Vietnam. Now, thanks in part to the use of body armor, "up-armored" vehicles, intense training of our combat personnel and surgical capability within minutes of the battlefield, survivability has increased dramatically to 90.2 percent as of February 2007.

The Armed Forces are attempting to return significantly injured warriors to full function or limit their disabilities to a functional level in the case of the most severe injuries. The ability to provide improved recovery of function moves toward the goal of keeping injured warriors part of the military team. Moreover, when they do leave the Armed Forces, these rehabilitated warriors have a greater chance of finding worthwhile occupations outside of the service to contribute positively to society. The

military believes that it has a duty and obligation to provide the highest level of care and rehabilitation to those men and women who have suffered the most while serving the country and our Academy fully supports those efforts.

It comes as no surprise that the vast majority of trauma experienced in Iraq and Afghanistan is orthopaedic-related, especially upper and lower extremity and spine. A recent article in the *Journal of Orthopaedic Trauma* reports on wounds sustained in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) based on data from the Joint Theater Trauma Registry, a database of medical treatment information from theater of combat operations at U.S. Army medical treatment facilities. From October, 2001 through January, 2005, of 1,566 soldiers who were injured by hostile enemy action, 1,281 (82 percent) had extremity injuries, with each soldier sustaining, on average, 2.28 extremity wounds. These estimates do not include non-American and civilians receiving medical care through U.S. military facilities. (Owens, Kragh, Macaitis, Svoboda and Wenke. Characterization of Extremity Wounds in Operation Iraqi Freedom and Operation Enduring Freedom. *J Orthopaedic Trauma*. Vol. 21, No. 4, April 2007. 254–257.)

An earlier article reported on 256 battle casualties treated at the Landstuhl Regional Medical Center in Germany during the first 2 months of OIF, finding 68 percent sustained an extremity injury. The reported mechanism of injury was explosives in 48 percent, gun-shot wounds in 30 percent and blunt trauma in 21 percent. As the war has moved from an offensive phase to the current counter-insurgency campaign, higher rates of injuries from explosives have been experienced. (Johnson BA, Carmack D, Neary M, et al. Operation Iraqi Freedom: the Landstuhl Regional Medical Center experience. *J Foot Ankle Surg*. 2005; 44:177–183.) According to the JTTR, between 2001 and 2005, explosive mechanisms accounted for 78 percent of the war injuries compared to 18 percent from gun shots.

While medical and technological advancements, as well as the use of fast-moving Forward Surgical Teams, have dramatically decreased the lethality of war wounds, wounded soldiers who may have died in previous conflicts from their injuries are now surviving and have to learn to recover from devastating injuries. While body armor is very effective in protecting a soldier's torso, his or her extremities are particularly vulnerable during attacks.

Characteristics of Military Orthopaedic Trauma

At this point there have been almost 40,000 warriors evacuated to Landstuhl Regional Medical Center in the Global War on Terror. Of these, almost 16,000 have been wounded in action. As mentioned earlier, the vast majority have injuries to their extremities—often severe and multiple injuries to the arms and legs. Most wounds are caused by exploding ordnance—frequently, improvised explosive devices (IEDs), rocket-propelled grenades (RPGs), as well as high-velocity gunshot wounds. Military surgeons report an average of 3 wounds per casualty.

According to the *New England Journal of Medicine*, blast injuries are producing an unprecedented number of “mangled extremities”—limbs with severe soft-tissue and bone injuries. (“Casualties of War—Military Care for the Wounded from Iraq and Afghanistan,” *NEJM*, December 9, 2004). The result of such trauma is open, complex wounds with severe bone fragmentation. Often there is nerve damage, as well as damage to tendons, muscles, vessels, and soft-tissue. In these types of wounds, infection is often a problem. According to the JTTR, 53 percent of the extremity wounds are classified as penetrating soft-tissue wounds, while fractures compose 26 percent of extremity wounds. Other types of extremity wounds composing less than 5 percent each are burns, sprains, nerve injuries, abrasions, amputations, contusions, dislocations, and vascular injuries.

The sheer number of extremity injuries represents a staggering health burden. Between January 2003, and February 2009, over 15,000 U.S. Warriors have been wounded-in-action severely enough to require evacuation out of theater. In addition, 780 American patients have lost at least one limb.

Military Versus Civilian Orthopaedic Trauma

While there are similarities between military orthopaedic trauma and the types of orthopaedic trauma seen in civilian settings, there are several major differences that must be noted.

With orthopaedic military trauma, there are up to five echelons of care, unlike in civilian settings when those injured are most likely to receive initial treatment at the highest level center. Instead, wounded warriors get passed from one level of care to the next, with physicians and other health care providers rendering the most appropriate type of care possible in the context of the limitations of a battlefield environment in order to ensure the best possible outcome. The surgeon in each subsequent level of care must try to recreate what was previously done. In addition, a

majority of injured soldiers have to be “med-evaced” to receive care and transportation is often delayed due to weather or combat conditions. It has been our experience that over 65-percent of the trauma is urgent and requires immediate attention.

Injuries from IEDs and other explosive ordnance in Iraq and Afghanistan differ markedly from those of gunshot wounds sustained in civilian society. The contamination, infection and soft-tissue injury caused by exploding ordnance requires more aggressive treatment and new techniques, especially when the wounded warrior was in close proximity to the blast radius.

Warriors are usually in excellent health prior to injury. However, through the evacuation process they may not be able to eat due to medical considerations resulting in impaired body nitrogen stores and decreased ability to heal wounds and fight infections. This presents many complicating factors when determining the most appropriate care.

The setting in which care is initially provided to wounded soldiers is less than ideal, to say the least, especially in comparison to a sterile hospital setting. The environment, such as that seen in Iraq and Afghanistan, is dusty and hot, leading to concerns about secondary contamination of wounds in the hospital setting. For example, infection from *acinetobacter baumannii*, a ubiquitous organism found in the desert soil of Afghanistan and Iraq, is extremely common. In addition, the surgical environment is under constant threat of attack by insurgents. Imagine teams of medical specialists working in close quarters to save an injured serviceman while mortars or rockets are raining down on the hospital. Finally, the forward-deployed surgical team is faced with limited resources that make providing the highest level of care difficult.

While, as I have stated, there are many unique characteristics of orthopaedic military trauma, there is no doubt that research done on orthopaedic military trauma also benefits trauma victims in civilian settings. Many of the great advancements in orthopaedic trauma care have been made during times of war, including principles of debridement of open wounds, utilization of external fixation and use of tourniquets for control of hemorrhage which has been used extensively during the current conflict.

Research Needs.—With such strong research interest and capacity, and the great need for medical breakthroughs in this field, the scientific community believes that a sustained, multi-year program funded at \$150 million per year is justified. Such significant funding is required allow the Defense Department to conduct multi-center clinical trials—research projects that would greatly advance the field and significantly benefit the battlefield injured warriors. In addition, basic and translational research also must be sustained, as in any major research undertaking, to provide the underpinnings for advancing clinical breakthroughs. Research in the management of extremity injuries and other disabling orthopaedic conditions will lead to quicker recovery times, improved function of limbs, better response rates to infection, and new advances in rehabilitation benefiting both military and civilian patients. General areas of research need include bone regeneration, improved healing of massive soft tissue damage, prevention of wound infection, techniques to improve irrigation and debridement of blast injuries, prevention of bone reformation abnormalities, and epidemiology of current battle-related injuries.

Specific areas of research need include:

- Prevention and treatment of post-traumatic arthritis;
- Prevention and treatment of infections following high-energy extremity war injury;
- Management of segmental bone defects;
- Establishment of tissue viability markers—this would assist surgeons in better understanding the ideal frequency and techniques of debridement wound cleaning);
- Timing of treatment—early versus late surgical treatment;
- Prevention and treatment of chronic neck and low back arthritic conditions resulting from combat associated stress and overuse injury;
- Treatment of severe muscle, nerve, ligament and other soft-tissue injury associated with combat trauma; and
- Rehabilitation of high-performance warriors after significant combat related injury.

Future Needs of Orthopaedic Research

As mentioned earlier, an important development in this scientific effort has been the convening of the annual Extremity War Injury Symposia, which began in January of 2006. These widely attended medical conferences in Washington, D.C. bring together leading military and civilian clinicians and researchers to focus on the immediate needs of personnel sustaining extremity injuries. Discussions at the con-

ferences have confirmed that there is tremendous interest and much untapped research capacity in the Nation's military and civilian research community.

These extraordinary scientific meetings were a partnership effort between organized orthopaedic surgery, military surgeons and researchers. They were attended by key military and civilian physicians and researchers committed to the care of extremity injuries. The first conference addressed current challenges in the management of extremity trauma associated with recent combat in Iraq and Afghanistan. The major focus was to identify opportunities to improve care for the sons and daughters of America who have been injured serving our Nation. The second focused on the best way to deliver care within the early echelons of treatment. The third explored the wide spectrum of needs in definitive reconstruction of injuries. Scientific proceedings from the symposia have been published by our Academy and made available to the military and civilian research community. Each conference has continued to refine the list of prioritized research needs which I will summarize:

Timing of Treatment

Better data are necessary to establish best practices with regard to timing of debridement, timing of temporary stabilization and timing of definitive stabilization. Development of animal models of early versus late operative treatment of open injuries may be helpful. Prospective clinical comparisons of treatment groups will be helpful in gaining further understanding of the relative role of surgical timing on outcomes.

Techniques of Debridement

More information is necessary about effective means of demonstrating adequacy of debridement. Current challenges, particularly for surgeons with limited experience in wound debridement, exist in understanding how to establish long-term tissue viability or lack thereof at the time of an index operative debridement. Since patients in military settings are typically transferred away from the care of the surgeon performing the initial debridement prior to delivery of secondary care, opportunities to learn about the efficacy of initial procedures are lost. Development of animal models of blast injury could help establish tissue viability markers. Additional study is necessary to understand ideal frequencies and techniques of debridement.

Transport Issues

Clinical experience suggests that current air evacuation techniques are associated with development of complications in wound and extremity management although the specific role of individual variables in the genesis of these complications is unclear. Possible contributing factors include altitude, hypothermia and secondary wound contamination. Clinical and animal models are necessary to help develop an understanding of transport issues.

Coverage Issues

Controlled studies defining the role of timing of coverage in outcome following high-energy extremity war injuries are lacking. Also necessary is more information about markers and indicators to help assess the readiness of a wound and host for coverage procedures. Additional animal modeling and clinical marker evaluation are necessary to develop understanding in this area.

Antibiotic Treatments

Emergence of resistant organisms continues to provide challenges in the treatment of infection following high-energy extremity war injuries. Broader prophylaxis likely encourages development of antibiotic resistance. In the context of a dwindling pipeline of new antibiotics, particularly those directed toward gram-negative organisms, development of new technologies to fight infection is necessary. This patient population offers opportunity to assess efficacy of vaccination against common pathogens. Partnerships with infectious disease researchers currently involved in addressing similar questions warrants further development.

Management of Segmental Bone Defects

A multitude of different techniques for management of segmental bone defects is available. These include bone transport, massive onlay grafting with and without use of recombinant proteins, delayed allograft reconstruction, and acute shortening. While some techniques are more appropriate than others after analysis of other clinical variables, controlled trials comparing efficacy between treatment methods are lacking. Variables that may affect outcome can be grouped according to patient characteristics including co-morbidities, injury characteristics including severity of bony and soft-tissue wounds, and treatment variables including method of internal fixation selected. Evaluation of new technologies for treatment of segmental bone

defects should include assessment of efficacy with adequate control for confounding variables and assessment of cost-effectiveness. Partnerships with other military research programs may be particularly effective in improving clinical capabilities in this area.

Development of an Animal Model

A large animal survival military blast injury model is necessary to serve as a platform for multiple research questions including: negative pressure wound therapy v. bead pouch v. dressing changes; wound debridement strategy; effect of topical antibiotics; modulation of inflammatory response; timing of wound closure; and vascular shunt utilization.

Prevention of Post-Traumatic Arthritis

More research is necessary to better understand how to address traumatic injuries to articular cartilage with associated articular loss. Current treatment options include artificial joint replacement and joint fusion. Regeneration of cartilage and re-growth of joint surfaces is poorly understood and warrants further investigation. Similarly, the role of cadaver joint surfaces in replacing injured joints in soldiers warrants further consideration and investigation. Initial research has been exciting in this area, particularly in the area of allograft hand transplantation.

Amputee Issues

Development and validation of “best practice” guidelines for multidisciplinary care of the amputee is essential. Treatment protocols should be tested clinically. Studies should be designed to allow for differentiation between the impacts of the process versus the device on outcome. Failure mode analysis as a tool to evaluate efficacy of treatment protocols and elucidate shortcomings should be utilized. Clinically, studies should focus on defining requirements for the residual limb length necessary to achieve success without proceeding to higher level amputation. Outcomes based comparisons of amputation techniques for similar injuries and similar levels should be performed. Use of local tissue lengthening and free tissue transfer techniques should be evaluated. In the context of current results and increasing levels of expectation for function following amputation, development of more sensitive and military appropriate outcomes monitors is necessary.

Heterotopic Ossification

This condition, known as “H.O.” by the many soldiers who experience it, is abnormal and uncontrolled bone growth that often occurs following severe bone destruction or fracture. Animal models of heterotopic ossification should be utilized to develop early markers for heterotopic ossification that could identify opportunities for early treatment and prevention. Better information is needed about burden of disease including prevalence following amputation for civilian versus military trauma and frequency with which symptoms develop. Treatment methods such as surgical debridement, while effective, necessarily interrupt rehabilitation. Prevention could expedite recovery and potentially improve outcome.

CONCLUSION

With extremity trauma injuries being the most common form of injury seen in current military conflicts and musculoskeletal injuries becoming an increasing factor in sidelining our troops, it is crucial that significant funding be directed specifically to the advancement of research. The AAOS has worked closely with the top military orthopaedic surgeons and medical leaders, at world-class facilities such as the U.S. Army Institute of Surgical Research, Brooke Army Medical Center, Bethesda Naval Hospital, Landstuhl Regional Medical Center, the Medical Research and Materiel Command and Walter Reed Army Medical Center to identify the gaps in research and clinical treatment—and the challenges are many.

Orthopaedic research currently being carried out at those and other facilities, and at civilian medical centers, is vital to the health of our soldiers and to the Armed Forces’ objective to return injured soldiers to full function in hopes that they can continue to be contributing soldiers and active members of society.

The 17,000 members of our Academy thank you for sustaining the Peer Reviewed Orthopedic Research Program. While Congress funds an extensive array of medical research through the Department of Defense, with over 80 percent of military trauma being extremity-related, I can assure you that this type of medical research will greatly benefit our men and women serving in the Global War on Terror and in future conflicts.

Mr. Chairman and Mr. Vice Chairman, the American Academy of Orthopaedic Surgeons, as well as the entire orthopaedic trauma community, stands ready to

work with this Subcommittee to identify and prioritize research opportunities for the advancement in the care of extremity and orthopaedic injuries. Military and civilian orthopaedic surgeons and researchers are committed to pursuing scientific inquiry that will benefit the unfortunately high number of soldiers afflicted with such conditions and return them to the highest level of function possible. This investment to improve treatment for our soldiers will be well spent. It is imperative that the Federal Government—when establishing its defense health research priorities in the future—continues to ensure that research on treating orthopaedic and extremity war injuries remains a top priority. We appreciate your consideration of our perspective on this critical issue and urge your continued action on behalf of our Nation's servicemen and women.

Chairman INOUE. And we'd like to thank the whole panel and now call upon the new panel.

Thank you very much.

The next panel consists of Ms. Frances Visco, Ms. Jackie S. Rowles, Mr. Rick Jones, Ms. Cara Tenenbaum, Colonel William Holahan, and Ms. Elizabeth Cochran.

I've been advised that Mr. Wicks will be substituting for Ms. Jackie Rowles.

And our next witness is the president of the National Breast Cancer Coalition, Ms. Frances Visco.

**STATEMENT OF FRAN VISCO, J.D., PRESIDENT, NATIONAL BREAST
CANCER COALITION**

Ms. VISCO. Thank you, Chairman Inouye, Senator Cochran.

I'm here as a 22-year breast cancer survivor, a wife, a mother, and the president of the National Breast Cancer Coalition. As you know, NBCC is a coalition of more than 600 organizations from across the country whose mission is to end breast cancer.

I want to thank you, as I do every year, for your continued support of this program. And I want to report to you that this program continues to be incredibly successful. It continues to create new models of science, new models of research, through a competitive, peer-reviewed process that releases funding to scientists around the world.

This program has funded innovative research, it has filled the gaps in the traditional funding mechanisms. It has also been copied by the National Institutes of Health, by private foundations. The models that this program has launched have now changed science in many different areas within the Department of Defense, collaborations within the Defense Department, and without. It has resulted in bringing many new young scientists into the field of research, and biomedical research. And I'm very proud to say—very proud of the military—that this program has incredibly low administrative costs, so that 90 percent—more than 90 percent of the appropriations go directly to research funding.

There's an incredibly high return on the investment of these funds. And, most importantly, this program is transparent, and it is accountable to the taxpayers. It is possible to see where every dollar of these funds has gone. And the public gets a report of the results of the research that has been funded with these dollars.

It has made an incredible difference to women with breast cancer, to their families, but really to all disease research. And I want to take my last moments to say how grateful we are to the members of the military, to—who administer this program. They are passionately committed to this mission, and they do an incredible

job. And I want to thank you very much for continuing and allowing this program to proceed.

Thank you.

Chairman INOUE. Thank you very much, Ms. Visco.

[The statement follows:]

PREPARED STATEMENT OF FRAN VISCO

Thank you, Mr. Chairman and members of the Appropriations Subcommittee on Defense, for the opportunity to submit testimony today about a Program that has made a significant difference in the lives of women and their families.

I am Fran Visco, a 21-year breast cancer survivor, a wife and mother, a lawyer, and President of the National Breast Cancer Coalition (NBCC). My testimony represents the hundreds of member organizations and thousands of individual members of the Coalition. NBCC is a grassroots organization dedicated to ending breast cancer through action and advocacy. The Coalition's main goals are to increase Federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates wherever breast cancer decisions are made.

You and your Committee have shown great determination and leadership in funding the Department of Defense (DOD) peer-reviewed Breast Cancer Research Program (BCRP) at a level that has brought us closer to eradicating this disease. Chairman Inouye and Ranking Member Cochran, we appreciate your longstanding personal support for this Program. I am hopeful that you and your Committee will continue that determination and leadership.

I know you recognize the importance of this Program to women and their families across the country, to the scientific and health care communities and to the Department of Defense. Much of the progress in the fight against breast cancer has been made possible by the Appropriations Committee's investment in breast cancer research through the DOD BCRP. This Program has launched new models of biomedical research that have benefited other agencies and both public and private institutions. It has changed for the better the way research is performed and has been replicated by programs focused on other diseases, by other countries and states. To support this unprecedented progress moving forward, we ask that you support a separate \$150 million appropriation for fiscal year 2010. In order to continue the success of the Program, you must ensure that it maintain its integrity and separate identity, in addition to the requested level of funding. This is important not just for breast cancer, but for all biomedical research that has benefited from this incredible government Program. In addition, as Institute of Medicine (IOM) reports concluded in 1997 and 2004, there continues to be excellent science that would go unfunded without this Program. It is only through a separate appropriation that this Program is able to continue to focus on breast cancer yet impact all other research. The separate appropriation of \$150 million will ensure that this Program can rapidly respond to changes and new discoveries in the field and fill the gaps in traditional funding mechanisms.

Since its inception, this Program has matured into a broad-reaching influential voice forging new and innovative directions for breast cancer research and science. Breast cancer is an extraordinarily complex disease. Despite the enormous successes and advancements in breast cancer research made through funding from the DOD BCRP, we still do not know what causes breast cancer, how to prevent it, or how to cure it. It is critical that innovative research through this unique Program continues so that we can move forward toward eradicating this disease.

OVERVIEW OF THE DOD BREAST CANCER RESEARCH PROGRAM

The DOD peer-reviewed Breast Cancer Research Program has established itself as a model medical research program, respected throughout the cancer and broader medical community for its innovative, transparent and accountable approach. The pioneering research performed through the Program has the potential to benefit not just breast cancer, but all cancers, as well as other diseases. Biomedical research is being transformed by the DOD BCRP's success.

This Program is both innovative and incredibly streamlined. It continues to be overseen by an Integration Panel including distinguished scientists and advocates, as recommended by the IOM. Because there is little bureaucracy, the Program is able to respond quickly to what is currently happening in the research community. Because of its specific focus on breast cancer, it is able to rapidly support innovative proposals that reflect the most recent discoveries in the field. It is responsive, not

just to the scientific community, but also to the public. The flexibility of the Program has allowed the Army to administer it with unparalleled efficiency and effectiveness.

An integral part of this Program has been the inclusion of consumer advocates at every level. Breast cancer is not just a problem of scientists; it is a problem of people. Advocates bring a necessary perspective to the table, ensuring that the science funded by this Program is not only meritorious, but it is also meaningful and will make a difference in people's lives. The consumer advocates bring accountability and transparency to the process. Many of the scientists who have participated in the Program have said that working with the advocates has changed the way they approach research. Let me quote Dr. Michael Diefenbach of Mount Sinai School of Medicine:

"I have served as a reviewer for the Department of Defense's Breast and Prostate Cancer Review programs and I am a member of the behavioral study section for the National Cancer Institute . . . I find survivors or advocate reviewers as they are sometimes called bring a sense of realism to the review process that is very important to the selection and ultimately funding process of important research . . . Both sides bring important aspects to the review process and the selected projects are ultimately those that can fulfill scientific rigor and translatability from the research arena to clinical practice. I urge that future review panels include advocate reviewers in the review process."

Since 1992, nearly 600 breast cancer survivors have served on the BCRP peer review panels. As a result of this inclusion of consumers, the Program has created an unprecedented working relationship between the public, scientists, and the military, and ultimately has led to new avenues of research in breast cancer. The vital role of the advocates in the success of the BCRP has led to consumer inclusion in other biomedical research programs at DOD. This Program now serves as an international model.

It is important to note that the Integration Panel that designs this Program has a strategic plan for how best to spend the funds appropriated. This plan is based on the state of the science—both what scientists know now and the gaps in our knowledge—as well as the needs of the public. While this plan is mission driven, and helps ensure that the science keeps that mission—eradicating breast cancer—in mind, it does not restrict scientific freedom, creativity or innovation. The Integration Panel carefully allocates these resources, but it does not predetermine the specific research areas to be addressed.

UNIQUE FUNDING OPPORTUNITIES

The DOD BCRP research portfolio includes many different types of projects, including support for innovative ideas, networks to facilitate clinical trials, and training of breast cancer researchers.

Developments in the past few years have begun to offer breast cancer researchers fascinating insights into the biology of breast cancer and have brought into sharp focus the areas of research that hold promise and will build on the knowledge and investment we have made. The Innovative Developmental and Exploratory Awards (IDEA) grants of the DOD Program have been critical in the effort to respond to new discoveries and to encourage and support innovative, risk-taking research. Concept Awards support funding even earlier in the process of discovery. These grants have been instrumental in the development of promising breast cancer research by allowing scientists to explore beyond the realm of traditional research and unleash incredible new ideas. IDEA and Concept grants are uniquely designed to dramatically advance our knowledge in areas that offer the greatest potential. IDEA and Concept grants are precisely the type of grants that rarely receive funding through more traditional programs such as the National Institutes of Health and private research programs. They therefore complement, and do not duplicate, other Federal funding programs. This is true of other DOD award mechanisms also.

Innovator awards invest in world renowned, outstanding individuals rather than projects, by providing funding and freedom to pursue highly creative, potentially groundbreaking research that could ultimately accelerate the eradication of breast cancer. The Era of Hope Scholar Award supports the formation of the next generation of leaders in breast cancer research, by identifying the best and brightest scientists early in their careers and giving them the necessary resources to pursue a highly innovative vision of ending breast cancer.

These are just a few examples of innovative funding opportunities at the DOD BCRP that are filling gaps in breast cancer research. Scientists have lauded the

Program and the importance of these award mechanisms. In 2005, Zelton Dave Sharp wrote about the importance of the Concept award mechanism:

“Our Concept grant has enabled us to obtain necessary data to recently apply for a larger grant to support this project. We could have never gotten to this stage without the Concept award. Our eventual goal is to use the technology we are developing to identify new compounds that will be effective in preventing and/or treating breast cancer . . . Equally important, however, the DOD BCRP does an outstanding job of supporting graduate student trainees in breast cancer research, through training grants and pre-doctoral fellowships . . . The young people supported by these awards are the lifeblood of science, and since they are starting their training on projects relevant to breast cancer, there is a high probability they will devote their entire careers to finding a cure. These young scientists are by far the most important ‘products’ that the DOD BCRP produces.”—Zelton Dave Sharp, Associate Professor, Interim Director/Chairman, Institute of Biotechnology/Dept. Molecular Medicine, University of Texas Health Science Center (August 2005).

The DOD BCRP also focuses on moving research from the bench to the bedside. DOD BCRP awards are designed to fill niches that are not addressed by other Federal agencies. The BCRP considers translational research to be the application of well-founded laboratory or other pre-clinical insight into a clinical trial. To enhance this critical area of research, several research opportunities have been offered. Clinical Translational Research Awards have been awarded for investigator-initiated projects that involve a clinical trial within the lifetime of the award. The BCRP has expanded its emphasis on translational research by also offering five different types of awards that support work at the critical juncture between laboratory research and bedside applications.

The Centers of Excellence award mechanism brings together the world’s most highly qualified individuals and institutions to address a major overarching question in breast cancer research that could make a significant contribution towards the eradication of breast cancer. Many of these Centers are working on questions that will translate into direct clinical applications. These Centers include the expertise of basic, epidemiology and clinical researchers, as well as consumer advocates.

Dr. John Niederhuber, now the Director of the National Cancer Institute (NCI), said the following about the Program when he was Director of the University of Wisconsin Comprehensive Cancer Center in April, 1999:

“Research projects at our institution funded by the Department of Defense are searching for new knowledge in many different fields including: identification of risk factors, investigating new therapies and their mechanism of action, developing new imaging techniques and the development of new models to study [breast cancer] . . . Continued availability of this money is critical for continued progress in the Nation’s battle against this deadly disease.”

Scientists and consumers agree that it is vital that these grants continue to support breast cancer research. To sustain the Program’s momentum, \$150 million for peer-reviewed research is needed in fiscal year 2010.

SCIENTIFIC ACHIEVEMENTS

One of the most promising outcomes of research funded by the DOD BCRP was the development of the first monoclonal antibody targeted therapy that prolongs the lives of women with a particularly aggressive type of advanced breast cancer. This drug could not have been developed without first researching and understanding the gene known as HER-2/neu, which is involved in the progression of some breast cancers. Researchers found that over-expression of HER-2/neu in breast cancer cells results in very aggressive biologic behavior. The same researchers demonstrated that an antibody directed against HER-2/neu could slow the growth of the cancer cells that over-expressed the gene. This research, which led to the development of the targeted therapy, was made possible in part by a DOD BCRP-funded infrastructure grant. Other researchers funded by the DOD BCRP are identifying similar kinds of genes that are involved in the initiation and progression of cancer.

Another example of innovation in the Program is in the area of imaging. One DOD BCRP awardee developed a new use for medical hyperspectral imaging (MHSI) technology. This work demonstrated the usefulness of MHSI as a rapid, noninvasive, and cost-effective evaluation of normal and tumor tissue during a real-time operating procedure. Application of MHSI to surgical procedures has the potential to significantly reduce local recurrence of breast tumors and may facilitate early determination of tumor malignancy.

Studies funded by the DOD BCRP are examining the role of estrogen and estrogen signaling in breast cancer. For example, one study examined the effects of the two main pathways that produce estrogen. Estrogen is often processed by one of two pathways; one yields biologically active substances while the other does not. It has been suggested that women who process estrogen via the biologically active pathway may be at higher risk of developing breast cancer. This research will yield insights into the effects of estrogen processing on breast cancer risk in women with and without family histories of breast cancer.

Another example of success from the Program is a study of sentinel lymph nodes (SLNs). This study confirmed that SLNs are indicators of metastatic progression of disease. The resulting knowledge from this study and others has led to a new standard of care for lymph node biopsies. If the first lymph node is negative for cancer cells, then it is unnecessary to remove all the lymph nodes. This helps prevent lymphedema which can be painful and have lasting complications.

FEDERAL MONEY WELL SPENT

The DOD BCRP is as efficient as it is innovative. In fact, 90 percent of funds go directly to research grants. The flexibility of the Program allows the Army to administer it in such a way as to maximize its limited resources. The Program is able to quickly respond to current scientific advances and fulfills an important niche by focusing on research that is traditionally under-funded. This was confirmed and reiterated in two separate IOM reports released in 1997 and 2004. The areas of focus of the DOD BCRP span a broad spectrum and include basic, clinical, behavioral, environmental sciences, and alternative therapy studies, to name a few. The BCRP benefits women and their families by maximizing resources and filling in the gaps in breast cancer research.

The Program is responsive to the scientific community and to the public. This is evidenced by the inclusion of consumer advocates at both the peer and programmatic review levels. The consumer perspective helps the scientists understand how the research will affect the community and allows for funding decisions based on the concerns and needs of patients and the medical community.

The outcomes of the BCRP-funded research can be gauged, in part, by the number of publications, abstracts/presentations, and patents/licensures reported by awardees. To date, there have been more than 12,241 publications in scientific journals, more than 12,000 abstracts and nearly 550 patents/licensure applications. The American public can truly be proud of its investment in the DOD BCRP. Scientific achievements that are the direct result of the DOD BCRP grants are undoubtedly moving us closer to eradicating breast cancer.

INDEPENDENT ASSESSMENTS OF PROGRAM SUCCESS

The success of the DOD peer-reviewed Breast Cancer Research Program has been illustrated by several unique assessments of the Program. The IOM, which originally recommended the structure for the Program, independently re-examined the Program in a report published in 1997. They published another report on the Program in 2004. Their findings overwhelmingly encouraged the continuation of the Program and offered guidance for program implementation improvements.

The 1997 IOM review of the DOD peer-reviewed Breast Cancer Research Program commended the Program, stating, "the Program fills a unique niche among public and private funding sources for cancer research. It is not duplicative of other programs and is a promising vehicle for forging new ideas and scientific breakthroughs in the Nation's fight against breast cancer." The 2004 report spoke to the importance of the program and the need for its continuation.

TRANSPARENT AND ACCOUNTABLE TO THE PUBLIC

The DOD peer-reviewed Breast Cancer Research Program not only provides a funding mechanism for high-risk, high-return research, but also reports the results of this research to the American people every 2 to 3 years at a public meeting called the Era of Hope. The 1997 meeting was the first time a federally-funded program reported back to the public in detail not only on the funds used, but also on the research undertaken, the knowledge gained from that research and future directions to be pursued.

Sixteen hundred and consumers and researchers met for the fifth Era of Hope meeting in June, 2008. As MSNBC.com's Bob Bazell wrote, this meeting "brought together many of the most committed breast cancer activists with some of the Nation's top cancer scientists. The conference's directive is to push researchers to think 'out of the box' for potential treatments, methods of detection and prevention in

ways.” He went on to say “the program . . . has racked up some impressive accomplishments in high-risk research projects . . .”

One of the topics reported on at the meeting was the development of more effective breast imaging methods. An example of the important work that is coming out of the DOD BCRP includes a new screening method called molecular breast imaging, which helps detect breast cancer in women with dense breasts—which can be difficult using a mammogram alone. I invite you to log on to NBCC’s new website <http://influence.stopbreastcancer.org/> to learn more about the exciting research reported at the 2008 Era of Hope.

The DOD peer-reviewed Breast Cancer Research Program has attracted scientists across a broad spectrum of disciplines, launched new mechanisms for research and facilitated new thinking in breast cancer research and research in general. A report on all research that has been funded through the DOD BCRP is available to the public. Individuals can go to the Department of Defense website and look at the abstracts for each proposal at <http://cdmrp.army.mil/bcrp/>.

COMMITMENT OF THE NATIONAL BREAST CANCER COALITION

The National Breast Cancer Coalition is strongly committed to the DOD BCRP in every aspect, as we truly believe it is one of our best chances for finding cures for and ways to prevent breast cancer. The Coalition and its members are dedicated to working with you to ensure the continuation of funding for this Program at a level that allows this research to forge ahead. From 1992, with the launch of our “300 Million More Campaign” that formed the basis of this Program, until now, NBCC advocates have appreciated your support.

Over the years, our members have shown their continuing support for this Program through petition campaigns, collecting more than 2.6 million signatures, and through their advocacy on an almost daily basis around the country asking for support of the DOD BCRP.

There are 3 million women living with breast cancer in this country today. This year, more than 40,000 will die of the disease and more than 240,000 will be diagnosed. We still do not know how to prevent breast cancer, how to diagnose it truly early or how to cure it. It is an incredibly complex disease. We simply cannot afford to walk away from this program.

Since the very beginning of this Program in 1992, Congress has stood with us in support of this important investment in the fight against breast cancer. In the years since, Chairman Inouye and Ranking Member Cochran, you and this entire Committee have been leaders in the effort to continue this innovative investment in breast cancer research.

NBCC asks you, the Defense Appropriations Subcommittee, to recognize the importance of what has been initiated by the Appropriations Committee. You have set in motion an innovative and highly efficient approach to fighting the breast cancer epidemic. We ask you now to continue your leadership and fund the Program at \$150 million and maintain its integrity. This is research that will help us win this very real and devastating war against a cruel enemy.

Thank you again for the opportunity to submit testimony and for giving hope to all women and their families, and especially to the 3 million women in the United States living with breast cancer.

Chairman INOUE. And now may I call upon Mr. Wicks, representing the American Association of Nurse Anesthetists.

STATEMENT OF TERRY WICKS, PAST PRESIDENT, ON BEHALF OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA)

Mr. WICKS. Chairman Inouye, Senator Cochran, and members of the subcommittee, good morning.

My name is Terry Wicks, and I am a past president of the 40,000-member American Association of Nurse Anesthetists. The quality of healthcare America provides our servicemen and women and their dependents has long been this subcommittee’s high priority. Today, I report to you the contributions that certified registered nurse anesthetists, or CRNAs, make toward our services’ mission. I will also provide you our recommendations to further improve military healthcare for these challenging times.

I also ask that—unanimous consent that my written statement be entered into the record.

Chairman INOUE. So ordered.

Mr. WICKS. America's CRNAs provide some 30 million anesthetics annually, in every healthcare setting requiring anesthesia care. And we provide that care safely. The Institute of Medicine reported, in 2000, that anesthesia care is 50 times safer than it was in the early 1980s.

For the United States Armed Forces, CRNAs are particularly critical. In 2005, 493 active duty and 790 reservist nurse anesthetists provided anesthesia care indispensable to our Armed Forces' current mission. Not long ago one CRNA, Major General Gail Pollock, served as Acting Surgeon General of the Army.

Today, CRNAs serve in major military hospitals, in educational institutions, aboard ships, and in isolated bases abroad and at home, and as members of forward surgical teams, and they are as close to the tip of the spear as they can be. In most of these environments, CRNAs provide anesthesia services, alone, with anesthesiologists, enabling surgeons and other clinicians to safely deliver lifesaving care to our soldiers.

In recent years, however, the number of CRNAs needed in the Armed Forces has fallen below—the number of CRNAs in the services has fallen below the number needed. The private market for nurse anesthetists is extremely strong, and the military has struggled to compete. The services, this subcommittee, and the authorizing committees have responded with increased benefits to CRNAs, incentive specialty pay, and the health professions loan repayment program, focusing on incentives for multiyear agreements.

The profession of nurse anesthesia has likewise responded. Our Council on Certification of Nurse Anesthetists reports that, in 2008, our schools produced 2,161 graduates, double the number since the year 2000, and 2,100 nurse anesthetists were certified. That growth is expected to continue, and the Council on Accreditation of Nurse Anesthesia Educational Programs projects that nurse anesthesia programs will produce over 2,400 graduates in 2009.

These combined actions have helped strengthen the services' readiness and the quality of healthcare available to our servicemen and women.

So, our first recommendation to you is to extend and strengthen this successful incentive service pay program for CRNAs. The authorizing committee has extended the ISP program, and we encourage this subcommittee to continue funding ISP levels sufficient for the services to recruit and retain CRNAs needed for the mission.

Our second recommendation is for the subcommittee to encourage all the services to adopt the joint scope of practice. Standard practice across the services enhances patient safety and the quality of healthcare of our servicemen and women. The Navy, in particular, has made a great deal of progress toward adopting the joint scope of practice of independent practitioners. We encourage its adoption in all the services.

Like our military CRNAs that serve each and every day, the American Association of Nurse Anesthetists stands ready to work with Congress to ensure that all our Nation's military men and women get the care they need and deserve.

Thank you, and I'll be happy to answer any question that you may have.

Chairman INOUE. All right. Thank you very much, Mr. Wicks. [The statement follows:]

PREPARED STATEMENT OF JACKIE S. ROWLES, CRNA, MBA, MA, FAAPM,
PRESIDENT, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA)

Chairman Inouye, Ranking Member Cochran, and Members of the Subcommittee: The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 40,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States, including more than 500 active duty and over 750 reservists in the military reported in 2009. The AANA appreciates the opportunity to provide testimony regarding CRNAs in the military. We would also like to thank this committee for the help it has given us in assisting the Department of Defense (DOD) and each of the services to recruit and retain CRNAs.

CRNAS AND THE ARMED FORCES: A TRADITION OF SERVICE

Let us begin by describing the profession of nurse anesthesia, and its history and role with the Armed Forces of the United States.

In the administration of anesthesia, CRNAs perform the same functions as anesthesiologists and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer some 30 million anesthetics given to patients each year in the United States. Nurse anesthetists are also the sole anesthesia providers in the vast majority of rural hospitals, assuring access to surgical, obstetrical and other healthcare services for millions of rural Americans.

Our tradition of service to the military and our Veterans is buttressed by our personal, professional commitment to patient safety, made evident through research into our practice. In our professional association, we state emphatically "our members' only business is patient safety." Safety is assured through education, high standards of professional practice, and commitment to continuing education. Having first practiced as registered nurses, CRNAs are educated to the master's degree level, and some to the doctoral level, and meet the most stringent continuing education and recertification standards in the field. Thanks to this tradition of advanced education and clinical practice excellence, we are humbled and honored to note that anesthesia is 50 times safer now than in the early 1980s (National Academy of Sciences, 2000). Research further demonstrates that the care delivered by CRNAs, physician anesthesiologists, or by both working together yields similar patient safety outcomes. In addition to studies performed by the National Academy of Sciences in 1977, Forrest in 1980, Bechtoldt in 1981, the Minnesota Department of Health in 1994, and others, Dr. Michael Pine, MD, MBA, recently concluded once again that among CRNAs and physician anesthesiologists, "the type of anesthesia provider does not affect inpatient surgical mortality" (Pine, 2003). Thus, the practice of anesthesia is a recognized specialty in nursing and medicine. Most recently, a study published in *Nursing Research* confirmed obstetrical anesthesia services are extremely safe, and that there is no difference in safety between hospitals that use only CRNAs compared with those that use only anesthesiologists (Simonson et al, 2007). Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures from the simplest to the most complex, either as single providers or together.

NURSE ANESTHETISTS IN THE MILITARY

Since the mid-19th century, our profession of nurse anesthesia has been proud and honored to provide anesthesia care for our past and present military personnel and their families. From the Civil War to the present day, nurse anesthetists have been the principal anesthesia providers in combat areas of every war in which the United States has been engaged.

Military nurse anesthetists have been honored and decorated by the U.S. and foreign governments for outstanding achievements, resulting from their dedication and commitment to duty and competence in managing seriously wounded casualties. In World War II, there were 17 nurse anesthetists to every one anesthesiologist. In Vietnam, the ratio of CRNAs to physician anesthesiologists was approximately 3:1. Two nurse anesthetists were killed in Vietnam and their names have been engraved on the Vietnam Memorial Wall. During the Panama strike, only CRNAs were sent with

the fighting forces. Nurse anesthetists served with honor during Desert Shield and Desert Storm.

Military CRNAs also provide critical anesthesia support to humanitarian missions around the globe in such places as Bosnia and Somalia. In May 2003, approximately 364 nurse anesthetists had been deployed to the Middle East for the military mission for "Operation Iraqi Freedom" and "Operation Enduring Freedom." When President George W. Bush initiated "Operation Enduring Freedom," CRNAs were immediately deployed. With the new special operations environment new training was needed to prepare our CRNAs to ensure military medical mobilization and readiness. Brigadier General Barbara C. Brannon, Assistant Surgeon General, Air Force Nursing Services, testified before this Senate Committee on May 8, 2002, to provide an account of CRNAs on the job overseas. She stated, "Lt. Col Beisser, a certified registered nurse anesthetist (CRNA) leading a Mobile Forward Surgical Team (MFST), recently commended the seamless interoperability he witnessed during treatment of trauma victims in Special Forces mass casualty incident."

Data gathered from the U.S. Armed Forces anesthesia communities reveal that CRNAs have often been the sole anesthesia providers at certain facilities, both at home and while forward deployed. For decades CRNAs have staffed ships, isolated U.S. Bases, and forward surgical teams without physician anesthesia support. The U.S. Army Joint Special Operations Command Medical Team and all Army Forward Surgical Teams are staffed solely by CRNAs. Military CRNAs have a long proud history of providing independent support and quality anesthesia care to military men and women, their families and to people from many nations who have found themselves in harm's way.

In the current mission, CRNAs are deployed all over the world, on land and at sea. This committee must ensure that we retain and recruit CRNAs for now and in the future to serve in these military deployments overseas. This committee must ensure that we retain and recruit CRNAs now and in the future to serve in these military overseas deployments and humanitarian efforts, and to ensure the maximum readiness of America's armed services.

NURSE ANESTHESIA PROVIDER SUPPLY AND DEMAND: SOLUTIONS FOR RECRUITMENT AND RETENTION

In all of the Services, maintaining adequate numbers of active duty CRNAs is of utmost concern. For several years, the number of CRNAs serving in active duty fell short of the number authorized by the Department of Defense (DOD). This is further complicated by strong demand for CRNAs in both the public and private sectors.

It is essential to understand that while there is strong demand for CRNA services in the public and private healthcare sectors, the profession of nurse anesthesia is working effectively to meet this workforce challenge. The AANA anticipates growing demand for CRNAs. Our evidence suggests that while vacancies exist, the demand for anesthesia professionals can be met if appropriate actions are taken. As of January 2009, there are 108 accredited CRNA schools to support the profession of nurse anesthesia. The number of qualified registered nurses applying to CRNA schools continues to climb. The growth in the number of schools, the number of applicants, and in production capacity, has yielded significant growth in the number of nurse anesthetists graduating and being certified into the profession, while absolutely maintaining and strengthening the quality and competence of these clinicians. The Council on Certification of Nurse Anesthetists reports that in 2008, our schools produced 2,161 graduates, double the number since 2000, and 2,110 nurse anesthetists were certified. The growth is expected to continue. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) projects that CRNA schools will produce over 2,417 graduates in 2009.

This Committee can greatly assist in the effort to attract and maintain essential numbers of nurse anesthetists in the military by their support to increase special pays.

INCENTIVE SPECIAL PAY FOR NURSES

According to a March 1994 study requested by the Health Policy Directorate of Health Affairs and conducted by DOD, a large pay gap existed between annual civilian and military pay in 1992. This study concluded, "this earnings gap is a major reason why the military has difficulty retaining CRNAs." In order to address this pay gap, in the fiscal year 1995 Defense Authorization bill Congress authorized the implementation of an increase in the annual Incentive Special Pay (ISP) for nurse anesthetists from \$6,000 to \$15,000 for those CRNAs no longer under service obliga-

tion to pay back their anesthesia education. Those CRNAs who remained obligated receive the \$6,000 ISP.

Both the House and Senate passed the fiscal year 2003 Defense Authorization Act Conference report, H. Rept. 107-772, which included an ISP increase to \$50,000. The report included an increase in ISP for nurse anesthetists from \$15,000 to \$50,000. The AANA is requesting that this committee fund the ISP at \$50,000 for all the branches of the armed services to retain and recruit CRNAs now and into the future. Per the testimony provided in 2006 from the three services' Nurse Corps leaders, the AANA is aware that there is an active effort with the Surgeons General to closely evaluate and adjust ISP rates and policies needed to support the recruitment and retention of CRNAs. In 2006, Major General Gale Pollock, MBA, MHA, MS, CRNA, FACHE, Deputy Surgeon General, Army Nurse Corps of the U.S. Army stated in testimony before this Subcommittee, "I am particularly concerned about the retention of our certified registered nurse anesthetists (CRNAs). Our inventory of CRNAs is currently at 73 percent. The restructuring of the incentive special pay program for CRNAs last year, as well as the 180 (day)-deployment rotation policy were good first steps in stemming the loss of these highly trained providers. We are working closely with the Surgeon General's staff to closely evaluate and adjust rates and policies where needed."

There have been positive results from the Nurse Corps and Surgeons General initiatives to increase incentive special pays for CRNAs. In testimony before the House Armed Services Committee in 2007, Gen. Pollock stated, "We have . . . increased the Incentive Special Pay (ISP) Certified Registered Nurse Anesthetist, and expanded use of the Health Professions Loan Repayment Program (HPLRP). The . . . Nurse Anesthetist bonuses have been very successful in retaining these providers who are critically important to our mission on the battlefield." She also stated in that same statement, "In 2004, we increased the multi-year bonuses we offer to Certified Registered Nurse Anesthetists with emphasis on incentives for multi-year agreements. A year's worth of experience indicates that this increased bonus, 180-day deployments, and a revamped Professional Filler system to improve deployment equity is helping to retain CRNAs."

There still continues to be high demand for CRNAs in the healthcare community leading to higher incomes widening the gap in pay for CRNAs in the civilian sector compared to the military. However, the ISP and other incentives the services are providing CRNAs has helped close that gap the past 3 years, according to the most recent AANA membership survey data. In civilian practice, all additional skills, experience, duties and responsibilities, and hours of work are compensated for monetarily. Additionally, training (tuition and continuing education), healthcare, retirement, recruitment and retention bonuses, and other benefits often equal or exceed those offered in the military. Therefore, it is vitally important that the Incentive Special Pay (ISP) be supported to ensure retention of CRNAs in the military.

AANA thanks this Committee for its support of the annual ISP for nurse anesthetists. AANA strongly recommends the continuation in the annual funding for ISP at \$50,000 or more for fiscal year 2010, which recognizes the special skills and advanced education that CRNAs bring to the DOD healthcare system, and supports the mission of our U.S. Armed Forces.

BOARD CERTIFICATION PAY FOR NURSES

Included in the fiscal year 1996 Defense Authorization bill was language authorizing the implementation of a board certification pay for certain clinicians who are not physicians, including advanced practice nurses.

AANA is highly supportive of board certification pay for all advanced practice nurses. The establishment of this type of pay for nurses recognizes that there are levels of excellence in the profession of nursing that should be recognized, just as in the medical profession. In addition, this pay may assist in closing the earnings gap, which may help with retention of CRNAs.

While many CRNAs have received board certification pay, some remain ineligible. Since certification to practice as a CRNA does not require a specific master's degree, many nurse anesthetists have chosen to diversify their education by pursuing an advanced degree in other related fields. But CRNAs with master's degrees in education, administration, or management are not eligible for board certification pay since their graduate degree is not in a clinical specialty. Many CRNAs who have non-clinical master's degrees either chose or were guided by their respective services to pursue a degree other than in a clinical specialty. The AANA encourages DOD and the respective services to reexamine the issue of restricting board certification pay only to CRNAs who have specific clinical master's degrees.

DOD/VA RESOURCE SHARING: U.S. ARMY-VA JOINT PROGRAM IN NURSE ANESTHESIA,
FORT SAM HOUSTON, SAN ANTONIO, TX

The establishment of the joint U.S. Army-VA program in nurse anesthesia education at the U.S. Army Graduate Program in Anesthesia Nursing, Fort Sam Houston, in San Antonio, TX holds the promise of making significant improvements in the VA CRNA workforce, as well as improving retention of DOD registered nurses in a cost effective manner. The current program utilizes existing resources from both the Department of Veterans Affairs Employee Incentive Scholarship Program (EISP) and VA hospitals to fund tuition, books, and salary reimbursement for student registered nurse anesthetists (SRNAs). This joint program also serves the interests of the Army.

This VA nurse anesthesia program started in June 2004 with three openings for VA registered nurses to apply to and earn a Master of Science in Nursing (MSN) in anesthesia granted through the University of Texas Houston Health Science Center. In the future, the program is granting degrees through the Northeastern University Bouve College of Health Sciences nurse anesthesia educational program in Boston, Mass. At a time of increased deployments in medical military personnel, this type of VA-DOD partnership is a cost-effective model to fill these gaps in the military healthcare system. At Fort Sam Houston, the VA faculty director has covered her Army colleagues' didactic classes when they are deployed at a moments notice. This benefits both the VA and the DOD to ensure the nurse anesthesia students are trained and certified in a timely manner to meet their workforce obligation to the Federal Government as anesthesia providers. We are pleased to note that the Department of Veterans' Affairs Acting Deputy Under Secretary for Health and the U.S. Army Surgeon General approved funding to start this VA nurse anesthesia school in 2004. In addition, the VA director has been pleased to work under the direction of the Army program director LTC Thomas Ceremuga, CRNA, PhD to further the continued success of this U.S. Army-VA partnership. With modest levels of additional funding in the VA EISP, this joint U.S. Army-VA nurse anesthesia education initiative can grow and thrive, and serve as a model for meeting other VA workforce needs, particularly in nursing.

CONCLUSION

In conclusion, the AANA believes that the recruitment and retention of CRNAs in the armed services is of critical concern. By Congress supporting these efforts to recruit and retain CRNAs, the military is able to meet the mission to provide benefit care and deployment care—a mission that is unique to the military.

The AANA would also like to thank the Surgeons General and Nurse Corp leadership for their support in meeting the needs of the profession within the military workforce. Last, we commend and thank this committee for their continued support for CRNAs in the military.

Chairman INOUE. Our next witness is the legislative director of the National Association for Uniformed Services, Mr. Rick Jones.

**STATEMENT OF RICHARD A. "RICK" JONES, LEGISLATIVE DIRECTOR,
NATIONAL ASSOCIATION FOR UNIFORMED SERVICES**

Mr. JONES. Chairman Inouye, Ranking Member Cochran, it's a privilege to be invited before your subcommittee.

My association is very proud of the job our young generation is doing overseas. They risk their lives every day, and what we do for them is vital for the debt we owe them and the vital job they do for security.

Mr. Chairman, quality healthcare is a strong incentive for a military career. My association asks that you ensure full funding is provided to maintain the value of the healthcare benefit that has been earned by these men and women who have served a career in our military.

Mr. Chairman, the war on terror is fought by an overstretched force. There are signs of wear; simply too many missions and too few troops. We must increase troop strength; it must be resourced.

We ask that you give priority to funding operation and maintenance accounts to reset, recapitalize, and renew the force.

My association asks, also, that you maintain the Walter Reed facility. Its operations support and medical services require an uninterrupted care for those who are catastrophically wounded. We request that funds be in place to ensure that Walter Reed remain open, fully operational, fully functional, until the planned facilities at Bethesda and Fort Belvoir are in place and ready to give appropriate care to these young servicemen and women.

Our wounded warriors deserve the Nation's best quality treatment. They earned it the hard way. With proper resources, we know our Nation will continue to hold the well-being of these troops in hand.

Traumatic brain injury is the signature injury of the war overseas. We request that the subcommittee fund a full spectrum of traumatic brain injury care. The approach to this problem requires resources for hiring doctors, nurses, clinicians, general caregivers. And we must meet the needs of these men and women and their families. They have given so much for our Nation.

We encourage the subcommittee to ensure funding for the Defense Department prosthetic research, to make sure that that is adequately funded. We support the Uniformed Service University Healthcare. That Federal school has the—provides medical instruction to all active duty troops who provide for wartime casualties, for national disasters, for emerging diseases. And we support the Armed Forces Retirement Home in Washington, DC, and in Gulfport, Mississippi.

Mr. Chairman, regarding the supplemental, NAUS received a message from one of our members who wanted us to assure that we support a strong, timely action on the emergency supplemental. The bill will assure that, as our sons and daughters go into harm's way under the flag of the United States, they will have the vital wherewithal to carry out their mission. He's concerned, however, that when he sees not one dime, one penny, nor a shadow of concern is given to our military survivors, yet \$1 billion will be spent on a program to replace older cars—cash for clunkers—he says he's concerned about our survivors.

Thank you very much for the opportunity to testify.

Chairman INOUE. Thank you very much, Director Jones.

[The statement follows:]

PREPARED STATEMENT OF RICK JONES

Chairman Inouye, Ranking Member Cochran, and members of the Subcommittee, it is a pleasure to appear before you today to present the views of the National Association for Uniformed Services on the fiscal year 2010 Defense Appropriations Bill.

My name is Richard "Rick" Jones, Legislative Director of the National Association for Uniformed Services (NAUS). And for the record, NAUS has not received any Federal grant or contract during the current fiscal year or during the previous 2 years in relation to any of the subjects discussed today.

As you know, the National Association for Uniformed Services, founded in 1968, represents all ranks, branches and components of uniformed services personnel, their spouses and survivors. The Association includes all personnel of the active, retired, Reserve and National Guard, disabled veterans, veterans community and their families. We love our country, believe in a strong national defense, support our troops, and honor their service.

Mr. Chairman, the first and most important responsibility of our government is the protection of our citizens. As we all know, we are at war. That is why the de-

fense appropriations bill is so very important. It is critical that we provide the resources to those who fight for our protection and our way of life. We need to give our courageous men and women everything they need to prevail. And we must recognize as well that we must provide priority funding to keep the promises made to the generations of warriors whose sacrifice has paid for today's freedom.

At the start, I want to express NAUS concern about the amount of our investment in our national defense. At the height of the War on Terror, our current defense budget represents only a little more than 4 percent of the gross national product, as opposed to the average of 5.7 percent of GNP in the peacetime years between 1940 and 2000.

We cannot look the other way in a time when we face such serious threats. Resources are required to ensure our military is fully staffed, trained, and equipped to achieve victory against our enemies. Leaders in Congress and the administration need to balance our priorities and ensure our defense in a dangerous world.

Here, I would like to make special mention of the leadership and contribution this panel has made in providing the resources and support our forces need to complete their mission. Defending the United States homeland and the cause of freedom means that the dangers we face must be confronted. And it means that the brave men and women who put on the uniform must have the very best training, best weapons, best care and wherewithal we can give them.

The members of this important panel have taken every step to give our fighting men and women the funds they need, despite allocations we view as insufficient for our total defense needs. You have made difficult priority decisions that have helped defend America and taken special care of one of our greatest assets, namely our men and women in uniform.

And the National Association for Uniformed Services is very proud of the job this generation of Americans is doing to defend America. Every day they risk their lives, half a world away from loved ones. Their daily sacrifice is done in today's voluntary force. What they do is vital to our security. And the debt we owe them is enormous.

Our Association does, however, have some concerns about a number of matters. Among the major issues that we will address today is the provision of a proper health care for the military community and recognition of the funding requirements for TRICARE for retired military. Also, we will ask for adequate funding to improve the pay for members of our armed forces and to address a number of other challenges including TRICARE Reserve Select and the Survivor Benefit Plan.

We also have a number of related priority concerns such as the diagnosis and care of troops returning with Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI), the need for enhanced priority in the area of prosthetics research, and providing improved seamless transition for returning troops between the Department of Defense (DOD) and the Department of Veterans Affairs (VA). In addition, we would like to ensure that adequate funds are provided to defeat injuries from the enemy's use of Improvised Explosive Devices (IEDs).

TRICARE AND MILITARY QUALITY OF LIFE: HEALTH CARE

Quality health care is a strong incentive to make military service a career. The provision of quality, timely care is considered one of the most important benefits afforded the career military. The TRICARE benefit, earned through a career of service in the uniformed services, reflects the commitment of a Nation, and it deserves your wholehearted support.

It should also be recognized that discussions have once again begun on increasing the retiree-paid costs of TRICARE earned by military retirees and their families. We remember the outrageous statement of Dr. Gail Wilensky, a co-chair of the Task Force on the Future of Military, calling congressional passage of TRICARE for Life "a big mistake."

And more recently, we heard Admiral Mike Mullen, the current Chairman of Joint Chiefs of Staff, call for an increase in TRICARE fees. Mullen said, "It's a given as far as I'm concerned."

Fortunately, President Obama has taken fee increases off the table this year in the administration budget recommendation. However, with comments like these from those in leadership positions, there is little wonder that retirees and active duty personnel are upset.

Seldom has NAUS seen such a lowing in confidence about the direction of those who manage the program. Faith in our leadership continues, but it is a weakening faith. And unless something changes, it is bound to affect recruiting and retention.

CRIMINAL ACTIVITY COSTS MEDICARE AND TRICARE BILLIONS OF DOLLARS

Recent testimony and studies from the Government Accountability Office (GAO), the investigative arm of the United States Congress, shows us that at least \$80 billion worth of Medicare money is being ripped off every year. Frankly, it demonstrates that criminal activity costs Medicare and TRICARE billions of dollars.

Here are a couple of examples. GAO reports that one company billed Medicare for \$170 million for HIV drugs. In truth, the company dispensed less than a million dollars. In addition, the company billed \$142 million for nonexistent delivery of supplies and parts and medical equipment.

In another example, fake Medicare providers billed Medicare for prosthetic arms on people who already have two arms. The fraud amounted to \$1.4 billion of bills for people who do not need prosthetics.

TRICARE is closely tied to Medicare and its operations are not immune. According to Rose Sabo, Director of the TRICARE Program Integrity Office, the Government Accountability Office says that 10 percent of all health care expenditures are fraudulent. With a military health system annual cost of \$47 billion, fraudulent purchase of care in the military health system would amount to \$4.7 billion.

Last year a Philippine corporation was ordered to pay back more than \$100 million following a TRICARE fraud conviction. But despite TRICARE efforts to uncover this type of criminal activity, money continues to go out the door with insufficient resources dedicated to its recovery.

Regarding TRICARE efforts to uncover fraud problems, it should be noted that documents by the Department of Defense Inspector General (DODIG) reported the fraud as early as 1998 to TRICARE Management Activity (TMA). But it wasn't until 2005 that TMA stopped paying the fraudulent claims reported 7 years earlier by DODIG.

NAUS urges the Subcommittee to challenge DOD and TRICARE authorities to put some guts behind efforts to drive fraud down and out of the system. If left unchecked, fraud will increasingly strip away resources from government programs like TRICARE. And unless Congress directs the administration to take action, you know who will be left in the breach, holding the bag—the law abiding retiree and family.

We recently learned of an incident of clear outright healthcare fraud involving a Medicare/TRICARE provider. The patient was a member of a veterans-related survivor organization and a TRICARE for Life beneficiary. She went to visit a doctor for the first time but was not content with the provider so she did not see him again. But bills against TRICARE continued to roll in for visits and services that were never provided. The beneficiary reported this suspicious activity to the TRICARE Management Activity. TRICARE officials were reticent to talk to the individual when she called them again to report additional fraudulent bills. When the individual's survivor organization became involved, it was told by TRICARE not to worry about the billings because the bogus charges only added up to about \$2,500, which fell below the level of investigative action. The TMA rationale is troublesome on many levels. It is, of course, quite possible that the same doctor charged TRICARE for the "care" of other patients.

A fair portion of the cost of controlling Medicare and TRICARE fraud can be directly attributed to the detection of it. In this instance, a beneficiary attempted to perform her civic duty by "sounding the alarm" only to be ignored by the agency that claims to be committed to preventing, identifying, and assisting in the prosecution of healthcare fraud, not only to save valuable benefit dollars but also to ensure that eligible beneficiaries receive appropriate medical care. Deceitful schemes can adversely impact the quality of the care received. NAUS believes that criminal activity should be identified and prosecuted to the fullest extent of the law, whether it is for \$2,500 or \$250,000.

America expects its government to move courageously and tackle the real problems of issues like fraud in the TRICARE system and the Medicare system. The government should direct and resource its investigative teams to root out criminal activity, rather than looking to take money out of the pockets of military retirees. With hard work and honest public service, we are confident Congress will have more than enough money to pay for earned benefits like TRICARE.

The National Association for Uniformed Services urges increased funding for the Defense Criminal Investigative Service (DCIS), the criminal investigative arm of the DOD Inspector General, and for the TRICARE Program Integrity Office, responsible for anti-fraud activity in the military health system.

We urge the Subcommittee to take the actions necessary for honoring our obligation to those men and women who have worn the Nation's military uniform. Root out the corruption, fraud and waste. And confirm America's solemn, moral obliga-

tion to support our troops, our military retirees, and their families. They have kept their promise to our Nation, now it's time for us to keep our promise to them.

MILITARY QUALITY OF LIFE: PAY

For fiscal year 2010, the administration recommends a 2.9 percent across-the-board pay increase for members of the Armed Forces. The proposal is designed, according to the Pentagon, to keep military pay in line with civilian wage growth.

The National Association for Uniformed Services calls on you to put our troops and their families first. Our forces are stretched thin, at war, yet getting the job done. We ask you to express the Nation's gratitude for their critical service, increase basic pay and drill pay one-half percent above the administration's request to 3.4 percent.

Congress and the administration have done a good job over the recent past to narrow the gap between civilian-sector and military pay. The differential, which was as great as 14 percent in the late 1990s, has been reduced to just under 4 percent with the January 2009 pay increase.

However, we can do better than simply maintaining a rough measure of comparability with the civilian wage scale. To help retention of experience and entice recruitment, the pay differential is important. We have made significant strides. But we are still below the private sector.

In addition, we urge the appropriations panel to never lose sight of the fact that our DOD manpower policy needs a compensation package that is reasonable and competitive. Bonuses have a role in this area. Bonuses for instance can pull people into special jobs that help supply our manpower for critical assets, and they can also entice "old hands" to come back into the game with their skills.

The National Association for Uniformed Services asks you to do all you can to fully compensate these brave men and women for being in harm's way, we should clearly recognize the risks they face and make every effort to appropriately compensate them for the job they do.

MILITARY QUALITY OF LIFE: BASIC ALLOWANCE FOR HOUSING

The National Association for Uniformed Services strongly supports revised housing standards within the Basic Allowance for Housing (BAH). We are most grateful for the congressional actions reducing out-of-pocket housing expenses for servicemembers over the last several years. Despite the many advances made, many enlisted personnel continue to face steep challenge in providing themselves and their families with affordable off-base housing and utility expenses. BAH provisions must ensure that rates keep pace with housing costs in communities where military members serve and reside. Efforts to better align actual housing rates can reduce unnecessary stress and help those who serve better focus on the job at hand, rather than the struggle with meeting housing costs for their families.

MILITARY QUALITY OF LIFE: FAMILY HOUSING ACCOUNTS

The National Association for Uniformed Services urges the Subcommittee to provide adequate funding for military construction and family housing accounts used by DOD to provide our service members and their families quality housing. The funds for base allowance and housing should ensure that those serving our country are able to afford to live in quality housing whether on or off the base. The current program to upgrade military housing by privatizing Defense housing stock is working well. We encourage continued oversight in this area to ensure joint military-developer activity continues to improve housing options. Clearly, we need to be particularly alert to this challenge as we implement BRAC and related rebasing changes.

The National Association for Uniformed Services also asks special provision be granted the National Guard and Reserve for planning and design in the upgrade of facilities. Since the terrorist attacks of Sept. 11, 2001, our Guardsmen and reservists have witnessed an upward spiral in the rate of deployment and mobilization. The mission has clearly changed, and we must recognize they account for an increasing role in our national defense and homeland security responsibilities. The challenge to help them keep pace is an obligation we owe for their vital service.

INCREASE FORCE READINESS FUNDS

The readiness of our forces is in decline. The long war fought by an overstretched force tells us one thing: there are simply too many missions and too few troops. Extended and repeated deployments are taking a human toll. Back-to-back deployments means, in practical terms, that our troops face unrealistic demands. To sus-

tain the service we must recognize that an increase in troop strength is needed and it must be resourced.

In addition, we ask you to give priority to funding for the operations and maintenance accounts where money is secured to reset, recapitalize and renew the force. The National Guard, for example, has virtually depleted its equipment inventory, causing rising concern about its capacity to respond to disasters at home or to train for its missions abroad.

The deficiencies in the equipment available for the National Guard to respond to such disasters include sufficient levels of trucks, tractors, communication, and miscellaneous equipment. If we have another overwhelming storm, hurricane or, God forbid, a large-scale terrorist attack, our National Guard is not going to have the basic level of resources to do the job right.

WALTER REED ARMY MEDICAL CENTER

Another matter of great interest to our members is the plan to realign and consolidate military health facilities in the National Capital Region. The proposed plan includes the realignment of all highly specialized and sophisticated medical services currently located at Walter Reed Army Medical Center in Washington, DC, to the National Naval Medical Center in Bethesda, MD, and the closing of the existing Walter Reed by 2011.

While we herald the renewed review of the adequacy of our hospital facilities and the care and treatment of our wounded warriors that result from last year's news reports of deteriorating conditions at Walter Reed Army Medical Center, the National Association for Uniformed Services believes that Congress must continue to provide adequate resources for WRAMC to maintain its base operations' support and medical services that are required for uninterrupted care of our catastrophically wounded soldiers and marines as they move through this premier medical center.

We request that funds be in place to ensure that Walter Reed remains open, fully operational and fully functional, until the planned facilities at Bethesda or Fort Belvoir are in place and ready to give appropriate care and treatment to the men and women wounded in armed service.

Our wounded warriors deserve our Nation's best, most compassionate healthcare and quality treatment system. They earned it the hard way. And with application of the proper resources, we know the Nation will continue to hold the well-being of soldiers and their families as our number one priority.

DEPARTMENT OF DEFENSE, SEAMLESS TRANSITION BETWEEN THE DOD AND VA

The development of electronic medical records remains a major goal. It is our view that providing a seamless transition for recently discharged military is especially important for servicemembers leaving the military for medical reasons related to combat, particularly for the most severely injured patients.

The National Association for Uniformed Services is pleased to receive the support of President Obama and the forward movement of Secretaries Gates and Shinseki toward this long-supported goal of providing a comprehensive e-health record.

The National Association for Uniformed Services calls on the appropriations committee to continue the push for DOD and VA to follow through on establishing a bi-directional, interoperable electronic medical record. Since 1982, these two departments have been working on sharing critical medical records, yet to date neither has effectively come together in coordination with the other.

The time for foot dragging is over. Taking care of soldiers, sailors, airmen, and marines is a national obligation, and doing it right sends a strong signal to those currently in military service as well as to those thinking about joining the military.

DOD must be directed to adopt electronic architecture including software, data standards, and data repositories that are compatible with the system used at the Department of Veterans Affairs. It makes absolute sense and it would lower costs for both organizations.

If our seriously wounded troops are to receive the care they deserve, the departments must do what is necessary to establish a system that allows seamless transition of medical records. It is essential if our Nation is to ensure that all troops receive timely, quality health care and other benefits earned in military service.

To improve the DOD/VA exchange, the hand-off should include a detailed history of care provided and an assessment of what each patient may require in the future, including mental health services. No veteran leaving military service should fall through the bureaucratic cracks.

DEFENSE DEPARTMENT FORCE PROTECTION

The National Association for Uniformed Services urges the Subcommittee to provide adequate funding to rapidly deploy and acquire the full range of force protection capabilities for deployed forces. This would include resources for up-armored high mobility multipurpose wheeled vehicles and add-on ballistic protection to provide force protection for soldiers in Iraq and Afghanistan, ensure increased activity for joint research and treatment effort to treat combat blast injuries resulting from improvised explosive devices (IEDs), rocket propelled grenades, and other attacks; and facilitate the early deployment of new technology, equipment, and tactics to counter the threat of IEDs.

We ask special consideration be given to counter IEDs, defined as makeshift or "homemade" bombs, often used by enemy forces to destroy military convoys and currently the leading cause of casualties to troops deployed in Iraq. These devices are the weapon of choice and, unfortunately, a very efficient weapon used by our enemy. The Joint Improvised Explosive Device Defeat Organization (JIEDDO) is established to coordinate efforts that would help eliminate the threat posed by these IEDs. We urge efforts to advance investment in technology to counteract radio-controlled devices used to detonate these killers. Maintaining support is required to stay ahead of our enemy and to decrease casualties caused by IEDs.

DEFENSE HEALTH PROGRAM—TRICARE RESERVE SELECT

Mr. Chairman, another area that requires attention is reservist participation in TRICARE. As we are all aware, National Guard and Reserve personnel have seen an upward spiral of mobilization and deployment since the terrorist attacks of Sept. 11, 2001. The mission has changed and with it our reliance on these forces has risen. Congress has recognized these changes and begun to update and upgrade protections and benefits for those called away from family, home, and employment to active duty. We urge your commitment to these troops to ensure that the long overdue changes made in the provision of their health care and related benefits is adequately resourced. We are one force, all bearing a critical share of the load.

DEPARTMENT OF DEFENSE, PROSTHETIC RESEARCH

Clearly, care for our troops with limb loss is a matter of national concern. The global war on terrorism in Iraq and Afghanistan has produced wounded soldiers with multiple amputations and limb loss who in previous conflicts would have died from their injuries. Improved body armor and better advances in battlefield medicine reduce the number of fatalities, however injured soldiers are coming back oftentimes with severe, devastating physical losses.

In order to help meet the challenge, Defense Department research must be adequately funded to continue its critical focus on treatment of troops surviving this war with grievous injuries. The research program also requires funding for continued development of advanced prosthesis that will focus on the use of prosthetics with microprocessors that will perform more like the natural limb.

The National Association for Uniformed Services encourages the Subcommittee to ensure that funding for Defense Department's prosthetic research is adequate to support the full range of programs needed to meet current and future health challenges facing wounded veterans. To meet the situation, the Subcommittee needs to focus a substantial, dedicated funding stream on Defense Department research to address the care needs of a growing number of casualties who require specialized treatment and rehabilitation that result from their armed service.

We would also like to see better coordination between the Department of Defense Advanced Research Projects Agency and the Department of Veterans Affairs in the development of prosthetics that are readily adaptable to aid amputees.

POST TRAUMATIC STRESS DISORDER (PTSD) AND TRAUMATIC BRAIN INJURY (TBI)

The National Association for Uniformed Services supports a higher priority on Defense Department care of troops demonstrating symptoms of mental health disorders and traumatic brain injury.

It is said that Traumatic Brain Injury (TBI) is the signature injury of the Iraq war. Blast injuries often cause permanent damage to brain tissue. Veterans with severe TBI will require extensive rehabilitation and medical and clinical support, including neurological and psychiatric services with physical and psycho-social therapies.

We call on the Subcommittee to fund a full spectrum of TBI care and to recognize that care is also needed for patients suffering from mild to moderate brain injuries, as well. The approach to this problem requires resources for hiring caseworkers,

doctors, nurses, clinicians, and general caregivers if we are to meet the needs of these men and women and their families.

The mental condition known as Post Traumatic Stress Disorder (PTSD) has been well known for over a hundred years under an assortment of different names. For example more than 60 years ago, Army psychiatrists reported, "That each moment of combat imposes a strain so great that . . . psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare."

PTSD is a serious psychiatric disorder. While the government has demonstrated over the past several years a higher level of attention to those military personnel who exhibit PTSD symptoms, more should be done to assist service members found to be at risk.

Pre-deployment and post-deployment medicine is very important. Our legacy of the Gulf War demonstrates the concept that we need to understand the health of our service members as a continuum, from pre- to post-deployment.

The National Association for Uniformed Services applauds the extent of help provided by the Defense Department, however we encourage that more resources be made available to assist. Early recognition of the symptoms and proactive programs are essential to help many of those who must deal with the debilitating effects of mental injuries, as inevitable in combat as gunshot and shrapnel wounds.

We encourage the Members of the Subcommittee to provide for these funds and to closely monitor their expenditure and to see they are not redirected to other areas of defense spending.

ARMED FORCES RETIREMENT HOME

The National Association for Uniformed Services encourages the Subcommittee's continued interest in providing funds for the Armed Forces Retirement Home (AFRH).

We urge the Subcommittee to continue its help in providing adequate funding to alleviate the strains on the Washington home. Also, we remain concerned about the future of the Gulfport home, so we urge your continued close oversight on its reconstruction. And we thank the subcommittee for the construction of a new Armed Forces Retirement Home at its present location in Gulfport.

The National Association for Uniformed Services also asks the Subcommittee to closely review administration plans to sell great portions of the Washington AFRH to developers. The AFRH home is a historic national treasure, and we thank Congress for its oversight of this gentle program and its work to provide for a world-class quality-of-life support system for these deserving veterans.

IMPROVED MEDICINE WITH LESS COST AT MILITARY TREATMENT FACILITIES

The National Association for Uniformed Services is also seriously concerned over the consistent push to have Military Health System beneficiaries age of 65 and over moved into the civilian sector from military care. That is a very serious problem for the Graduate Medical Education (GME) programs in the MHS; the patients over 65 are required for sound GME programs, which, in turn, ensure that the military can retain the appropriate number of physicians who are board certified in their specialties.

TRICARE/HA policies are pushing out those patients not on active duty into the private sector where the cost per patient is at least twice as expensive as that provided within Military Treatment Facilities (MTFs). We understand that there are many retirees and their families who must use the private sector due to the distance from the closest MTF; however, where possible, it is best for the patients themselves, GME, medical readiness, and the minimizing the cost of TRICARE premiums if as many non-active duty beneficiaries are taken care of within the MTFs. As more and more MHS beneficiaries are pushed into the private sector, the cost of the MHS rises. The MHS can provide better medicine, more appreciated service and do it at improved medical readiness and less cost to the taxpayers.

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

As you know, the Uniformed Services University of the Health Sciences (USUHS) is the Nation's Federal school of medicine and graduate school of nursing. The medical students are all active-duty uniformed officers in the Army, Navy, Air Force, and U.S. Public Health Service who are being educated to deal with wartime casualties, national disasters, emerging diseases, and other public health emergencies.

The National Association for Uniformed Services supports the USUHS and requests adequate funding be provided to ensure continued accredited training, especially in the area of chemical, biological, radiological, and nuclear response. In this regard, it is our understanding that USUHS requires funding for training and edu-

cational focus on biological threats and incidents for military, civilian, uniformed first responders, and healthcare providers across the Nation.

JOINT POW/MIA ACCOUNTING COMMAND (JPAC)

We also want the fullest accounting of our missing servicemen and ask for your support in DOD dedicated efforts to find and identify remains. It is a duty we owe to the families of those still missing as well as to those who served or who currently serve. And as President Bush said, "It is a signal that those who wear our country's military uniform will never be abandoned."

In recent years, funding for the Joint POW/MIA Accounting Command (JPAC) has fallen short, forcing the agency to scale back and even cancel many of its investigative and recovery operations. NAUS supports the fullest possible accounting of our missing servicemen. It is a duty we owe the families, to ensure that those who wear our country's uniform are never abandoned. We request that appropriate funds be provided to support the JPAC mission for fiscal year 2010.

APPRECIATION FOR THE OPPORTUNITY TO TESTIFY

As a staunch advocate for our uniformed service men and women, the National Association for Uniformed Services recognizes that these brave men and women did not fail us in their service to country, and we, in turn, must not fail them in providing the benefits and services they earned through honorable military service.

Mr. Chairman, the National Association for Uniformed Services appreciates the Subcommittee's hard work. We ask that you continue to work in good faith to put the dollars where they are most needed: in strengthening our national defense, ensuring troop protection, compensating those who serve, providing for DOD medical services including TRICARE, and building adequate housing for military troops and their families, and in the related defense matters discussed today. These are some of our Nation's highest priority needs and we ask that they be given the level of attention they deserve.

The National Association for Uniformed Services is confident you will take special care of our Nation's greatest assets: the men and women who serve and have served in uniform. We are proud of the service they give to America every day. They are vital to our defense and national security. The price we pay as a Nation for their earned benefits is a continuing cost of war, and it will never cost more nor equal the value of their service.

We thank you for your efforts, your hard work. And we look forward to working with you to ensure we continue to provide sufficient resources to protect the earned benefits for those giving military service to America every day.

Again, the National Association for Uniformed Services deeply appreciates the opportunity to present the Association's views on the issues before the Defense Appropriations Subcommittee.

Chairman INOUE. Our next witness represents the Ovarian Cancer National Alliance, Ms. Cara Tenenbaum.

**STATEMENT OF CARA TENENBAUM, SENIOR POLICY DIRECTOR,
OVARIAN CANCER NATIONAL ALLIANCE**

Ms. TENENBAUM. Good morning, Mr. Chairman, Vice Chairman. I want to thank you and all the members of the subcommittee for the opportunity to testify today. I'm here to talk about the Department of Defense's Ovarian Cancer Research Program, one of the congressionally directed medical research programs.

For more than 10 years, the Ovarian Cancer National Alliance has worked with you to fund groundbreaking research that will help women diagnosed with, and women at high risk for, ovarian cancer. The ovarian cancer community is so grateful for the money you've appropriated in the past and last year, and we respectfully request further funding for this year, fiscal year 2010.

Simply put, the ovarian cancer research program's mission is to eliminate ovarian cancer. It's the only Federal research program with that mission, conquering the disease. Of course, that's a complicated effort. It requires understanding the cause of the disease, its development, how the disease spreads, and recurrence.

The Ovarian Cancer Research Program has a two-tiered peer-review system that chooses the best potential research. Much of this research has been published, patented, granted further Federal funding by the National Cancer Institute, and/or gone into commercial development.

Ovarian cancer is rarely diagnosed in early stages, when survival is best. There is no reliable early-detection test, but the Ovarian Cancer Research Program has made progress on this front. There is one early-detection test that's currently looking at commercialization—it's a urine biomarker test—and another you may have read about in the newspaper, the cancer-sniffing dogs.

The Ovarian Cancer Research Program has also developed two working models—animal models of ovarian cancer—for ovarian cancer: the mouse model, which is commonly used in research, but also the chicken model, which is the only other known animal to get ovarian cancer.

I'm here, not only as an employee of the Ovarian Cancer National Alliance, but as someone with a personal interest in ovarian cancer. I'm an Ashkenazi Jew, my family is from Eastern Europe, and I have a strong family history of cancer. My mother, a breast cancer survivor, is here with me. And I know that I'm at high risk for both breast cancer and ovarian cancer. Because there is no early-detection test, I know that I, and so many other women, have to remain vigilant about our health.

I'm here, and I'm honored to be here, on behalf of the ovarian cancer community. And I ask, on behalf of all of these daughters, mothers, and sisters, like my own—my sister is also here—that you continue to support the Ovarian Cancer Research Program, so that we all have a better chance at detecting ovarian cancer early. We ask you to continue supporting the Ovarian Cancer Research Program's mission to eliminate this deadly disease.

Thank you for your time.

Chairman INOUE. All right. Thank you very much, Ms. Tenenbaum.

[The statement follows:]

PREPARED STATEMENT OF CARA TENENBAUM

Mr. Chairman, Ranking Member, and Members of the Committee, thank you for the opportunity to testify before you today about the Department of Defense's Ovarian Cancer Research Program, one of the Congressionally Directed Medical Research Programs.

My name is Cara Tenenbaum, and I'm the Senior Policy Director at the Ovarian Cancer National Alliance. For more than 10 years, we have worked with you to fund ground breaking research that will help women diagnosed with, and women at high risk for, ovarian cancer. The ovarian cancer community is so grateful for the \$20 million you appropriated to the Ovarian Cancer Research Program for fiscal year 2009. This year we respectfully request \$30 million for this program.

Simply put, the Ovarian Cancer Research Program's mission is to eliminate ovarian cancer. It is the only Federal research program that seeks to conquer this disease, rather than explore it. Of course, conquering ovarian cancer is a complicated effort that requires understanding the causes of the disease, its development, how it spreads and recurrence. The Ovarian Cancer Research Program has a two tiered peer review system that chooses the best potential research. Much of this research has been published, patented, granted further Federal funding by the National Cancer Institute and/or gone into commercial development.

Ovarian cancer is rarely diagnosed in the early stages when survival is best. There is no reliable early detection test, which is an urgent priority for the ovarian cancer community. The Ovarian Cancer Research Program has funded two early de-

tection tests that are in development: one in progress is the discovery and commercialization of a urine biomarker test; the second is a breath test, which you may have read about in the popular press under headlines like “Cancer Sniffing Dogs.”

The Ovarian Cancer Research Program has also developed working animal models of ovarian cancer: the mouse model, which is commonly used in medical research; and the chicken model, which is the only other animal known to get ovarian cancer.

What makes this program unique is not just its use of ovarian cancer survivors as patient reviewers, and its transparency and low overhead, but the numerous grant mechanisms that provide a flexible model that funds innovative research.

I am here, not only as an employee of the Ovarian Cancer National Alliance, but as someone with a personal interest in ovarian cancer. As an Ashkenazi Jew with a strong family history of cancer—my mother, a breast cancer survivor is here with me—I know that I am at high risk for both breast and ovarian cancer. As there is no reliable early detection test for ovarian cancer, I, like so many others, have to rely on my own vigilance for early detection of ovarian cancer.

As a single woman who hopes to have children one day, I’m not ready for prophylactic surgery, although many of the patients I speak with have urged me to consider it. I am not even interested in genetic testing at this point, because without any action steps, I’m left with more worry than solutions. And so, on behalf of the millions of daughters, mothers, and sisters, like my own who has joined me here, I ask that you continue to support funding the Ovarian Cancer Research Program so that we all have a better chance of detecting ovarian cancer early, fighting it with better treatments and fulfilling the Ovarian Cancer Research Program’s mission to eliminate this deadly disease.

I am honored to be here representing the ovarian cancer community in respectfully requesting that Congress provide \$30 million for the Ovarian Cancer Research Program (OCRP) in fiscal year 2010 as part of the Federal Government’s investment in the Department of Defense’s Congressionally Directed Medical Research Programs (CDMRP).

THE OVARIAN CANCER RESEARCH PROGRAM

The Ovarian Cancer Research Program was created in 1997 to address a lack of ovarian cancer research, which remains the deadliest gynecologic cancer. The program uses a two tier peer review system, including patient advocates in both levels of review. Reviews are made not only on scientific rigor, but on the impact the proposed research will have on the disease and patients.

To date, accomplishments reported by awardees include 371 publications, 431 abstracts/presentations, and 15 patents applied for/obtained. The Ovarian Cancer Research Program meets each year to evaluate the science and determine funding priorities for the upcoming year. This flexibility, along with input from patient advocates and leading researchers, allows the Ovarian Cancer Research Program to fill current research gaps. Much of the research funded by the Ovarian Cancer Research Program continues to get larger grants from this seed money, including four Ovarian Cancer Specialized Programs of Research Excellence (SPORES) funded by the National Cancer Institute.

The program provides awards in the following categories: Collaborative Translational Research Award, Consortium Development Award, Idea Development Award, Ovarian Cancer Academy Award, Career Development Award, Translational Research Partnership Award, Historically Black Colleges and Universities/Minority Institution Collaborative Research Awards, Pilot Awards, and the New Investigator Research Award. From 1997 to 2009 more than \$140 million has been awarded through these mechanisms.

In fiscal year 2009 alone:

- A New Investigator Award funded a research project using immunotherapy, rather than chemotherapy or surgery, to fight tumors;
- An Idea Development award funded a research project on biomarkers, including the discovery of a biomarker that is elevated 3 years prior to clinical diagnosis of ovarian cancer;
- An Idea Development award to explore the use of a new drug as a single agent and in combination with existing chemotherapy regimens to shrink tumors;
- An Idea Development Award to fund preclinical studies of DNA therapies that induce ovarian cancer cell death without any toxicity to normal cells;
- Phase II research in angiogenesis inhibitors, which stop new blood vessels from forming in a tumor.

OVARIAN CANCER'S DEADLY STATISTICS

According to the American Cancer Society, in 2009, more than 21,000 American women will be diagnosed with ovarian cancer, and more than 15,000 will lose their lives to this terrible disease. Ovarian cancer is the fifth leading cause of cancer death in women. Currently, more than half of the women diagnosed with ovarian cancer will die within 5 years. When detected early, the 5-year survival rate increases to more than 90 percent, but when detected in the late stages, the 5-year survival rate drops to less than 29 percent.

In the more than 30 years since the War on Cancer was declared, ovarian cancer mortality rates have not significantly improved. A valid and reliable screening test—a critical tool for improving early diagnosis and survival rates—still does not exist for ovarian cancer. Behind the sobering statistics are the lost lives of our loved ones, colleagues, and community members. While we have been waiting for the development of an effective early detection test, thousands of our wives, mothers, daughters, and sisters have lost their battle with ovarian cancer.

More than three-quarters of women diagnosed with ovarian cancer will have at least one recurrence. These recurrences may indicate that the tumor cells are no longer responsive to some therapies, leaving women with fewer treatment options. The Ovarian Cancer Research Program spends almost 20 percent of its grant money studying recurrence. Almost a third is spent on understanding ovarian cancer cell biology, genetics, and molecular biology, areas that we hope will lead to a more reliable early detection test.

In 2007, a number of prominent cancer organizations released a consensus statement identifying the early warning symptoms of ovarian cancer. Without a reliable diagnostic test, we can rely only on this set of vague symptoms of a deadly disease, and trust that both women and the medical community will identify these symptoms and act promptly and quickly. Unfortunately, we know that this does not always happen. Too many women are diagnosed late due to the lack of a test; too many women and their families endure life-threatening and debilitating treatments to kill cancer; too many women are lost to this horrible disease.

SUMMARY

The Ovarian Cancer National Alliance has made commitments to work with Congress, the Administration, and other policymakers and stakeholders to improve the survival rate from ovarian cancer through education, public policy, research, and communication. Please know that we appreciate and understand that our Nation faces many challenges and that Congress has limited resources to allocate; however, we are concerned that without increased funding to bolster and expand ovarian cancer research efforts, the Nation will continue to see growing numbers of women losing their battle with this terrible disease.

On behalf of the entire ovarian cancer community—patients, family members, clinicians, and researchers—we thank you for your leadership and support of Federal programs that seek to reduce and prevent suffering from ovarian cancer. Thank you in advance for your support of \$30 million in fiscal year 2010 funding for the Ovarian Cancer Research Program.

Chairman INOUE. You know, I just can't resist this temptation but if you'll forgive me, the Ovarian Cancer Treatment Program and the Breast Cancer Treatment Program are earmarks. They were not suggested by the administration or by experts. The Congress did that. And today we're being condemned for earmarks. But—

The next witness represents the Reserve Officers Association, Colonel William Holahan.

STATEMENT OF COLONEL WILLIAM HOLAHAN, UNITED STATES MARINE CORPS (RET.), DIRECTOR, MEMBER SERVICES, RESERVE OFFICERS ASSOCIATION OF THE UNITED STATES

Colonel HOLAHAN. Mr. Chairman, Senator Cochran, we ask the subcommittee that our submitted written testimony, particularly with regard to the unfunded equipment and priorities of those Reserve components noted therein, be accepted for the record.

Chairman INOUE. It will be made part of the record.

Colonel HOLAHAN. Thank you for the opportunity to speak once again on the issue of funding for our Nation's Reserve components.

Today the United States cannot conduct extended military operations without the augmentation and reinforcement of its active component. That reinforcement must come from one of two sources: a draft, or the National Guard and Reserve.

The 700,000 men and women of our Nation's Reserve components have provided that reinforcing and augmenting force since 2001. They have saved the country from a draft. Every indication I see and hear is that they can and will continue to do so, if they are properly trained, equipped, and supported. The Congress has made great strides in increasing the funding for these important needs, but realism demands that we recognize the armed services frequently push the needs of their Reserve components to a lower priority in times when funding is tight.

The Reserve Officers Association—and I have been authorized to speak on this subject for the Reserve Enlisted Association, as well—urges this subcommittee to specifically identify appropriations for resetting of both the National Guard and the Reserve, such that it must be spent to train and re-equip the Reserve components for both their homeland defense mission and any overseas contingency operations that they may be assigned.

Each Reserve component has shared with ROA that there is a continued problem of tracking equipment specifically appropriated to the Reserves from manufacturers to a service's Reserve component. Frustrations continue with the belief that the active component either pushes out Reserve items during production, or actually redirects equipment in distribution channels before it reaches their reserve.

At the end of the day, the Nation wants an All-Volunteer Force, and it does not want a draft. The only way to achieve both of these objectives is to ensure that the Reserve and the National Guard continue to be filled with the same type of great American patriots who serve, today. To do that, you must ensure that they are fully trained, properly re-equipped, and that their families are adequately supported. And you ensure that your appropriations get where you intend that they go.

Thank you for your consideration.

Chairman INOUE. Thank you very much, Colonel Holahan.

[The statement follows:]

PREPARED STATEMENT OF WILLIAM HOLAHAN

PRIORITIES

CY 2009 Legislative Priorities are:

Providing adequate resources and authorities to support the current recruiting and retention requirements of the Reserves and National Guard.

Reset the whole force to include fully funding equipment and training for the National Guard and Reserves.

Support citizen warriors, families and survivors.

Assure that the Reserve and National Guard continue in a key national defense role, both at home and abroad.

Issues To Help Fund, Equip, and Train

Advocate for adequate funding to maintain National Defense during overseas contingency operations.

Regenerate the Reserve Components (RC) with field compatible equipment.

Fence RC dollars for appropriated Reserve equipment.

Fully fund Military Pay Appropriation to guarantee a minimum of 48 drills and 2 weeks training.

Sustain authorization and appropriation to National Guard and Reserve Equipment Account (NGREA) to permit flexibility for Reserve Chiefs in support of mission and readiness needs.

Optimize funding for additional training, preparation and operational support.

Keep Active and Reserve personnel and Operation & Maintenance funding separate.

Equip Reserve Component members with equivalent personnel protection as Active Duty.

Issues To Assist Recruiting and Retention

Support continued incentives for affiliation, reenlistment, retention and continuation in the Reserve Component.

Pay and Compensation

Provide permanent differential pay for Federal employees.

Offer Professional pay for RC medical professionals.

Eliminate the 1/30th rule for Aviation Career Incentive Pay, Career Enlisted Flyers Incentive Pay, Diving Special Duty Pay, and Hazardous Duty Incentive Pay.

Education

Continued funding for the GI Bill for the 21st Century.

Health Care

Provide Medical and Dental Readiness through subsidized preventive health care.

Extend military coverage for restorative dental care for up to 180 days following deployment.

Spouse Support

Repeal the SBP-Dependency Indemnity Clause (DIC) offset.

NATIONAL GUARD & RESERVE EQUIPMENT & PERSONNEL ACCOUNTS

It is important to maintain separate equipment and personnel accounts to allow Reserve Component Chiefs the ability to direct dollars to needs.

Key Issues Facing the Armed Forces Concerning Equipment

Developing the best equipment for troops fighting in overseas contingency operations.

Procuring new equipment for all U.S. Forces.

Maintaining or upgrading the equipment already in the inventory.

Replacing the equipment deployed from the homeland to the war.

Making sure new and renewed equipment gets into the right hands, including the Reserve Component.

Reserve Component Equipping Sources

Procurement.

Cascading of equipment from Active Component.

Cross-leveling.

Recapitalization and overhaul of legacy (old) equipment.

Congressional adds.

National Guard and Reserve Appropriations (NGREA).

Supplemental appropriation.

CONTINUED RESETTING OF THE FORCE

Resetting or reconstitution of the force is the process to restore people, aircraft and equipment to a high state of readiness following a period of higher-than-normal, or surge, operations.

Some equipment goes through recapitalization: stripping down and rebuilding equipment completely. Recapitalization is one of the fastest ways to get equipment back to units for use, and on some equipment, such as trucks, recapitalization costs only 75 percent of replacement costs. A second option is to upgrade equipment, such as adding armor. A third option is to simply extend the equipment's service life through a maintenance program.

Theater operations in Iraqi and Afghanistan are consuming the Reserve Component force's equipment. Wear and tear is at a rate many times higher than planned. Battle damage expends additional resources. New equipment suited for mountain warfare will be needed with the shift back into Afghanistan.

In addition to dollars already spent to maintain this well-worn equipment for ongoing operations, the Armed Forces will likely incur large expenditures in the future to repair or replace (reset) a significant amount of equipment when hostilities cease. It is still unknown how much equipment will be left in Afghanistan.

PERSONNEL TRAINING

When Reserve Component personnel participate in an operation they are focused on the needs of the particular mission, which may not include everything required to maintain qualification status in their military occupation specialty (MOS, AFSC, NEC).

- There are many different aspects of training that are affected:
 - Skills that must be refreshed for specialty;
 - Training needed for upgrade but delayed by mission;
 - Ancillary training missed;
 - Professional military education needed to stay competitive;
 - Professional continuing education requirements for single-managed career fields and other certified or licensed specialties required annually;
 - Graduate education in business related areas to address force transformation and induce officer retention.
- Loss, training a replacement: There are particular challenges that occur to the force when a loss occurs during a mobilization or operation and depending on the specialty this can be a particularly critical requirement that must be met:
 - Recruiting may require particular attention to enticing certain specialties or skills to fill critical billets;
 - Minimum levels of training (84 days basic, plus specialty training);
 - Retraining may be required due to force leveling as emphasis is shifted within the service to meet emerging requirements.

END STRENGTH

The ROA would like to place a moratorium on reductions to the Guard and Reserve manning levels. Manpower numbers need to include not only deployable assets, but individuals in the accession pipeline. ROA urges this subcommittee to fund to support:

- Army National Guard of the United States, 358,200.
- Army Reserve, 206,000.
- Navy Reserve, 66,700.
- Marine Corps Reserve, 39,600.
- Air National Guard of the United States, 106,756.
- Air Force Reserve, 69,900.
- Coast Guard Reserve, 10,000.

In a time of war and the highest OPTEMPO in recent history, it is wrong to make cuts to the end strength of the Reserve Components. We need to pause to permit force planning and strategy to catch-up with budget reductions.

With the Navy's requested increase by 2,500 sailors, corresponding increases need to be made in the Navy Reserve. The Navy Reserve is providing most of the individual augmentee support for the Navy in overseas operations. Five years ago was the last time the Navy evaluated its USNR requirements; such a study needs to be done again.

READINESS

Readiness is a product of many factors, including the quality of officers and enlisted, full staffing, extensive training and exercises, well-maintained weapons and authorized equipment, efficient procedures, and the capacity to operate at a fast tempo.

The Defense Department does not attempt to keep all Active units at the C-1 level. The risk is without resetting the force returning Active and Reserve units will be C-4 or lower because of missing equipment, and without authorized equipment their training levels will deteriorate.

NONFUNDED ARMY RESERVE COMPONENT EQUIPMENT

The Army National Guard and Army Reserve have made significant contributions to ongoing military operations, but equipment shortages and personnel challenges continue and if left unattended, may hamper the Reserves' preparedness for future overseas and domestic missions. To provide deployable units, the Army National Guard and the Army Reserve have cross-leveled large quantities of personnel and

equipment to deploying units, an approach that has resulted in growing shortages in nondeployed units.

Army Reserve Unfunded Requirements

The 21st Century Army Reserve mobilizes continuously with 12 percent of its force consistently deployed in support of the current contingencies. However, the Army Reserve lacks the ability to fully train Army Reserve Soldiers on the same equipment the Army uses in the field. To prepare to perform a dangerous mission, soldiers must have modern equipment and state-of-the-art training facilities. The Army Reserve has 73 percent of its required equipment on hand. Under currently programmed funding, the Army Reserve should reach 85 percent equipment on hand by fiscal year 2016 with the goal of 100 percent on hand by fiscal year 2019.

C-12 Huran Cargo Transport Airplane (7)—\$63 Million

Replace aircraft permanently transferred to Intelligence, Surveillance and Reconnaissance (ISR) mission. Seven below total authorized count. Capacity lift 5,185 lbs, distance 1,710 miles.

Communications Security (COMSEC) AKMS/Computer Sets (3648)—\$8.6 Million

Provide secure communications to (4) companies with AN/GYK-49(V)1 & AN/PYQ-10(C) sets.

Cargo Bed, Demountable PLS 8 x20 (5498)—\$109.7 Million

Transportation Support: pacing item for Medium Truck Company, 360 each.

Optical Data Entry Reader (115)—\$25.5 Million

Imaging/Reader automation to fix trailer transfer and Inland Cargo units.

Heavy/Medium Trailers (1760)—\$115.8 Million

Cargo—MTV with dropsides (M1095); flatbed—LMTV w/dropsides (M1086)

Army National Guard Unfunded Equipment Requirements

Army National Guard (ARNG) units deployed overseas have the most up-to-date equipment available. However, a significant amount of equipment is currently unavailable to the Army National Guard in the States due to continuing rotational deployments and emerging modernization requirements. Many States have expressed concern about the resulting shortfalls of equipment for training as well as for domestic emergency response operations.

Aviation Upgrade Kits—\$100.5 Million

UH-60A to UH-60L Upgrade Kits; LUH-72A S&S Mission Equipment Package.

Homeland Security Command and Control Package—\$168.4 Million

Joint Incident Site Communications and Interim Satcom Incident Site. (JISC & ISISCS); Wideband Imagery Satellite Terminals, and Full Motion Video (FMV) downlink to support state and local leaders during natural and manmade disasters.

M777A2 Lightweight 155mm Howitzer (18)—\$54 Million

To ensure readiness of Army National Guard (ARNG) Fire Support, Field Artillery units.

Transportation—\$1.15 Billion

FMTV/LMTV Cargo Trucks; HMMWV; HTV 8x8 Heavy Trucks; Tactical Trailers.

Force XXI Battlefield Command Brigade and Below (FBCB2)—\$179 Million

To ensure readiness of ARNG Combat Support and Combat Service Support (CS/CSS) units.

Also needed: To organize a second Stryker Brigade Combat Team (SBCT)

AIR FORCE RESERVE COMPONENT EQUIPMENT PRIORITIES

ROA continues to support military aircraft Multi-Year Procurement (MYP) beginning with 15 for more C-17s and 8 more C-130Js for USAir Force and its Reserve. Further, ROA supports additional funding for continued Research and Development of the next generation bomber.

Air Force Reserve Unfunded Requirements

The Air Force Reserve (AFR) mission is to be an integrated member of the Total Air Force to support mission requirements of the joint warfighter. To achieve interoperability in the future, the Air Force Reserve top priorities for nonfunded equipment are:

C-40 D multi-role airlift (3)—\$370 Million

To replace aging C-9 C's at Scott Air Force Base: mission requests exceed aircraft availability.

KC-130J Aircraft (2)—\$148 Million

These Aircraft are needed to fill the shortfall in Search and Rescue refueling capabilities.

Cyber Systems Defense—\$109 Million

Upgrade Active Duty and AF Reserve network infrastructure to ensure overall A.F. mission.

Helmet Mounted Cueing System—\$38 Million

Upgrade and enhancement to engagement systems.

Defensive Systems

Airlift Defensive Systems (16) Install ADS systems onto (16) AFRC C-5As at Lackland Air Force Base against IR missile threats.

Infra-Red Counter Measures (42) Procure and install (42) LAIRCM lite systems on AFRC C-5s. Protects high value national assets against advanced IR missile threats.

Missile Warning System (MWS) Upgrade/replacement—Improve and integrate the existing Electronic Attack (EA) for A-10 and F-16 and Electronic Protection (EP) for A-10, F-16 and HC-130.

Air National Guard Unfunded Equipment Requirements

Shortfalls in equipment will impact the Air National Guard's ability to support the National Guard's response to disasters and terrorist incidents in the homeland. Improved equipping strengthens readiness for both overseas and homeland missions and improves the ANG capability to train on mission-essential equipment.

Infra-Red Counter Measures—\$240.7 Million

Procure and install LAIRCM systems on C-5, C-17, C-130, 130, HC-130, EC-130, KC-135 a/c.

Air Defensive Systems—\$59.31 Million

Install ADS systems onto C-5, C-17, F-15 aircraft.

Missile Warning Systems—\$22.48 Million

Upgrade/replacement—Improve and integrate the existing Electronic Attack (EA) and Electronic Protection (EP) for A-10, C-130.

Rear Aspect Visual Scan Capability/Safire—\$57.2 Million

Increase the field of view on C-5, C-17 transports and add a larger window in the C-130 paratroop doors.

*Personal Protective Equipment, M4 Rifles—\$34.77 Million**Force Protection Mobility Bag Upgrades/Replacements—\$113.72 Million*

NAVY RESERVE UNFUNDED PRIORITIES

Active Reserve Integration (ARI) aligns Active and Reserve component units to achieve unity of command. Navy Reservists are fully integrated into their Active component supported commands. Little distinction is drawn between Active component and Reserve component equipment, but unique missions remain.

C-40 A Combo Cargo/Passenger Airlift (4)—\$402 Million

The Navy requires a Navy Unique Fleet Essential Airlift Replacement Aircraft. The C-40A is able to carry 121 passengers or 40,000 pounds of cargo, compared with 90 passengers or 30,000 pounds for the C-9.

KC-130J Super Hercules Aircraft Tankers (4)—\$160 Million

These Aircraft are needed to fill the shortfall in Navy Unique Fleet Essential Airlift (NUFEA). Procurement price close to upgrading existing C-130Ts with the benefit of a long life span.

P-3 Maritime Patrol Aircraft Fixes—\$312 Million

Due to the grounding of 39 airframes in December 2007, there is a shortage of maritime patrol and reconnaissance aircraft, which are flown in associate Active and Reserve crews. P-3 wing crack kits are still needed for fiscal year 2010.

F-5 Radar/Electronic Attack Block-2—\$148.3 Million

Aircraft used in adversarial training of F-18 pilots. Heightens adversary competition conditions.

C-40 Hangar, Oceana—\$31.4 Million

MARINE CORPS RESERVE UNFUNDED PRIORITIES

The Marine Corps Reserve faces two primary equipping challenges, supporting and sustaining its forward deployed forces in the Long War while simultaneous re-setting and modernizing the Force to prepare for future challenges. Only by equally equipping and maintaining both the Active and Reserve forces will an integrated Total Force be seamless.

KC-130J Super Hercules Aircraft tankers (4)—\$160 Million

These Aircraft are needed to fill the shortfall in Marine Corps Essential Airlift. Procurement price close to upgrading existing C-130Ts with the benefit of a long life span. Commandant, USMC, has testified that acquisition must be accelerated.

Light Armored Vehicles—LAV (14)—\$21 Million

A shortfall in a USMCR light armor reconnaissance company, the LAV-25 is an all-terrain, all-weather vehicle with night capabilities. It provides strategic mobility to reach and engage the threat, tactical mobility for effective use of fire power.

Training Allowance (T/A) Shortfalls—\$187.7 Million

Shortfalls consist of over 300 items needed for individual combat clothing and equipment, including protective vests, poncho, liner, gloves, cold weather clothing, environmental test sets, tool kits, tents, camouflage netting, communications systems, engineering equipment, combat and logistics vehicles and weapon systems.

MCB Vehicle Maintenance Facility—\$10.9 Million

Additional vehicle storage and maintenance: routine preventive and corrective maintenance are still performed throughout the country by Marines. Ground equipment maintenance efforts have expanded over the past few years, leveraging contracted services and depot-level capabilities.

TRANSPARENCY OF PROCUREMENT

Each Reserve Component has shared with ROA that there is a continued problem of tracking equipment specifically appropriated to the Reserves from manufacturer to a service's Reserve Component. Frustrations continue with a belief that the Active Component either pushes out Reserve items during production or actual misappropriates equipment in distribution before it reaches the Reserve.

NATIONAL GUARD AND RESERVE EQUIPMENT APPROPRIATION

Much-needed items not funded by the respective service budget are frequently purchased through this appropriation. In some cases it is used to bring unit equipment readiness to a needed State for mobilization. With the war, the Reserve and Guard are faced with mounting challenges. Funding levels, rising costs, lack of replacement parts for older equipment, etc. have made it difficult for the Reserve Components to maintain their aging equipment, not to mention modernizing and recapitalizing to support a viable legacy force. The Reserve Components benefit greatly from a National Military Resource Strategy that includes a National Guard and Reserve Equipment Appropriation.

CIOR/CIOMR FUNDING REQUEST

The Interallied Confederation of Reserve Officers (CIOR) was founded in 1948, and its affiliate organization, The Interallied Confederation of Medical Reserve Officers (CIOMR) was founded in 1947. The organization is a nonpolitical, independent confederation of national reserve associations of the signatory countries of the North Atlantic Treaty (NATO). Presently there are 16 member nation delegations representing over 800,000 reserve officers. CIOR supports four programs to improve professional development and international understanding.

Military Competition.—The CIOR Military Competition is a strenuous 3-day contest on warfighting skills among Reserve Officers teams from member countries. These contests emphasize combined and joint military actions relevant to the multinational aspects of current and future Alliance operations.

Language Academy.—The two official languages of NATO are English and French. As a non-government body, operating on a limited budget, it is not in a position to

afford the expense of providing simultaneous translation services. The Academy offers intensive courses in English and French as specified by NATO Military Agency for Standardization, which affords international junior officer members the opportunity to become fluent in English as a second language.

Partnership for Peace (PfP).—Established by CIOR Executive Committee in 1994 with the focus of assisting NATO PfP nations with the development of Reserve officer and enlisted organizations according to democratic principles. CIOR's PfP Committee, fully supports the development of civil-military relationships and respect for democratic ideals within PfP nations. CIOR PfP Committee also assists in the invitation process to participating countries in the Military Competition.

Young Reserve Officers Workshop.—The workshops are arranged annually by the NATO International Staff (IS). Selected issues are assigned to joint seminars through the CIOR Defense and Security Issues (SECDEF) Commission. Junior grade officers work in a joint seminar environment to analyze Reserve concerns relevant to NATO.

Dues do not cover the workshops and individual countries help fund the events. The Department of the Army as Executive Agent hasn't been funding these programs. Senate leadership support would be beneficial.

CONCLUSION

DoD is in the middle of executing a war and operations in Iraq and Afghanistan. The impact of these operations is affecting the very nature of the Guard and Reserve, not just the execution of Roles and Missions. Without adequate funding, the Guard and Reserve may be viewed as a source to provide funds to the Active Component. It makes sense to fully fund the most cost efficient components of the Total Force, its Reserve Components.

At a time of war, we are expending the smallest percentage of GDP in history on National Defense. Funding now reflects close to 4 percent of GDP including supplemental dollars. ROA has a resolution urging that defense spending should be 5 percent to cover both the war and homeland security. While these are big dollars, the President and Congress must understand that this type of investment is what it will take to equip, train and maintain an all-volunteer force for adequate National Security.

The Reserve Officers Association, again, would like to thank the sub-committee for the opportunity to present our testimony. We are looking forward to working with you, and supporting your efforts in any way that we can.

Chairman INOUE. Our next witness is the Secretary of the Associations for America's Defense, Ms. Elizabeth Cochran.

STATEMENT OF ELIZABETH COCHRAN, SECRETARY, ASSOCIATIONS FOR AMERICA'S DEFENSE

Ms. COCHRAN. Thank you, Mr. Chairman and Mr. Vice Chairman.

The Associations for America's Defense is very grateful to testify today, and we'd like to submit written testimony at this time.

We would like to thank this subcommittee for its stewardship on defense issues and setting an example by its nonpartisan leadership. The Associations for America's Defense is concerned that U.S. defense policy is sacrificing future security for near-term readiness. It's been suggested that the United States should focus on wars we're fighting today, not on future wars that may not occur. The Pentagon's priorities sound like money will be redirected to more immediate needs.

Erosion in the capability in the force means added risk will be faced today and tomorrow. According to the Office of Management and Budget, base defense spending, projected at \$534 billion in 2010, will stay relatively flat for the next 5 years. We disagree with placing such budgetary constraints on defense, because it can lead to readiness and effectiveness being subtly degraded, which won't be immediately evident. We support increasing defense spending to 5 percent of the gross domestic product during times of war to

cover procurement, and prevent unnecessary personnel end-strength cuts.

The Associations for America's Defense is alarmed about the fiscal year 2010 unfunded programs list, submitted by the military services, which is 87 percent lower than fiscal year 2009's request. We're concerned the unfunded requests were driven by budgetary factors more than risk assessment, which will impact national security.

As always, our military will do everything to accomplish its missions, but response time is measured by equipment readiness. Due to the DOD's tactical aircraft acquisition programs having been blunted by cost and schedule overruns, the Air Force has offered to retire 250 fighter jets in one year, which the Secretary of Defense has accepted. Until new systems are acquired in sufficient quantities to replace legacy fleets, those legacy systems must be sustained. Airlift contributions in moving cargo and passengers are indispensable to American warfighters. As the military continues to become more expeditionary, more airlifts in C-17 and C-130Js will be required. Procurement needs to be accelerated and modernized, and mobility requirements need to be reported upon.

The need for air refueling is utilized worldwide in DOD operations. But, significant numbers of tankers are old and plagued with structural problems. The Air Force would like to retire as many as 131 of the Eisenhower-era KC-135E tankers by the end of the decade. These aircraft must be replaced.

Finally, we ask this subcommittee to continue to provide appropriations for the National Guard and Reserve equipment requirements. The National Guard's goal is to make at least one-half the army and air assets available to Governors and adjutants general at any given time. Appropriating funds to Guard and Reserve equipment provides Reserve chiefs with flexibility prioritizing funding.

Once again, I thank you for your ongoing support for the Nation's armed services and the fine men and women who defend our country. Please contact us with any questions.

Thank you.

Chairman INOUE. Thank you very much, Ms. Cochran.

And I thank the panel.

[The statement follows:]

PREPARED STATEMENT OF ELIZABETH COCHRAN

INTRODUCTION

Mister Chairman and distinguished members of the Committee, the Associations for America's Defense (A4AD) is again very grateful for the invitation to testify before you about our views and suggestions concerning current and future issues facing the defense appropriations.

The Association for America's Defense is an adhoc group of 12 military and veteran associations that have concerns about national security issues. Collectively, we represent armed forces members and their families, who are serving our Nation, or who have done so in the past.

CURRENT VERSUS FUTURE: ISSUES FACING DEFENSE

The Associations for America's Defense would like to thank this subcommittee for the on-going stewardship that it has demonstrated on issues of Defense. At a time of war, its pro-defense and non-partisan leadership continues to set the example.

Emergent Risks

Members of this group are concerned that U.S. Defense policy is sacrificing future security for near term readiness. So focused are our efforts to provide security and stabilization in Afghanistan and a withdrawal from Iraq, that risk is being accepted as an element in future force planning. Force planning is being driven by current overseas contingency operations, and to allow for budget limitations. Careful study is needed to make the right choice. A4AD is pleased that Congress and this subcommittee continue oversight in these decisions.

What seems to be overlooked is that the United States is involved in a Cold War as well as a Hot war. With the United States preoccupied with the Middle East, North Korea, China, Russia, and Iran are growing areas of risk.

Korean Peninsula

Provocatively, North Korea successfully tested a nuclear weapon at full yield, unilaterally withdrew from that 1953 armistice, and continues to test-fire missiles from both its coasts. The South sent a high speed missile patrol boat into Western waters in response to a reported amphibious assault training staged by the North. South Korean and U.S. troops have been put on the highest alert level in 3 years, and the South Korean Coast Guard is escorting its fishing boats.

North Korea has 1.2 million troops, with the 655,000 South Korean soldiers and 30,000 U.S. troops stationed to the South. While not an immediate danger to the United States, North Korea is still viewed as a threat by its neighbors, and represents a destabilizing factor in Asia. Recent events may be mere posturing, but North Korea is still a failed state, where misinterpretation clouded by hubris could start a war. The North has prepositioned and could fire up to 250,000 rounds of heavy artillery in the first 48 hours of war along the border and into Seoul.

China

China remains the elephant in the war room. As the United States expends resources in the Middle East and continues to restructure the military to fight terrorism, China patiently waits for America's ability to project force to weaken.

China's armed forces are the biggest in the world and have undergone double-digit increases in military spending since the early 1990s. The Pentagon has reported that China's actual spending on military is up to 250 percent higher than figures reported by the Chinese government, and their cost of materials and labor is much lower. This year, China chose to increase its defense budget by almost 15 percent. China's build-up of sea and air military power appears aimed at the United States, according to Admiral Michael Mullen, the chairman of the U.S. Joint Chiefs of Staff.

The U.S. military strategy cannot be held hostage by international debts. While China is the biggest foreign holder of U.S. Treasuries with \$768 billion at the end of the first quarter, we can't be lulled into a sense of complacency.

Russia

Russian President Dmitry Medvedev has called for "comprehensive rearmament." Last March, in televised remarks to defense ministry officials, Medvedev proclaimed the "most important task is to re-equip the [Russian] armed forces with the newest weapons systems." Russia's defense budget could jump 30 percent this year, increasing Moscow's military might and preserving its arms-export industry, reports Peter Brookes of the Heritage Foundation. The country will aim for 70 percent of its weaponry to be "modern" by 2020, Defense Minister Anatoly Serdyukov said, according to RIA-Novosti, the state-run news agency.

Following an April meeting with President Medvedev, the Obama administration is seeking a new start with Russia. Underlying U.S.-Russian frictions are issues of NATO military expansion to countries like Georgia and Ukraine, and U.S. plans to base a missile defense system in Poland and the Czech Republic to defend against attacks from countries like Iran. Concerns have been voiced about a European military threat to Russian gas and oil fields.

Iran

While Iran lobs petulant rhetoric towards the United States, the real international tension is between Israel and Iran. Israel views Tehran's atomic work as a threat, and would consider military action against Iran. If Iran was attacked, it has threatened to "eliminate Israel." Israeli leadership has warned Iran that any attack on Israel would result in the "destruction of the Iranian nation." Israel is believed to have between 75 to 200 nuclear warheads with a megaton capacity.

Force Structure: An Erosion in Capability

Supporting the National Security Strategy requires that the United States to maintain robust and versatile military forces that can accomplish a wide variety of missions. The two major theater war (2MTW) approach was an innovation at the end of the Cold War. It was based on the proposition that the United States should prepare for the possibility that two regional conflicts could arise at the same time, so that if the United States were engaged in a conflict in one theater, an adversary in a second theater could be prevented from gaining his objectives in the other. In 1996, the United States adopted the “win-hold-win” concept—a strategy to fight and win one major regional contingency, with enough force to hold another foe at a stalemate until the first battle is won, and then to move the forces to the second theater.

The Bush Administration’s “1–4–2–1 strategy” from the 2001 Quadrennial Defense Review (QDR) called their new military strategy “1–4–2–1,” which meant: “1” Defend the United States; “4” Deter aggression in four critical regions: Europe, Northeast Asia, Southwest Asia, the Middle East; “2” Maintain the capability to combat aggression in two of these regions simultaneously; and “1” Maintain a capability to “win decisively” up to and including forcing regime change and occupation in one of those two conflicts “at a time and place of our choosing.”

A top to bottom review in 2005, suggested change to the national strategy as to mount one conventional campaign while devoting more resources to defending American territory and antiterrorism efforts.

In a speech announcing the fiscal year 2010 Defense Budget, Secretary of Defense Robert Gates stated “Our conventional modernization goals should be tied to the actual and prospective capabilities of known future adversaries—not by what might be technologically feasible for a potential adversary given unlimited time and resources . . .”

“This budget is less about numbers than it is about how the military thinks about the nature of warfare and prepares for the future,” Secretary of Defense Robert Gates testified before the Senate Armed Services Committee on May 14, 2009. Gates says that the United States should focus on the wars that we are fighting today, not on future wars that may never occur. He also asserts that U.S. conventional capabilities will remain superior for another 15 years. Anthony Cordesman, a national security expert for the Center for Strategic and International Studies, says that Gates’ plan should be viewed as a set of short-term fixes aimed at helping “a serious cost containment problem,” not a new national security policy.

War planners are often accused of planning for the last war. Secretary Gates speaks to enhancing the capabilities of fighting today’s wars. A concern arises on whether the Pentagon’s focus should be on irregular or conventional warfare, and whether it should be preparing for a full scale “peer” war. From his priorities, it sounds like Secretary Gates will be redirecting money to more immediate needs.

Each strategy permitted change to resize a force that was originally oriented to global war to a smaller force focused on smaller regional contingencies. But the erosion in the capability and the force means added risks will be faced today and tomorrow than when the 2MTW standard was established. “The danger is in the poverty of expectation, a routine obsession with danger that are familiar rather than likely,” wrote Thomas Schelling, in the Forward to: Pearl Harbor: Decision and Warning (1962).

Funding for the Future

Base defense spending, projected at \$534 billion in 2010, will stay relatively flat for the next 5 years, counting inflation, according to spending outlines by the Office of Management and Budget. “It is simply not reasonable to expect the defense budget to continue increasing at the same rate it has over the last number of years,” Secretary Gates told the Senate committee. “We should be able to secure our Nation with a base budget of more than half a trillion dollars.”

Hollow Force

The Associations for America’s Defense couldn’t disagree more by placing such budgetary constraints on the defense. A4AD members question the spending priorities of the current administration. “Fiscal restraint for defense and fiscal largesse for everything else,” commented Rep. John McHugh at a HASC hearing on the Defense Budget in May.

The result of such budgetary policy could again lead to a hollow force whose readiness and effectiveness has been subtly degraded and whose lessened efficiency will not be immediately evident. This process which echoes of the past, raises no red flags and sounds no alarms, and the damage can go unnoticed and unremedied until a crisis arises that highlights just how much readiness has decayed.

Defense as a Factor of GDP

Secretary Gates has warned that that each defense budget decision is “zero sum,” providing money for one program will take money away from another. A4AD encourages the appropriations subcommittee on defense to scrutinize the recommended spending amount for defense. Each member association supports increasing defense spending to 5 percent of Gross Domestic Product during times of war to cover procurement and prevent unnecessary personnel end strength cuts.

A Changing Manpower Structure

Secretary Gates proposed spending an extra \$11 billion to finish enlarging the Army and the Marine Corps and to halt reductions in the Air Force and the Navy. The Navy has asked for an increase in end strength of nearly 2,500 to 328,800 sailors. The Navy Reserve (USNR) on the other hand would be reduced to 65,506, a cut of 1,194. The Navy Reserve continues to be cut, and it is the main contributor to the Navy’s individual augmentees (IA) force on the ground in Iraq and, now, Afghanistan. Of the requested dollars to support 4,400 by the Navy, the Navy Reserve supplies 3,000.

A4AD supports a moratorium on further cuts including the Navy Reserve. We further suggest that a Zero Based Review (ZBR) be performed to evaluate the manning level of the USNR. The last review was done over 5 years ago, and much has changed since.

Maintaining a Surge Capability

The armed forces need to provide critical surge capacity for homeland security, domestic and expeditionary support to national security and defense, and response to domestic disasters, both natural and man-made that goes beyond operational forces. A strategic surge construct includes manpower, airlift and air refueling, sea-lift inventory, logistics, and communication to provide a surge-to-demand operation. This requires funding for training, equipping and maintenance of a mission-ready strategic reserve composed of active and reserve units. An additional requirement is excess infrastructure which would permit the housing of additional forces that are called-up beyond the normal operational force.

Dependence on Foreign Partnership

Part of the U.S. military strategy is to rely on long-term alliances to augment U.S. forces. “To succeed in any efforts the Department must harness and integrate all aspects of national power and work closely with a wide range of allies, friends and partners,” as stated in a DOD progress report. “Our strategy emphasizes the capacities of a broad spectrum of partners . . . We must also seek to strengthen the resiliency of the international system . . . helping others to police themselves and their regions.” It’s been recommended in the budget to increase funding of global partnerships efforts by \$500 million in the fiscal year 2010 base budget proposal, to support training and equipping foreign militaries to undertake counter terrorism and stability operations. Performances by allies have yet proven to be a good return on investment.

The risk of basing a national security policy on foreign interests and good world citizenship is increasingly uncertain because the United States does not necessarily control our foreign partners; countries whose objectives may differ with from own. This is more an exercise of consensus building rather than security integration. Alliances should be viewed as a tool and a force multiplier, but not the foundation of National Security.

UNFUNDED REQUIREMENTS

The fiscal year 2010 Unfunded Program Lists submitted by the military services to Congress was 87 percent less than was requested for fiscal year 2009 with requests for only \$3.44 billion versus \$29.9 billion the year before. A4AD has concerns that the unfunded requests were driven more by budgetary factors than risk assessment which will impact national security. The following are lists submitted by A4AD including additional non-funded recommendations.

Tactical Aircraft

DOD’s efforts to recapitalize and modernize its tactical air forces have been blunted by cost and schedule overruns in its new tactical aircraft acquisition programs. The Air Force has offered a plan to retire 250 fighter jets in 1 year alone, which the Secretary of Defense has accepted.

Until new systems are acquired in sufficient quantities to replace legacy fleets, legacy systems must be sustained and kept operationally relevant. The risk of the

older aircraft and their crews and support personnel being eliminated before the new aircraft are on line could result in a significant security shortfall.

Airlift

Hundreds of thousands of hours have been flown, and millions of passengers and tons of cargo have been airlifted. Their contributions in moving cargo and passengers are absolutely indispensable to American warfighters in the Global War on Terrorism. Both Air Force and Naval airframes and air crew are being stressed by these lift missions. As the U.S. military continues to become more expeditionary, it will require more airlift. Procurement needs to be accelerated and modernized, and mobility requirements need to be reported upon.

DOD should buy an additional (35) C-17s above the current 205 to ensure an adequate airlift force for the future and allow for attrition—C-17s are being worn out at a higher rate than anticipated in the Global War on Terrorism. Given the C-5's advanced age, it makes more sense to retire the oldest and most worn out of these planes and use the upgrade funds to buy more C-17s. DOD should also continue with a joint multi-year procurement of C-130Js.

The Navy and Marine Corps need C-40-A replacements for the C-9B aircraft. The Navy requires Navy Unique Fleet Essential Airlift. The C-40A, a derivative of the 737-700C a Federal Aviation Administration (FAA) certified, while the aging C-9 fleet is not compliant with either future global navigation requirements or noise abatement standards that restrict flights into European airfields.

Tankers

The need for air refueling is reconfirmed on a daily basis in worldwide DOD operations. A significant number of tankers are old and plagued with structural problems. The Air Force would like to retire as many as 131 of the Eisenhower-era KC-135E tankers by the end of the decade. DOD and Congress must work together to replace of these aircraft.

NGREA

A4AD asks this committee to continue to provide appropriations for unfunded National Guard and Reserve Equipment Requirements. The National Guard's goal is to make at least half of Army and Air assets (personnel and equipment) available to the Governors and Adjutants General at any given time. To appropriate funds to Guard and Reserve equipment provides Reserve Chiefs with a flexibility of prioritizing funding.

UNFUNDED EQUIPMENT REQUIREMENTS

[The services are not listed in priority order.]

	Amount
Air Force:	
C-17 Globemaster III transport aircraft (15)	\$3.9 billion
C-130J Super Hercules (5)	395 million
Battlefield Airborne Communications Node (2) lease and operation	180.2 million
Upgrade kits for the EC-130s/Compass Call Modifications (4)	78 million
HH-60G Pave Hawk (3) Search and Rescue	120 million
AAQ-29 Forward Looking Infra Red System—FLIR (81) HH-60G	81 million
Air Force Reserve:	
C-5A Airlift Defense system (ADS) (42)	17.3 million
C-130H LAIRCM—Large Aircraft I/R Counter Measures (6)	56.6 million
C-130J LAIRCM (2)	22 million
Missile Warning Systems and Electronic Protection, A-10, F-16	27.9 million
C-5 Structural repair	22 million
Note: USAFR has a \$1 billion MILCON backlog.	
Air National Guard:	
C-40C pax aircraft, procurement (1) and avionics upgrade	98.6 million
C-38 aircraft, replacement program	110 million
Radio, Beyond Line of Sight (BLOS) ADS TACSAT, F-15, F-16C	109.7 million
Electronic Attack Pod, A-10, F-16C	44 million
Helmet Mounted Cueing System, A-10, F-16C, HH-60G	38 million
Note: Air National Guard faces a MILCON backlog of \$2 billion to recapitalize facilities.	
Army:	
Aviation Support Equipment	36.2 million
Field Feeding	30.7 million

UNFUNDED EQUIPMENT REQUIREMENTS—Continued

[The services are not listed in priority order.]

	Amount
Force XXI Battlefield Command Brigade and Below	179 million
Information System Security COMSEC	44.8 million
Liquid Logistics Storage and Distribution	2 million
Army Reserve:	
Palletized Load System (PLS) Trailer	27.8 million
Tactical Light Truck (Ambulance HMMWV, Armament Carrier HMMWV, Troop/Cargo Carrier HMMWV)	183.8 million
Command Post (FBCB2/TOCS/UYK-128) computer set, shelter	181.4 million
Support (Antenna-OE-361(V)/Loudspeakers tactical)	13.4 million
HEMTT (Tactical Heavy wrecker)	55.9 million
Army National Guard:	
CH-47F Chinook helicopters (6) in fiscal year 10	66 million
UH-60M Black Hawk medium-lift helicopter (10) in fiscal year 10	164 million
Warfighter Information Network-Tactical (WIN-T)	1.2 billion
Communication Systems (JNN, SINCGARS, HF)	1.5 billion
Stryker combat vehicles, various configurations (549)	1.4 billion
Note: \$280 million/year is the investment necessary to effectively recapitalize MILCON.	
Navy:	
P-3 Repair/Recovery Plan, kit installation	462 million
Aviation Depot Maintenance, to fund 86 deferred airframes and 314 engines	195 million
Ship Depot Maintenance, for 20 surface ship availabilities	200 million
C-130J Super Hercules (1) to replace Blue Angels transport	64 million
Navy Reserve:	
C-40A Combo cargo/passenger airlift aircraft (4)	402 million
KC-130J Super Hercules aircraft (4)	256 million
Maritime Expeditionary Warfare Equipment	35.5 million
Maritime Prepositioning Force Utility Boats (RHIB)	6.6 million
Information Systems Security Program	5.5 million
Marine Corps:	
MTVR trailers (buys 352) to cover shortfall	28.9 million
Engineer Equipment for Logistics Support:	
TRAMs, bucket loader (93)	21 million
Forklift, Light Rough Terrain—LRTF (96)	13 million
Forklift, Extended Boom (177)	24 million
MV-22 Osprey Aircraft, Improvements, and Upgrades	17.4 million
Mountain Terrain Support Vehicles (10)	10.2 million
Tier I UAS (146) Digital Data Link upgrade kits	10.5 million
Note: Military Construction requirements are \$70.5 million.	
Marine Forces Reserves:	
KC-130Js Super Hercules tanker aircraft (2)	128 million
Light Armored Vehicles (14)	21 million
Helmet Mounted Displays (SA-HMDs) Systems	
Theater Provided Equipment Sensors	

Conclusion

A4AD is a working group of military and veteran associations looking beyond personnel issues to the broader issues of National Defense.

This testimony is an overview, and expanded data on information within this document can be provided upon request.

Thank you for your ongoing support of the Nation, the Armed Services, and the fine young men and women who defend our country. Please contact us with any questions.

Chairman INOUE. Now we have our final panel, consisting of Dr. Philip Boudjouk; the president and CEO, Ms. Sandra Raymond, Dr. George Zitnay, Captain Ike Puzon, of the Navy, Ms. Mary Hesdorffer, Dr. Jonathan Berman, vice president—Mr. George Dahlman, and General Michael Dunn.

Thank you very much.

Representing the Coalition of EPSCoR/IDeA States, Dr. Philip Boudjouk. Is that the correct pronunciation?

Dr. BOUDJOUK. Mr. Chairman, “boo-jock” is the correct pronunciation.

Chairman INOUE. Boudjouk.

Dr. BOUDJOUK. Boudjouk, thank you.

STATEMENT OF PHILIP BOUDJOUK, Ph.D., VICE PRESIDENT, RESEARCH, CREATIVE ACTIVITIES AND TECHNOLOGY TRANSFER, NORTH DAKOTA STATE UNIVERSITY; CHAIR, COALITION OF EPSCoR/IDeA STATES

Dr. BOUDJOUK. Chairman Inouye, Ranking Member Cochran, members of the subcommittee, thank you for the opportunity to testify today on the importance of maintaining and adequately funding the Department of Defense DEPSCoR program.

My name is Philip Boudjouk, and I serve as the vice president of research, creative activities, and technology transfer at North Dakota State University, and I also serve as chair of the Coalition of EPSCoR/IDeA States, a nonprofit organization representing the 21 States and two territories currently eligible to receive DOD DEPSCoR research awards.

DEPSCoR was originally authorized by section 257 of the National Defense Authorization Act of 1995 to ensure a nationwide, multi-State infrastructure to support the 6.1 basic research needs of the Department of Defense. In recent years, Congress has generously provided funding for DEPSCoR between \$15 and \$17 million, and has affirmatively rejected efforts by the previous administration to reduce the size of the program.

In the fiscal year 2009 National Defense Authorization Act, the Senate directed a federally funded Research and Development Center assessment of the DEPSCoR program to determine its value to the Department and to the American taxpayer. The Institute for Defense Analyses concluded that DEPSCoR has strengthened the nationwide basic research capacity. More importantly, the assessment determined that the DEPSCoR States’ share of nondefense—non-DEPSCoR DOD science and engineering funding increased steadily from inception of the program to today.

However, the administration’s proposed 2010 DOD budget recommends no funding for DEPSCoR. The 23 eligible DEPSCoR jurisdictions must therefore rely on Congress to ensure the DEPSCoR program is adequately funded, at a level that ensures our Nation maintains a nationwide infrastructure of DOD research capabilities.

Allowing the DEPSCoR program to go unfunded in fiscal year 2010 will not only create a critical shortfall in our national research infrastructure, but it will, likewise, have dire consequences for DEPSCoR States that otherwise may not receive an investment of DOD research funding. Therefore, we respectfully request that the DEPSCoR program at a minimum of \$20 million.

Mr. Chairman, every State has important contributions to make to our Nation’s research competitiveness, and every State has scientists and engineers that can contribute significantly to supporting the research needs of DOD.

Thank you for the opportunity to testify before the subcommittee. Chairman INOUE. I thank you very much, sir.

[The statement follows:]

PREPARED STATEMENT OF PHILIP BOUDJOUK

Chairman Inouye, Ranking Member Cochran, Members of the Subcommittee: Thank you for the opportunity to testify today on the importance of maintaining and adequately funding the Department of Defense Experimental Program to Stimulate Competitive Research (DEPSCoR)¹.

My name is Philip Boudjouk and I serve as the Vice President of Research, Creative Activities and Technology Transfer at North Dakota State University. I also currently serve as Chair of the Coalition of EPSCoR/IDeA States, a non-profit organization representing the 21 States and 2 territories currently eligible to receive Department of Defense DEPSCoR research awards.

EPSCoR States have a vast reservoir of talent and capacity. They represent 20 percent of the U.S. population, 25 percent of the research and doctoral universities, and 18 percent of the Nation's scientists and engineers. The EPSCoR program is critical to ensuring that we maintain a national infrastructure of research and engineering by providing much needed funding to these leading universities and scientists.

As you know, DEPSCoR was initially authorized by Section 257 of the National Defense Authorization Act of 1995 (Public Law 103-337) to ensure a nationwide, multi-State infrastructure to support the 6.1 basic research needs of the Department of Defense. Today, 21 States and two territories participate in DEPSCoR, receiving grants from the Department to perform research that directly responds to specific priorities identified by the Department and announced under competitive solicitations to the eligible DEPSCoR States.

At the program's peak funding level, DEPSCoR received nearly \$25 million to fund Department of Defense basic research in eligible States. In recent years, Congress has generously provided funding for DEPSCoR between \$15 million and \$17 million, and has affirmatively rejected efforts by the previous administration to reduce the size of the DEPSCoR program.

Additionally, in the fiscal year 2009 National Defense Authorization Act, the Senate directed a federally funded research and development center assessment of the DEPSCoR program to determine its value to the Department and to the American taxpayer. The Institute for Defense Analyses (IDA) was entrusted with the assessment and concluded in its study that DEPSCoR has strengthened the nationwide basic research capacity in the following areas:

- DEPSCoR awards have funded first-time investigators in defense-related basic research;
- DEPSCoR awards have contributed to publications and patents;
- DEPSCoR awards have supported graduate student and postdoctoral training;
- DEPSCoR awards have supported purchase and maintenance of cutting edge research equipment; and
- DEPSCoR awards have supported collaborations among researchers in all States.

Perhaps most importantly, the IDA assessment determined that the DEPSCoR States' share of non-DEPSCoR Department of Defense science and engineering funding increased steadily from inception of the program to today. This finding provides firm evidence that DEPSCoR is a valuable use of taxpayer dollars because it demonstrates that DEPSCoR provides a return on investment to the Department of Defense that far exceeds the funding amount provided for the program each year.

Mr. Chairman, DEPSCoR is also a valuable use of taxpayer dollars because it represents Federal research money well spent. Past DEPSCoR research has included:

- designing helicopter rotors;
- modeling sea ice predictions to aid ship and submarine navigation;
- prediction of river currents for Navy operations;
- securing critical software systems;
- developing chem.-biodefense agents;
- enhancing stored energy density for weapons;
- improving wireless communication for warfighter systems;
- determining the effect of exposure of military personnel to extreme physical and climatic conditions;
- preventing laser damage to aircraft optical guidance systems;
- increasing durability of lightweight composite materials; and

¹Alabama, Alaska, Arkansas, Delaware, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Puerto Rico, Rhode Island, South Carolina, South Dakota, Vermont, Virgin Islands, West Virginia, and Wyoming.

States in bold letters are eligible for the DEPSCoR program. All of the States listed above are also eligible for the EPSCoR program.

—developing small plastic air-vehicles for the Air Force.

Despite this important work, and despite the positive assessment provided to the Senate by the Institute for Defense Analyses, the administration's proposed fiscal year 2010 Department of Defense budget recommends no funding for DEPSCoR. The 23 DEPSCoR eligible jurisdictions must therefore rely on Congress once again to ensure the DEPSCoR program is adequately funded at a level that ensures our Nation maintains a nationwide infrastructure of Department of Defense research capabilities.

Mr. Chairman, every State has important contributions to make to our Nation's research competitiveness and every State has scientists and engineers that can contribute significantly to supporting the research needs of the Department of Defense. Accordingly, it is vital that we build a Department of Defense research infrastructure that leaves no State behind. Allowing the DEPSCoR program to go unfunded in fiscal year 2010 will not only create a critical shortfall in our national research infrastructure, but it will likewise have dire consequences for DEPSCoR States that otherwise may not receive an investment of Department of Defense research funding.

As the Committee considers the President's fiscal year 2010 budget proposal for the Department of Defense, the Coalition of EPSCoR/IDeA States, representing major research universities and institutions across 23 participating jurisdictions, respectfully requests that the DEPSCoR program be funded at a minimum of \$20 million. Participating DEPSCoR institutions continue to advance the basic research priorities of the Department of Defense and it is the sincere hope of our Coalition that this Subcommittee will consider robustly funding the DEPSCoR program in fiscal year 2010.

The Coalition of EPSCoR/IDeA States is grateful for this opportunity to testify before the Subcommittee. We look forward to continuing to work with the Senate to ensure the DEPSCoR program fully supports our Nation's critical research infrastructure requirements.

Thank you Mr. Chairman.

Chairman INOUE. And our next witness is the president and chief executive officer of the Lupus Foundation of America, Ms. Sandra Raymond.

Ms. Raymond?

STATEMENT OF SANDRA C. RAYMOND, PRESIDENT AND CHIEF EXECUTIVE OFFICER, LUPUS FOUNDATION OF AMERICA, INC.

Ms. RAYMOND. Thank you, Chairman Inouye, Ranking Member Cochran, and all of the subcommittee members. We thank you for the work that you are doing to serve and protect our country and the health of our servicemen and women. I'm here today to talk with you about a largely undiagnosed health issue of concern in the military and in the population at large, and that is lupus.

In April 2003, a 22-year-old female soldier was about to be deployed to Iraq. As is the practice, she was given the standard battery of vaccines, and soon after she received the shots, she died. This soldier had undiagnosed lupus, and the live viruses in the vaccine were said, by a panel of medical experts, to have caused a fatal reaction.

In people with compromised immune systems, live viruses and other triggers can cause the body to attack its own tissues and organs, and this can lead to morbidity and death.

Lupus is a chronic, life-threatening disease of the immune system. It's the prototypical autoimmune disease, and learning more about it will provide clues to understanding autoimmune diseases that affect 23 million Americans.

The disease principally affects young women in their child-bearing years, but men and children also develop lupus. It is two to three times more common among African-Americans, Hispanics,

Asian Americans and Pacific Islanders, and American Indians. This health disparity remains unexplained.

Three issues make lupus directly relevant to the DOD's medical research program.

First, vaccinations given routinely to American servicemen and women may trigger fatal reactions, especially since military doctors have no way to screen for lupus or underlying autoimmune diseases.

Second, lupus disproportionately affects minority populations and young people, those most likely to be in the military. Minorities comprise over one-third of the active duty military members; and among enlisted women the percentage in 2004 was almost 40 percent.

Third, environmental stresses are known to cause lupus. We know that genes linked to lupus are triggered by environmental, hormonal, and stress factors. These may be exacerbated by intense training, foreign deployment, exposure to chemical agents, battle, and more.

But, there is a way to insure that military personnel are protected, and that is through identification of biological markers that can detect lupus. We all know that measurement of blood pressure or cholesterol are biological markers that can tell us if we're at risk for cardiovascular disease or stroke. In lupus, scientists have now identified a number of biomarkers that are prime candidates for validation. And, once validated, an early detection test can be developed to screen for lupus. With the leadership of military lupus scientists, and academic centers across the United States, this research can get off to a running start.

While it's important that lupus remain in the peer-review program, we respectfully ask you to consider initiating what we call the Lupus Biomarker and Test Development Research Project. As part of the defense program, or the clinical investigation program of force health protection and readiness, establishing this program has the potential to save lives. Start-up costs are estimated to be \$6 million.

We thank you for the opportunity to speak today, and we look forward to working with you to address this public health issue.

Thank you.

Chairman INOUE. Thank you very much, Ms. Raymond.

[The statement follows:]

PREPARED STATEMENT OF SANDRA C. RAYMOND

Chairman Inouye, Ranking Member Cochran, and Distinguished Subcommittee Members, my name is Sandra Claire Raymond and I am the President and CEO of the Lupus Foundation of America. I want to take this opportunity to thank you for all you are doing to serve and protect our country and the health of our servicemen and women.

In April of 2003, a 22-year-old female soldier about to be deployed to Iraq was given the standard battery of vaccines and soon after these were administered she died. This soldier had undiagnosed lupus and live viruses in the vaccines triggered a fatal reaction. Lupus is a chronic and life-threatening disease that causes the immune system to become unbalanced, causing inflammation and tissue damage to virtually every organ system. It is the prototypical autoimmune disease and learning more about lupus will have broad-ranging implications for the estimated 23 million Americans suffering from autoimmune diseases. Lupus affects women, men and children, but, women in their child-bearing years are most at risk. The disease is two to three times more common among African Americans, Hispanics, Asian Amer-

icans and Pacific Islanders and American Indians. This health disparity remains unexplained. A recent study indicates that lupus annually costs the Nation an estimated \$31.4 billion in direct and indirect expenditures.

Here are the issues that are directly relevant to the DOD's medical research programs:

- Vaccinations given routinely to American Service men and women may trigger fatal reactions. Military physicians have no way to screen personnel for lupus or other autoimmune diseases prior to administering necessary vaccinations.
- Lupus disproportionately affects minorities and young people—those most likely to be in the military. Minorities comprise over one third of the active duty military members. 2004 statistics indicate that among active duty enlisted women, the minority percentage is even higher: 38.7 percent are minorities. And, again the 2004 statistics indicate that African Americans make up 18.3 percent of the military but less than 13 percent of the general population. African Americans are among those most at risk for lupus. Their disease begins earlier in life and is generally more severe. More than 90 percent of active duty military personnel are age 40 or younger and lupus strikes people between the ages of 15 and 44. In 2004, 11,000 individuals with lupus, active duty personnel and dependents, receive care through the DOD healthcare system and that number has been increasing in these last 5 years.
- Environmental stresses are known to cause lupus flares. Genes linked to lupus may be triggered by environmental, hormonal and stress factors exacerbated by intense training, foreign deployment, exposure to unaccustomed environment, chemical agents, battle and trauma.

Chairman Inouye, I want to thank you and the Congress for naming lupus as one of the diseases that can be researched under the Peer Reviewed Medical Research Program. The research projects that have been funded since 2005 have provided valuable insights into this devastating disease. However, in order to ensure that military personnel and their families are protected, there is an urgent and unmet need to validate biomarkers to detect lupus. Scientists have identified a number of biomarkers that are now ready for validation and this work will lead to an early detection test to screen for lupus. In fact, there is a network of academic medical centers across the country interested in this project and with leadership and coordination from the military lupus scientists, this project can get off to a running start. We ask that lupus remain in the congressionally directed Peer Reviewed Medical Research Program; however, in addition, we believe that lupus biomarker and test development research should originate in the DOD's Defense Health Program. With respect, we ask for \$6 million to establish this program. Thank you for providing me with this opportunity to speak today and I look forward to working with all of you to help improve the lives of our soldiers living with lupus.

Chairman INOUE. Our next witness is Dr. Zitnay, co-founder of the Defense and Veterans Brain Injury Center.

STATEMENT OF GEORGE A. ZITNAY, Ph.D., CO-FOUNDER, DEFENSE AND VETERANS BRAIN INJURY CENTER

Dr. ZITNAY. Good morning, Mr. Chairman, Vice Chairman Cochran. It's a pleasure to be with you today.

As the chairman stated, I'm the co-founder of the Defense and Veterans Brain Injury Center, and I recently retired, so I'm here today as a volunteer on behalf of the participants in the 2008 International Conference on Behavioral Health and Traumatic Brain Injury, convened at the request of the Congressional Brain Injury Task Force, chaired by Mr. Bill Pascrell and Todd Platts.

I come before you today to request \$370 million in funding for brain injury care, research, treatment, and training, through the Defense and Veterans Brain Injury Center, an affiliate of the Defense Center of Excellence in Psychological Health and TBI. As you know, TBI is the signature injury in the wars in Iraq and Afghanistan, affecting over 360,000 of our troops. Some 300,000 have also been identified as experiencing post traumatic stress disorder.

Blast-related injuries, extended deployments, all contribute to the unprecedented number of warriors suffering from TBI and psy-

chological conditions such as anxiety, depression, PTSD, and, unfortunately, suicide.

The long-term effects and consequences of TBI and PTSD will cost millions unless we start treating now, with available technology that is now currently available in the private sector.

In a report to Congress issued earlier this year, the experts at the international conference noted that the private sector—mostly academic centers of excellence across the country, and major clinics—have available the advanced technology and treatments that should be made available now to our men and women, and our wounded warriors, especially in the rural areas. They will benefit from this advanced care through the use of telemedicine and rehabilitation.

For example, new technology, and new advances in brain imaging, reveals that even the most severe—the most severe TBI patient improves, with brain stimulation. It's electrical stimulation applied to the inner brain. This helps the individual wake up. And once they wake up we can then provide rehabilitation until they gain function. We also know that neutraceuticals can also help repair brain tissue.

Our request includes \$50 million for a—DVBIC demonstration project, to utilize these advanced techniques to improve the standard of care for severe TBI patients. While many with severe TBI will never return to active duty, some may, if they get this advanced technology. But, most importantly, they will be able to live a life worth living.

DVBIC is a partnership between the DOD and the VA with the—trauma centers, and it was created by Congress to ensure the optimum care is given.

Finally, we request \$20 million for education and training of brain injury specialists. There is confusion between mild TBI and PTSD, but they are distinct conditions. TBI can be mild, as in concussion, or severe, as in unresponsive states of consciousness. Training is particularly needed in our rural areas of the country, as some of our young men and women who return home never get the chance to seek treatment, because it is too far away.

Thank you for your leadership; thank you for your support of the Defense and Veterans Brain Injury; but most of all for your care for our wounded warriors.

Chairman INOUE. Thank you very much, Dr. Zitnay.

[The statement follows:]

PREPARED STATEMENT OF GEORGE A. ZITNAY

Dear Chairman Inouye, Vice Chairman Cochran and Members of the Senate Appropriations Subcommittee on Defense: Thank you for this opportunity to submit testimony in support of funding brain injury programs and initiatives in the Department of Defense. I am George A. Zitnay, PhD, a neuropsychologist and co-founder of the Defense and Veterans Brain Injury Center (DVBIC).

I have over 40 years of experience in the fields of brain injury, psychology and disability, including serving as the Executive Director of the Kennedy Foundation, Assistant Commissioner of Mental Retardation in Massachusetts, Commissioner of Mental Health, Mental Retardation and Corrections for the State of Maine, and a founder and Chair of the International Brain Injury Association and the National Brain Injury Research, Treatment and Training Foundation. I have served on the Advisory Committees to the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), was an Expert Advisor on Trauma to the

Director General of the World Health Organization (WHO) and served as Chair of the WHO Neurotrauma Committee.

In 1992, as President of the national Brain Injury Association, I worked with Congress and the Administration to establish what was then called the Defense and Veterans Head Injury Program (DVHIP) after the Gulf War as there was no brain injury program at the time. I have since worn many hats, and helped build the civilian partners to DVBIC: Virginia NeuroCare, Laurel Highlands and DVBIC-Johnstown. I recently retired as an advisor to the Department of Defense (DOD) regarding policies to improve the care and rehabilitation of wounded warriors sustaining brain injury.

I am pleased to report that DVBIC continues to be the primary leader in DOD for all brain injury issues. DVBIC has come to define optimal care for military personnel and veterans with brain injuries. Their motto is “to learn as we treat.”

The DVBIC has been proactive since its inception, and what began as a small research program, the DVBIC now has 19 sites.¹ In 2007 your committee helped move DVBIC funding from under the auspices of the Uniformed Services University of the Health Sciences (USUHS) over to the Army’s Medical and Materiel Command at Fort Detrick. DVBIC is now the key operational component for brain injury of Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) under DOD Health Affairs.

I am here today to ask for your support for \$370 million in the Defense Appropriations bill for fiscal year 2010 for the DCoE which includes \$50 million specifically for a consortium of private sector entities to partner with DCoE and DVBIC to move the standard of care for brain injury forward, as well as \$20 million for education and training of brain injury specialists.

As you know, traumatic brain injury (TBI) is the “signature injury” of the conflicts in Iraq and Afghanistan, affecting some 360,000 service personnel and some 300,000 have experienced post traumatic stress disorder (PTSD). Blast-related injuries and extended deployments are contributing to an unprecedented number of warriors suffering from traumatic brain injury (ranging from mild, as in concussion, to severe, as in unresponsive states of consciousness) and psychological conditions such as anxiety, depression, PTSD and suicide.

The Rand Corporation, DOD, and CDC report that the long term effects and consequences of TBI, PTSD, and other psychological health issues will cost billions of dollars in care, treatment, and rehabilitation unless action is taken. The Rand Report estimates that PTSD-related and major depression-related costs could range from a 1-year cost of \$25,000 in mild cases to \$408,000 for severe cases. The total cost for TBI-related health issues is in the billions of dollars and does not include the lost productivity or the deleterious effects to quality of life. In reality, it has been well-established that the health care needs of our young service members returning from OIF/OEF are not being met and are overwhelming the current veterans’ health care system that has been primarily designed to care for elderly veterans.

In 2005, the Conemaugh International Symposium, brought together 60 of the world’s finest neuroscientists and physicians from across the United States and from 12 other nations, including representatives from the National Institutes of Health (NIH), CDC, DOD, Veterans Administration (VA), and the National Institute for Disability and Rehabilitation Research, resulting in a strong recommendation for United States Congressional action to significantly improve outcomes in wounded warriors with traumatic brain injury. In addition, the Symposium report called for the creation of Seven Centers of Excellence in TBI treatment, research and training to be located across the Nation.

A second international meeting on Disorders of Consciousness produced the Mohonk Report, in which scientists, ethicists, physicians, and family members from across the United States, as well as leading neuroscientists from Israel, Europe, and South America, collaborated to prepare an action report to Congress that focused on Improving Outcomes for Individuals with Disorders of Consciousness. The report called on Congress to fund a network of highly specialized centers, utilizing the lat-

¹Walter Reed Army Medical Center, Washington, DC; Landstuhl Regional Medical Center, Germany; National Naval Medical Center, Bethesda, MD; James A. Haley Veterans Hospital, Tampa, FL; Naval Medical Center San Diego, San Diego, CA; Camp Pendleton, San Diego, CA; Minneapolis Veterans Affairs Medical Center, Minneapolis, MN; Veterans Affairs Palo Alto Health Care System, Palo Alto, CA; Fort Bragg, NC; Fort Carson, CO; Fort Hood, TX; Camp Lejeune, NC; Fort Campbell, Kentucky; Boston VA, Massachusetts; Virginia Neurocare, Inc., Charlottesville, VA; Hunter McGuire Veterans Affairs Medical Center, Richmond, VA; Wilford Hall Medical Center, Lackland Air Force Base, TX; Brooks Army Medical Center, San Antonio, TX; Laurel Highlands, Johnstown, PA; DVBIC-Johnstown, PA.

est technology available, to significantly improve outcomes for wounded warriors living in the minimally conscious state.

A third follow-up meeting of experts, the Symposium on Severe and Minimally Conscious Wounded Warriors, occurred in the spring of 2008, in Johnstown, Pennsylvania. This meeting rendered a Feasibility Study on treating wounded warriors with disorders of consciousness which was subsequently delivered to the DVBIC for consideration.

Based upon the history and results of these international meetings, the International Conference on Behavioral Health and Traumatic Brain Injury was convened in October 2008, hosted by Congressmen Bill Pascrell and Todd Platts, co-chairs of the Congressional Brain Injury Task Force, and sponsored by the DOD, DVBIC, and numerous other groups to prepare recommendations for action and funding by the United States Congress.

The Executive Report from this meeting of over 100 international experts generated critical recommendations in the areas of Research, Education, Assessment, Family, and Treatment. The authors of the report concluded: "The over-arching goal is to provide our wounded warriors and their families with what they deserve: the best health care and support services that our state-of-the-art science and medicine have to offer. In doing so, we will create a standard of excellence in military health care, research, and training that will serve as an exemplary model for the rest of the world." The report requested from Congress a total of \$350 million in funding to achieve that goal.

On March 12, 2009 representatives of the International Conference unveiled a Report to Congress (the Paterson Report) calling for action now to improve the care of wounded warriors.

The Paterson Report noted:

- new advances in brain imaging are revealing that even those with the most severe levels of TBI have preserved brain tissue which can be used through deep brain electrical stimulation to help the individual wake up and regain function;
- new advanced technologies can help those wounded warriors with loss of sight regain some vision;
- new cognitive prostheses can help those wounded warriors with severe memory loss regain the ability to plan and remember;
- neutraceuticals can help restore parts of damaged brains; and
- new screening and early automated psychological tools and tests can help detect those at risk for PTSD and other psychological disorders.

What we need to do now is to make these advanced technologies and treatments that are available in the private sector available to our wounded warriors, and we need to offer services and clinics in our rural areas through telemedicine and tele-rehabilitation.

TREAT NOW CONSORTIUM

Our funding request includes \$50 million specifically for the work of a consortium of private sector providers (called TREAT NOW: Treatment and Research Excellence Achieved Today: Neuroscientists for Our Warriors) who have come together to improve the standard of care of wounded warriors as soon as possible.

For those warriors who have sustained the most severe TBIs, the recommendations from the Reports of the Aspen and Mohonk Meetings are not being followed. Thus, the current standard of care for these warriors is inconsistent, clinically unreliable, and not maximally effective. The exact number of these wounded warriors from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) who suffer from severe disorders of consciousness (SDOC) is unknown. The DVBIC reports that 4 percent of the 15,000 TBI patients examined and/or treated by their Center suffer from SDOC. This is an underestimation of the true number of warriors because it does not include those seen or treated at other military hospitals and programs and the dependents of wounded warriors and veterans.

Serving under the auspices of the DCoE, the Consortium will complement, and partner with the DVBIC and the National Intrepid Center of Excellence (NICoE) in their vision and commitment to improve the current system of medical care and support for troops sustaining severe TBIs. The partners include some of the best scientists, researchers and rehabilitation specialists from around the United States. While geographically diverse, participating members are heavily invested in improving tele-health technologies. There is no project like it and DOD Health Affairs is interested in moving it forward.

Much has been accomplished by the DCoE in its efforts to improve public awareness of TBI and psychological disorders, address the stigma associated with such conditions, and help connect family, caregivers and wounded warriors with appropriate information, treatment and services.

There are concerns however about an overemphasis on psychological disorders that affects the public perception of TBI. Many in the brain injury medical and family support community do not want to see TBI becoming considered a “psychological disorder.” This concern comes from the fact that in no other health care system are psychological issues and brain injury combined—not in the DVA, NIH, or any university medical program. Brain injury specialists and family advocates want to be assured that as much focus and funding is being put into the science of brain injury rehabilitation and treatment as is being put into the psychological effects of combat. Of the 25 programs funded under the Congressionally Directed Medical Research Program with 2007 supplemental funding, only 8 were for brain injury.

We must not lose sight of the actual cause of subsequent psychological problems. TBI can lead to depression and suicide but TBI is not itself a psychological disorder. Treatments for TBI and PTSD are not only different, but can be contraindicated and make the patient worse. In working with the Wounded Warrior Project, I have heard many stories of warriors with brain injury not getting the right treatment because they were sent to a psychologist instead of a neuropsychologist and given drugs for PTSD that exacerbated the effects of TBI.

There are harmful reports like the USA Today article on April 15, 2009², in which Cols. Charles Hoge and Carl Castro argue that the DOD and DVA are overemphasizing mild TBI among troops and that the focus should be more on the symptoms rather than the cause. Citing the Hoge-Castro article in *The New England Journal of Medicine*, USA Today reports that “symptoms blamed on TBI after troops return home likely are due to depression, PTSD or substance abuse . . . and overemphasis on mild TBI keeps troops with those conditions from being properly treated . . . most troops who suffered a concussion in battle recovered within days of the injury.” This is very damaging to the efforts to improve public awareness of TBI.

A plethora of leading brain injury specialists dispute Hoge and Castro’s claims and urge caution in making changes to screening procedures. David Hovda, PhD, Director of the Brain Injury Research Center at UCLA, strongly recommended continuing screening, saying that without it, troops may develop long-term neurological problems after numerous concussions, similar to former professional football players. Research conducted at the Defense Advanced Research Projects Agency (DARPA) shows that the most common cause of TBI in combat, blast injury, causes a range of injury from mild (concussion) to severe.

I urge your Committee to recommend that DOD continue its practice of screening which is based on the best science available and offers troops the best chance at recovery.

In addition the Paterson Report recommended that the National Institutes of Health and the DOD convene a “Consensus Conference” to clearly define mild TBI and PTSD and establish specific standards for treatment. The Report recommended that definitions and treatment standards be evidence based and incorporate a thorough review of available treatment programs and outcome measures. The Report urged the Consensus Conference to strive to equitably involve all stakeholders.

The confusion has devastating effects when it results in wounded warriors not seeking treatment. DVBIC officials have reported that troops are now less likely to seek help for mild brain injury if it is considered to be a “psychological disorder.”

President Obama made a speech last week regarding health care reform and urged that we “fix what’s broken and move forward with what works.” The same should be said about improving DOD’s health system. While the increase in suicides has brought public attention to the stresses of combat, the complex issues of TBI should not get lost or overlooked. The research and treatment for TBI must remain distinct and the focus of the DVBIC must be preserved. DVBIC needs to continue to be recognized as the center of excellence in providing brain injury care and research.

\$20 MILLION FOR EDUCATION AND TRAINING BRAIN INJURY SPECIALISTS

We recommend an additional \$20 million be appropriated specifically for training medical students in brain injury diagnosis, treatment and rehabilitation. We need

²Zoroya, Gregg, “Officials: Troops Hurt by Brain Injury Focus,” USA Today, April 15, 2009.

more brain injury specialists in the medical field. More neurologists, neuropsychologists and psychiatrists and rehabilitation specialists should be educated by the Uniformed Services University for the Health Sciences.

In summary, we respectfully request \$370 million for fiscal year 2010 to enhance ongoing projects of the DCoE and to develop new initiatives to improve the care of wounded warriors and support for their families. We need to assure that our brave men and women who are injured in the course of duty are given every possible opportunity for the best medical care, rehabilitation and community reentry assistance that we as a Nation can provide.

Thank you for your consideration of this request to help improve the care of our wounded warriors.

Chairman INOUE. Our next witness is the director of legislation, Association of the United States Navy, Captain Ike Puzon.

STATEMENT OF CAPTAIN IKE PUZON, UNITED STATES NAVY (RET.), DIRECTOR OF LEGISLATION, ASSOCIATION OF THE UNITED STATES NAVY

Captain PUZON. Mr. Chairman, Mr. Vice Chairman, and the Association of the United States Navy is grateful to have the opportunity to testify today.

Our newly transitioned association is now focused on equipment, force structure, policy issues, manpower issues, for a total force.

Your unwavering support for our deployed servicemembers in Iraq and Afghanistan and the worldwide fight against terrorism is of crucial importance. AUSN would like to highlight three areas of importance.

The C-40—first, the C-40 aircraft originally listed in the unfunded list, to replace critically overused C-20G aircraft, and to replace overaged and overused C-9 transport, both are playing a vital role in Iraq and Afghanistan and worldwide contingency operations.

Second, the EF-18 Growler aircraft for U.S. Navy and U.S. Navy Reserves, specifically in the Navy Reserve, to replace aged aircraft in a Maryland-based squadron that is currently deployed to Iraq and Afghanistan.

And finally, number three, stabilization of authorized end-strength for active Navy and Navy Reserve.

In recent years, the Pentagon has recommended the repeal of separate budget requests for procurement Reserve equipment. A combined appropriations for each service does not guarantee needed equipment for National Guard and Reserve components. We do not agree with the Pentagon's position on this issue, and ask that the subcommittee continue to provide separate appropriations against National Guard and Reserve equipment.

For the foreseeable future, we must be realistic about what the unintended consequences are for a very high rate of usage for active and Reserve components. Our active duty Navy and the current Reserve members are pleased to making it—a significant contribution to the Navy's defense as operational forces. However, the reality of it all is that the added stress on the total force could pose long-term consequences for our country in terms of recruiting, retention, and family support. The Navy has a total of over 10,000 people—personnel deployed in Operation Iraqi Freedom (OIF). The Navy Reserve continues to mobilize 4,500 sailors for the support of the ongoing global war on terror (GWOT). Your Navy is engaged throughout.

We recognize that there are many issues that need address by the subcommittee. We are perplexed by the short Navy unfunded program list. History points to a larger list. Overwhelmingly, we hear that—discussions and requirements for more and better equipment for training total force is necessary.

In summary, we believe the subcommittee needs to address the following issues for total force, in the best interest of our national security: fund the C-40A for Navy Reserve and Navy, per previous supplementals, and we replace the C-9 transport and the C-20G; fund the E/F-18 Growler; increase funding for the National Guard and Reserve equipment; and establish end-strength stabilization for the Navy and Navy Reserve.

Thank you for your—opportunity.

Chairman INOUE. Thank you very much, Captain Puzon.

[The statement follows:]

PREPARED STATEMENT OF IKE PUZON

Mister Chairman and distinguished members of the Committee, the Association of the United States Navy is very grateful to have the opportunity to testify.

Our newly transitioned association looks at equipment, force structure, policy issues, and manpower issues.

We would like to thank this Committee for the on-going stewardship on the important issues of national defense and, especially, the reconstitution and transformation of the Navy. At a time of war, non-partisan leadership sets the example.

Your unwavering support for our deployed Service Members in Iraq and Afghanistan and the world-wide fight against terrorism and piracy is of crucial importance. AUSN would like to highlight some areas of emphasis.

—C-40A Aircraft to replace critically overused C-20G in Hawaii and Maryland; and, to replace over aged C-9 transports—both are playing a vital role in Iraq and Afghanistan. They are not VIP aircraft—but, can be used for such missions.

—EF/A 18 Growler aircraft for U.S. Navy and U.S. Navy Reserve—specifically to replace aged aircraft in a Maryland based squadron that is currently deployed to Iraq and Afghanistan.

—C-130J aircraft—to meet the intra-theater needs of the Geographic Commanders and Navy component commanders.

These issues are in line with all previous years Navy and Navy Reserve unfunded list.

As a Nation, we need to supply our service members (active duty and reserve) with the critical equipment and support needed for individual training, unit training, and combat.

In recent years, the Pentagon has recommended the repeal of separate budget requests for procuring Reserve Equipment. A combined equipment appropriation for each service does not guarantee needed equipment for the National Guard and Reserve Components. For the Navy Reserve, this is especially true. We do not agree with the Pentagon's position on this issue and history has proven the requirements for NGREA, and we ask this committee to continue to provide separate appropriations against NG and RE requirements.

In addition to equipment to accomplish assigned missions, AUSN believes that the Administration and Congress must make it a high priority to maintain, if not increase, the end strengths of already overworked, and perhaps even overstretched, military forces. This includes the Active Duty Navy & Navy Reserve. The Navy Reserve has always proven to be a highly cost-effective and superbly capable operational and surge force in times of both peace and war. At a minimum, the Navy Reserve should be stabilized since they are deployed with active forces in Iraq and Afghanistan.

For the foreseeable future, we must be realistic about what the unintended consequences are from a high rate of usage. History shows that a Reserve force is needed for any country to adequately meet its defense requirements, and to enable success in offensive operations. Our Active Duty Navy and the current Reserve members are pleased to be making a significant contribution to the Nation's defense as operational forces; however, the reality of it all is that the added stress on the Reserve could pose long term consequences for our country in recruiting, retention, family and employer support. This issue deserves your attention in Family Support

Programs, Transition Assistance Programs and for the Employer Support for the Guard and Reserve programs.

At the same time, the Navy has a total of over 10,000 personnel deployed in OIF/OEF theaters; Navy Reserve continues to mobilize over 4,500 Sailors in support for the on-going GWOT. Your Navy is engaged throughout the world in operations.

Care must be taken that that tremendous reservoir of operational capability be maintained and not capriciously dissipated. Officers, Chief Petty Officers, and Petty Officers need to exercise leadership and professional competence to maintain their capabilities. There is a risk that they will not be able to do so in the present model of utilization of Navy Reserve and Active Duty IA utilizations.

AUSN is perplexed by this year's Navy Unfunded Programs list provided by the Chief of Naval Operations. We fully support CNO's unfunded list. However, history points at a much larger unfunded list and the needs are there.

Specific Equipment and Funding needs of the Navy Reserve include:

—C-40 funding to replace dangerously aged C-9s. These are war fighting logistic weapons systems. 2 Aircraft were programmed for fiscal year 2009 supplemental, and 4 were programmed for fiscal year 2009 funding. The Navy did not get these funded. We have to replace aging C-9s to maintain Navy and Marine Corps engagement in the GWOT.

First:

—It is the Navy's only world-wide intra-theater organic airlift, operated by the U.S. Navy.

—Navy currently operates 9 C-40As, in three locations: Fort Worth, Jacksonville, San Diego.

—These aircraft are needed for Hawaii, Maryland, Texas and Washington units.

—A pending CNA study—substantiates the requirements for 31-35 C-40As to replace aging C-9s.

Second:

—CNO, SECNAV, & DOD have supported the requirement for C-40As.

—Commander, Naval Air Force 2007 Top Priority List stated the requirement for at least 32 aircraft.

Third:

—Current average age of remaining C-9s that the C-40 replaces is: 38 years.

—There will be no commercial operation of the C-9s or derivatives by 2011.

—C-9s can not meet the GWOT requirement, due to MC rates, and availability of only 171 days in 2006.

—Modifications required to make C-9s compliant with stage III Noise compliance, and worldwide Communications/Navigation/Surveillance/Air Traffic Management compliance—are cost prohibitive.

—There are growing concerns about the availability and Mission Capability rates of the C-20Gs at Hawaii and Maryland units.

Fourth:

—737 Commercial Availability is slipping away, if we do not act now; loss of production line positions in fiscal year 2008-09—due to commercial demand would slip to 2013, and increase in DOD, Service expenditures.

—C-130J procurement funding for 6 C-130s for the Navy Reserve.

—E/F-18 Growler procurement to replace aged and retiring EA-6B aircraft at Maryland units, and for Active Duty Navy usage. Currently the NR EA-6B unit provides 90 continuous detachments in support of OIF/OEF.

—A full range of Navy Expeditionary Command equipment.

People join the Reserve Components to serve their country and operate equipment. Recruiting and retention issues have moved to center stage for all services and their reserve components. In all likelihood the Navy will not meet its target for new Navy Reservists and the Navy Reserve will be challenged to appreciably slow the departure of experienced personnel this fiscal year. We've heard that Reserve Chiefs are in agreement, expressing concern that senior personnel could leave when equipment is not available for training. Besides reenlistment bonuses which are needed, we feel that dedicated Navy Reserve equipment and Navy Reserve units are a major factor in recruiting and retaining qualified personnel in the Navy Reserve.

Overwhelmingly, we have heard Reserve Chiefs and Senior Enlisted Advisors discuss the need and requirement for more and better equipment for Reserve Component training. The Navy Reserve is in dire need of equipment to keep personnel in the Navy Reserve and to keep them trained. We must have equipment and unit cohesion to keep personnel trained. This means—Navy Reserve equipment and Navy Reserve specific units with equipment.

THE RESERVE COMPONENT AS A WORKER POOL

Issue: The view of the Reserve Component that has been suggested within the Pentagon is to consider the Reserve as of a labor pool, where Reservists could be brought onto Active Duty at the needs of a Service and returned, when the requirement is no longer needed. It has also been suggested that an Active Duty member should be able to rotate off active duty for a period, spending that tenure as a Reservist, returning to active duty when family, or education matters are corrected.

Position: The Guard and Reserve should not be viewed as a temporary-hiring agency. Too often the Active Component views the recall of a Reservist as a means to fill a gap in existing active duty manning.

EQUIPMENT OWNERSHIP

Issue: An internal study by the Navy has suggested that Naval Reserve equipment should be transferred to the Navy. At first glance, the recommendation of transferring Reserve Component hardware back to the Active component appears not to be a personnel issue. However, nothing could be more of a personnel readiness issue and is ill advised. Besides being attempted several times before, this issue needs to be addressed if the current National Security Strategy is to succeed.

Position: The overwhelming majority of Reserve members join the RC to have hands-on experience on equipment. The training and personnel readiness of Reserve members depends on constant hands-on equipment exposure. History shows, this can only be accomplished through Reserve equipment, since the training cycles of Active Components are rarely if ever—synchronized with the training or exercise times of Reserve units. Additionally, historical records show that Reserve units with hardware maintain equipment at or higher than average material and often better training readiness. Current and future war fighting requirements will need these highly qualified units when the Combatant Commanders require fully ready units.

Reserve and Guard units have proven their readiness. The personnel readiness, retention, and training of Reserve and Guard members will depend on them having Reserve equipment that they can utilize, maintain, train on, and deploy with when called upon. Depending on hardware from the Active Component, has never been successful for many functional reasons. The AUSN recommends the Committee strengthen the Reserve and Guard equipment appropriation in order to maintain optimally qualified and trained Reserve and Guard personnel.

In summary, we believe the Committee needs to address the following issues for Navy and Navy Reservists in the best interest of our National Security:

- Fund C-40A for the Navy Reserve, per the fiscal year 2009 Supplemental; we must replace the C-9s and replace the C-20Gs in Hawaii and Maryland.
- Fund 6 C-130Js for the Navy Reserve, per the CNO unfunded list.
- Moratorium on Active Duty end-strength cuts.
- Establish an End-strength cap of 68,000 as a floor for end strength to Navy Reserve manpower—providing for surge-ability and operational force.
- Increase funding for Naval Reserve equipment in NAREA
 - E/F-18 Growler aircraft for Navy and Navy Reserve units, especially the NR unit stationed in Maryland.
 - Explosive Ordnance Disposal Equipment

We thank the committee for consideration of these tools to assist the Navy and Navy Reserve in an age of increased sacrifice and utilization of these forces.

Thank you for your ongoing support of the Nation, the Armed Services, The United States Navy, The United States Navy Reserve, and the fine men and women who defend our country.

Chairman INOUE. Our next witness represents the Mesothelioma Applied Research Foundation, Ms. Mary Hesdorffer.

STATEMENT OF MARY HESDORFFER, NURSE PRACTITIONER, MEDICAL LIAISON, MESOTHELIOMA APPLIED RESEARCH FOUNDATION (MARF)

Ms. HESDORFFER. Good morning, distinguished members of the U.S. Senate Defense Appropriations Subcommittee. Thank you for the opportunity to address you on a cruel cancer that kills our veterans.

My name is Mary Hesdorffer, I'm a nurse practitioner, and I'm the medical liaison to the Mesothelioma Applied Research Foundation.

Your subcommittee has recognized the strong connection between mesothelioma and military service. Because asbestos was heavily used all over Navy ships, millions of servicemen and shipyard workers were exposed. One study found that one-third of today's meso victims were exposed on U.S. Navy ships, or shipyards, like Pearl Harbor, Puget Sound, and Groton.

A renowned meso researcher from Lake Forest just shared with me, the other night, that the rate of veterans who have been exposed to asbestos have a sevenfold increase in mesothelioma over the normal population. Dangerous exposures continue today, and have been reported among the troops in Iraq and Afghanistan, and there's also grave concern for our first responders to 9/11. My son just returned from Iraq, and he was a responder at 9/11, so I have a deep concern over these exposures.

Asbestos is common in buildings, including the utility tunnels right below us. For all those who develop mesothelioma as a result, the only hope is that we will develop an effective treatment, yet mesothelioma has virtually received no Federal funding. Therefore, treatments have not advanced. We only have one approved treatment for this disease; it takes a life expectancy of between 6 to 9 months to, now, 12.2 months.

Your subcommittee has recognized the need and has taken the lead. For the past 2 years, you have directed DOD to spur research for meso by including it in the PR and RP. However, your leadership was thwarted this year. Thirty-eight mesothelioma research grants were submitted to the—for the review year for 2008, which demonstrates a huge interest in mesothelioma. But, while other diseases got six grants each, DOD is funding only one mesothelioma grant.

It's critically needed, our research funding. The research with—Dr. Courtney Broaddus is one of the world's top meso experts, and she told us that, without this grant, she was going to have to close her lab. This really has salvaged her career.

Going forward on an award rate of 2.6 percent is still not enough to encourage top researchers to apply, or new researchers to establish their careers in mesothelioma. The research will not advance, effective treatments will not be found. We believe that the subcommittee must make clear to DOD its intent to spur mesothelioma research by directing DOD to establish funding of \$67 million to DOD for seven new programs, including a peer-reviewed cancer research program that does not currently include mesothelioma.

It's a rapidly fatal, excruciatingly painful cancer, directly related to military service. We ask the subcommittee to appropriate DOD \$5 million for a peer-reviewed cancer research program that will boost the long-neglected field of mesothelioma research, translating directly to saving lives and reducing suffering in veterans.

Thank you.

Chairman INOUE. I thank you very much, Ms. Hesdorffer.

[The statement follows:]

PREPARED STATEMENT OF MARY HESDORFFER

Distinguished members of the U.S. Senate Defense Appropriations Subcommittee: Thank you for this opportunity to address a tragic disease that kills our veterans. My name is Mary Hesdorffer. I am a nurse practitioner with over a decade's experi-

ence in mesothelioma treatment and research, and am the Medical Liaison for the Mesothelioma Applied Research Foundation.

MALIGNANT MESOTHELIOMA

Mesothelioma is an aggressive cancer caused by asbestos. It is among the most painful and fatal of cancers, as it invades the chest, destroys vital organs, and crushes the lungs.

THE "MAGIC MINERAL"—EXPOSURES WERE WIDESPREAD

From the 1930s through the 1970s asbestos was used all over Navy ships. Millions of servicemen and shipyard workers were exposed. Many of them are now developing mesothelioma, following the disease's long latency period.

MESOTHELIOMA TAKES OUR HEROES

These are the people who served our country's defense. Heroes like Admiral Elmo Zumwalt, Jr., Chief Naval Officer during Vietnam, Commander Harrison Starn, who served from World War II through Vietnam, and thousands of servicemen like USS *Kitty Hawk* Boilerman Lewis Deets, who volunteered for Vietnam at barely 18, all struck down by mesothelioma. Last year I testified about mesothelioma patient Bob Tregget, who was exposed to asbestos aboard a nuclear submarine from 1965 to 1972. Following grueling best-available treatment, Bob was recurrent and in extreme untreatable pain. But he was hanging on, hoping the next treatment advance would come soon enough to help him. It didn't and Bob passed away a few months ago.

Almost 3,000 more Americans like Bob die each year of mesothelioma, and one study found that one-third were exposed on U.S. Navy ships or shipyards, lost through service to country just as if they had been on a battlefield.

Many more are being exposed now. Asbestos exposures have been reported among the troops in Iraq and Afghanistan. There is grave concern for the heroic first responders from 9/11, including my son, who just returned from service in Iraq. Asbestos is common in buildings. The utility tunnels in this very building have dangerous levels. Even low-dose, incidental exposures cause mesothelioma. Minnesota Congressman Bruce Vento worked near an asbestos-insulated boiler in a summer college job. He died of mesothelioma in 2000. His wife Sue Vento testified before you in 2007. For all those who will develop mesothelioma as a result of these past or ongoing exposures, the only hope is that we will develop effective treatment.

MESOTHELIOMA FUNDING HAS NOT KEPT PACE

Yet mesothelioma research has been overlooked. With the huge Federal investment in cancer research through the NCI, and \$4.8 billion spent in biomedical research through the DOD Congressionally Directed Research Program since 1992, we are winning the war on cancer and many other diseases. But for mesothelioma, the National Cancer Institute has provided virtually no funding, in the range of only \$1.7 to \$3 million annually over the course of the last 6 years, and the DOD has not invested in any mesothelioma research despite the military-service connection. As a result, advancements in the treatment of mesothelioma have lagged far behind other cancers. In fact, for decades, there was no approved treatment better than doing nothing at all. Our veterans who develop mesothelioma have an average survival of only 4–14 months.

NEW OPPORTUNITIES

But there is good news. Brilliant researchers are dedicated to mesothelioma. The FDA has now approved one drug which has some effectiveness, proving that the tumor is not invincible. Biomarkers are being identified. Two of the most exciting areas in cancer research—gene therapy and anti-angiogenesis—look particularly promising in mesothelioma. The Meso Foundation has funded \$6 million to support research in these and other areas. Now we need the Federal Government's partnership, to develop the promising findings into effective treatments.

COMMITTEE'S LEADERSHIP THWARTED

Your committee has recognized the need and taken the lead. For the past 2 years (fiscal years 2008 and 2009), you have directed DOD to spur research for this service-related cancer by including it as an area of emphasis in the Peer Reviewed Medical Research Program.

However, I have to report to you that unfortunately your leadership in acting to spur mesothelioma research has been thwarted. DOD just announced the results of the PRMRP program for fiscal year 2008. Thirty-eight mesothelioma research projects were submitted. This demonstrates the huge demand for mesothelioma research funding that we testified about and that you directed DOD to address. But while other diseases got six grants each, DOD (tentatively) funded only one researcher (Courtney Broaddus) for a mesothelioma project. This is a successful application rate of just 2.6 percent.

This is critically-needed funding. Dr. Broaddus is one of the world's top mesothelioma researchers. Indeed she was president of the International Mesothelioma Interest Group from 1999 through 2002. She and her team were surviving on three now concluded grants from the Meso Foundation. This DOD grant salvaged career in mesothelioma research. (See attached 5/24/09 email from Dr. Broaddus to Meso Foundation Executive Director Chris Hahn.) We are extremely grateful that thanks to your leadership and the DOD's awarding this one grant this renowned researcher will not have to abandon her investment and expertise in mesothelioma. But 37 other researchers put in the time, effort and expense to gather preliminary data and apply, and then were rejected. What happens to them? Going forward, a success rate of just 2.6 percent will discourage top researchers from applying in mesothelioma; they will direct their effort and expertise into other, better funded cancers. Similarly, new researchers will not establish their careers in mesothelioma either. Mesothelioma research will not advance, effective treatments will not be found, and veterans and current members exposed to asbestos through their military service will be left without hope.

A DEDICATED INVESTMENT

Since the Committee's intent to spur mesothelioma research is not being executed through the PRMRP, we believe the Committee must respond by directing DOD to establish a dedicated mesothelioma program. For 2009, Congress added dedicated funding for all of the following as new programs, in addition to the DOD's existing programs for Breast Cancer, Prostate Cancer, Ovarian Cancer, Neurofibromatosis, Tuberos Sclerosis Complex, and the Peer Reviewed Medical Research Program:

- Autism Research Program, \$8 million;
- Gulf War Illness Research Program, \$8 million;
- Amyotrophic Lateral Sclerosis Research Program, \$5 million;
- Bone Marrow Failure Research Program, \$5 million;
- Multiple Sclerosis Research Program, \$5 million;
- Peer Reviewed Lung Cancer Research Program, \$20 million;
- Peer Reviewed Cancer Research Program, \$16 million, restricted as follows: \$4 million for research of melanoma and other skin cancers as related to deployments of service members to areas of high exposure; \$2 million for research of pediatric brain tumors within the field of childhood cancer research; \$8 million for genetic cancer research and its relation to exposure to the various environments that are unique to a military lifestyle; and \$2 million for non-invasive cancer ablation research into non-invasive cancer treatment including selective targeting with nano-particles.

All of these research areas warrant attention, but mesothelioma is a rapidly fatal, excruciatingly painful cancer directly related to military service. We ask the Committee to appropriate to DOD for fiscal year 2010 \$5 million for a dedicated Mesothelioma Research Program or as a specific restriction within the Peer Reviewed Cancer Research Program. This will boost the long-neglected field of mesothelioma research, enabling mesothelioma researchers to build a better understanding of the disease and develop effective treatments. This will translate directly to saving lives and reducing suffering of veterans battling mesothelioma.

We look to the Senate Defense Appropriations Subcommittee to provide continued leadership and hope to the servicemen and women and veterans who develop this cancer after serving our Nation. Thank you for the opportunity to provide testimony before the Subcommittee and we hope that we can work together to develop life-saving treatments for mesothelioma.

Chairman INOUE. And now may I call upon the secretary treasurer of the American Society of Tropical Medicine and Hygiene, Dr. Jonathan Berman.

STATEMENT OF JONATHAN D. BERMAN, MD, Ph.D., COLONEL, UNITED STATES ARMY (RET.), SECRETARY-TREASURER, AMERICAN SOCIETY OF TROPICAL MEDICINE AND HYGIENE

Dr. BERMAN. Mr. Chairman, ranking member, I welcome the opportunity to testify before you today on behalf of the American Society of Tropical Medicine and Hygiene, ASTMH.

I commend this subcommittee for its focus on the vital issue of military infectious disease research, and the important role of that research in protecting troops deployed abroad.

I am Dr. Jonathan Berman, secretary/treasurer of ASTMH, and a retired U.S. Army colonel.

With nearly 3,500 members, ASTMH is the world's largest professional membership organization dedicated to the prevention and control of tropical diseases. We represent, educate, and support tropical medicine's scientists and clinicians. I want to talk to you today about the importance of funding for the DOD's infectious disease research and particularly malaria research.

Malaria is one of the most serious health threats facing U.S. troops serving abroad. The U.S. military has, for decades, been on the forefront of global efforts to develop new antimalarial drugs and the world's first malaria vaccine. These research efforts are appropriately aimed at protecting and treating the warfighter, but they have important civilian applications, as well. Malaria is one of the greatest infectious-disease killers, and countless lives worldwide have been saved by antimalarial medicines developed in part or primarily by the DOD.

Unfortunately, the parasite that causes malaria, like all microorganisms, is adaptive and develops resistance to drugs quickly. Until very recently, the military's first-line malaria therapeutic and prophylactic agent was mefloquine, a drug developed by military researchers to create a replacement for chloroquine, used soon after World War II.

Mefloquine came into use in the 1980s, but parasites in Southeast Asia have already developed resistance to it, and resistance is now being identified in West Africa and South America, as well. Consequently, the military no longer considers mefloquine to be a first-line treatment, and at this time the military does not have an ideal malarial prophylactic agent. Ensuring that we can protect troops from malaria in future deployments means that we must continue to develop new drugs and an effective vaccine.

Military malaria research funding represented approximately \$23 million in fiscal year 2008, the most recent fiscal year for which figures are available. This level is not commensurate with the health threat malaria poses to military operations, therefore ASTMH respectfully requests that the subcommittee increase funding for malaria research in fiscal year 2010 to \$30 million, and provide subsequent annual increases, ending up at \$77 million in funding in fiscal year 2015.

Mr. Chairman and ranking member, thank you for providing me with the opportunity to speak today on behalf of ASTMH regarding this important but often overlooked defense issue.

Chairman INOUE. Thank you very much, Dr. Berman.

[The statement follows:]

PREPARED STATEMENT OF JONATHAN D. BERMAN

Overview: The American Society of Tropical Medicine and Hygiene (ASTMH) appreciates the opportunity to submit written testimony to the Senate Defense Appropriations Subcommittee. With nearly 3,300 members, ASTMH is the world's largest professional membership organization dedicated to the prevention and control of tropical diseases. We represent, educate, and support tropical medicine scientists, physicians, clinicians, researchers, epidemiologists, and other health professionals in this field.

Because the military operates in and deploys to so many tropical regions, reducing the risk that tropical diseases present to servicemen and women is often critical to mission success. Malaria is a particularly important disease in this respect, because it is both one of the world's most common and deadly infectious diseases, and the U.S. military has a long history of deploying to regions endemic to malaria and suffering malaria casualties as a result.

For this reason, we respectfully request that the Subcommittee expand funding for the Department of Defense's longstanding and successful efforts to develop new drugs, vaccines, and diagnostics designed to protect servicemen and women from malaria while deployed abroad. Specifically, we request that in fiscal year 2010, the Subcommittee ensure that the Department of Defense spends \$30 million on malaria research and development. Furthermore, we request that the Subcommittee provide annual increases such that total military spending on malaria research is \$76.5 million in fiscal year 2015. This funding will support ongoing efforts by military researchers to develop a vaccine against malaria and to develop new anti-malaria drugs to replace older drugs that are losing their effectiveness as a result of parasite resistance. Increased malaria research will help ensure that our soldiers, sailors, airmen, and marines are protected from this deadly disease when deployed to tropical regions.

We very much appreciate the Subcommittee's consideration of our views, and we stand ready to work with Subcommittee members and staff on these and other important tropical disease matters.

ASTMH

ASTMH plays an integral and unique role in the advancement of the field of tropical medicine. Its mission is to promote global health by preventing and controlling tropical diseases through research and education. As such, the Society is the principal membership organization representing, educating, and supporting tropical medicine scientists, physicians, researchers, and other health professionals dedicated to the prevention and control of tropical diseases. Our members reside in 46 States and the District of Columbia and work in a myriad of public, private, and nonprofit environments, including academia, the U.S. military, public institutions, Federal agencies, private practice, and industry.

The Society's long and distinguished history goes back to the early 20th century. The current organization was formed in 1951 with the amalgamation of the National Malaria Society and the American Society of Tropical Medicine. Over the years, the Society has counted many distinguished scientists among its members, including Nobel laureates. ASTMH and its members continue to have a major impact on the tropical diseases and parasitology research carried out around the world.

The central public policy priority of ASTMH is reducing the burden of infectious disease in the developing world. To that end, we advocate implementation and funding of Federal programs that address the prevention and control of infectious diseases that are leading causes of death and disability in the developing world, and which pose threat to U.S. citizens. Priority diseases include malaria, Dengue fever, Leishmaniasis, Ebola, cholera, and tuberculosis.

MALARIA AND MILITARY OPERATIONS

Servicemen and women deployed from the U.S. military comprise a majority of the healthy adults traveling each year to malarial regions on behalf of the U.S. Government. For this reason, the U.S. military has long taken a primary role in the development of anti-malarial drugs, and nearly all of the most effective and widely used anti-malarials were developed in part by U.S. military researchers. Drugs that have saved countless lives throughout the world were originally developed by the U.S. military to protect troops serving in tropical regions during WWII, the Korean War, and the Vietnam War.

Fortunately, in recent years the broader international community has stepped up its efforts to reduce the impact of malaria in the developing world, particularly by reducing childhood malaria mortality, and the U.S. military is playing an important

role in this broad partnership. But military malaria researchers are working practically alone in the area most directly related to U.S. national security: drugs and vaccines designed to protect or treat healthy adults with no developed resistance to malaria who travel to regions endemic to the disease. These drugs and vaccines would benefit everyone living or traveling in the tropics, but are particularly essential to the United States for the protection of forces from disease during deployments.

Unfortunately, the prophylaxis and therapeutics currently given to U.S. servicemen and women are losing their effectiveness. During World War II, the Korean War, and Vietnam, the quinine-based anti-malaria drug chloroquine was the chemoprophylaxis and therapy of choice for the U.S. military. Over time, however, the malaria parasite developed widespread resistance to chloroquine, making the drug less effective at protecting deployed troops from malaria. Fortunately, military researchers at the Walter Reed Army Institute of Research (WRAIR) achieved the scientific breakthroughs that led to the development of mefloquine, which quickly replaced chloroquine as the military's front-line drug against malaria.

The malaria parasite has consistently demonstrated a notorious ability to quickly become resistant to new drugs, and the latest generation of medicines is no exception. Malaria parasites in Southeast Asia have already developed significant resistance to mefloquine, and resistant strains of the parasite have also been identified in West Africa and South America. In addition, there are early indications that parasite populations in southeast Asia may already be developing limited resistance to artemisinin, currently the most powerful anti-malarial available. Indeed, the most deadly variant of malaria—*Plasmodium falciparum*—is believed by the World Health Organization to have become resistant to “nearly all antimalarials in current use.” This resistance is not yet universal among the global *Plasmodium falciparum* population, with parasites in a given geographic area having developed resistance to some drugs and not others. But the sheer speed with which the parasite is developing resistance to mefloquine and artemisinin—drugs developed in the 1970s and 1980s—reminds us that military malaria researchers cannot afford to rest on their laurels. Developing new anti-malarials as quickly as the parasite becomes resistant to existing ones is an extraordinary challenge, and one that requires significant resources. Without new anti-malarials to replace existing drugs as they become obsolete, U.S. military operations in regions endemic to malaria may be compromised.

Unfortunately, our limited ability to protect forces from malaria infection is not hypothetical: overseas operations are already being impacted. A 2007 study by Army researchers found that from 2000 through 2005, at least 423 U.S. service members contracted malaria while deployed overseas, with the vast majority of these cases the result of deployments to South Korea (where malaria has recently reemerged along the demilitarized zone with North Korea), Afghanistan and, to a lesser extent, Iraq. Notably, none of these countries are thought of by experts as being especially dangerous in terms of malaria, as opposed to the many countries in Sub-Saharan Africa and Southeast Asia where malaria is much more prevalent, and where more deadly strains of the parasite thrive. For example, a 2003 peacekeeping operation in Liberia resulted in a 44 percent malaria infection rate among Marines who spent at least one night ashore.

Clearly, U.S. service members are insufficiently protected from malaria. The reasons for this are many, and include drug resistance as well as ongoing issues with compliance by soldiers who have difficulty maintaining a malaria prophylaxis regimen under combat conditions, or who have contraindications to the use of mefloquine or other drugs.¹ Regardless of the cause for continuing vulnerability to malaria, however, the outlook is the same: until a malaria vaccine is finally developed, ensuring the safety and health of U.S. troops deploying to 1 of the more than 100 countries where malaria is endemic will require the constant development of new malaria drugs, in a race against the parasite's ability to develop drug resistances.

To ensure that as many American soldiers as possible are protected from tropical and other diseases, Congress provides funding each year to support Department of Defense programs focused on the development of vaccines and drugs for priority infectious diseases. To that end, the Walter Reed Army Institute of Research and the Naval Medical Research Center coordinate one of the world's premier tropical disease research programs. These entities contributed to the development of the gold standard for experimental malaria immunization of humans, and the most advanced and successful drugs current being deployed around the world.

¹The aforementioned 2007 Army study found that of 11,725 active duty Army personnel deployed to Afghanistan during the study period, 9.6 percent had contraindications to the use of mefloquine, the Army's first-line malaria treatment.

The need to develop new and improved malaria prophylaxis and treatment for U.S. service members is not yet a crisis, but it could quickly become one if the United States were to become involved in a large deployment to a country or region where malaria is endemic, especially sub-Saharan Africa. Fortunately, a comparatively tiny amount of increased support for this program would restore the levels of research and development investment required to produce the drugs that will safeguard U.S. troops from malaria. In terms of the overall DOD budget, that malaria research program's funding is small—approximately \$23.1 million in fiscal year 2008—but very important. Cutting funding for this program would deal a major blow to the military's work to reduce the impact of malaria on soldiers and civilians alike, thereby undercutting both the safety of troops deployed to tropical climates, and the health of civilians in those regions.

FISCAL YEAR 2010 DOD APPROPRIATIONS

To protect U.S. military personnel, research must continue to develop new anti-malarial drugs and better diagnostics, and to identify an effective malaria vaccine appropriate for adults with no developed resistance to malaria. Much of this important research currently is underway at the Department of Defense. Additional funds and a greater commitment from the Federal Government are necessary to make progress in malaria prevention, treatment, and control.

In fiscal year 2008, the Department of Defense spent only \$23.1 million on malaria research, despite the fact that malaria historically has been a leading cause of troop impairment and continues to be a leading cause of death worldwide. As the 2006 Institute of Medicine report *Battling Malaria: Strengthening the U.S. Military Malaria Vaccine Program* noted, "Malaria has affected almost all military deployments since the American Civil War and remains a severe and ongoing threat." ASTMH agrees that malaria remains a severe and ongoing threat to U.S. military deployments to countries and regions endemic to malaria, and we believe that increased support for efforts to reduce this threat is warranted. A more substantial investment will help to protect American soldiers and potentially save the lives of millions of individuals around the world.

Therefore, we request that the Subcommittee take support a fiscal year 2010 Department of Defense malaria research funding level of \$30 million. Furthermore, we request that the Subcommittee provide annual increases to this account such that total military spending on malaria research is \$76.5 million in fiscal year 2015.

By way of comparison with this request, in March of 2007 the Department of Defense estimated that it would spend \$23.1 million on malaria research in fiscal year 2008. Unfortunately, neither an estimated level of fiscal year 2009 spending nor a fiscal year 2010 request is available, because the Department of Defense does not typically report these numbers. However, recent funding trends suggest that military spending on research in this vital area is falling steadily.

The role of infectious disease in the success or failure of military operations is often overlooked, but even a cursory review of U.S. and world military history underscores the fact that keeping military personnel safe from infectious disease is critical to mission success. The drugs and prophylaxis used to keep our men and women safe from malaria during previous conflicts in tropical regions are no longer reliable. Ensuring the safety of those men and women in future conflicts and deployments will require research on new anti-malaria tools. Thank you for your attention to this matter. We appreciate the opportunity to share our views, and please be assured that ASTMH stands ready to serve as a resource on this and any other tropical disease policy matters.

Our next witness is the senior vice president for public policy of The Leukemia & Lymphoma Society, Mr. George Dahlman.

STATEMENT OF GEORGE DAHLMAN, SENIOR VICE PRESIDENT FOR PUBLIC POLICY, THE LEUKEMIA & LYMPHOMA SOCIETY

Mr. DAHLMAN. Thank you very much, Mr. Chairman and Senator Cochran.

I am George Dahlman, I'm pleased to appear today on behalf of The Leukemia & Lymphoma Society, and all the thousands of blood cancer patients we represent.

As you know, there have been impressive strides in blood cancers—that's leukemia, lymphoma, myeloma, and some others—but, there is a lot of work to be done, and we believe that the public/

private partnership that's part of the DOD's congressionally directed medical research program is an important part of that effort, and should be strengthened.

The Leukemia & Lymphoma Society, along with its partners, believe that this is especially important for the Department of Defense to address. First, research in blood-related cancers has significant relevance to the Armed Forces because the incidence of these cancers is substantially higher among individuals with chemical and nuclear exposure. Higher incidences of leukemia have been substantiated in extreme nuclear incidents in both military and civilian populations, and individual exposures to chemical agents, such as Agent Orange in the Vietnam war, caused an increased risk of contracting lymphoid malignancies.

And now we're seeing the applicability of blood cancer research played out once again in Iraq and Afghanistan as U.S. service personnel face consequences of burn pits and the blood cancers that have been reported.

DOD research on blood cancers addresses the importance of preparing civilian and military exposure to the weapons being developed by several hostile nations, and aid in the research of all cancers.

Mr. Chairman, and members of the subcommittee, with all due respect to our colleagues fighting a broad range of malignancies that are represented in this program, and certainly not to diminish their significance, a cancer research program designed for application of military and national security needs would invariably begin with a strong blood-cancer research foundation. And recognizing that fact and the opportunity this research represents, a bipartisan group of 48 Members of Congress recently requested that the program be instated for \$25 million, and be expanded to all blood cancers.

Furthermore, we respectfully request that funding be dedicated to a collaborative, public/private effort between the United States Military Cancer Institute, The Leukemia & Lymphoma Society, and a blue-ribbon panel of scientific academicians.

Chairman Inouye, as the cosponsor of Senate Bill 51, which authorizes the U.S. Military Cancer Institute, surely you recognize that the USMCI has over 9 million electronic medical records detailing the health histories of servicemen and women and their families. The military also has serum and tissue specimens from these individuals stored, as a routine step in their healthcare. These records and samples together provide a unique base that can power blood cancer research relevant to the military environment and lifestyle in a way that is not possible for any other population. A joint effort, tapping the expertise of both the USMCI and The Leukemia & Lymphoma Society represents a unique opportunity to identify valuable research opportunities and state-of-the-art technology that can address significant questions on the origins and diagnosis of blood cancers.

And I would just add, Senator Inouye, it seems odd that there is this disconnect between the USMCI, on the one hand, that studies cancer, and the cancer programs that are done through the CDMRP, as part—at Fort Dietrich—these two groups do not communicate with one another.

The Leukemia & Lymphoma Society strongly endorses and enthusiastically supports an effort to pursue this project, and respectfully urges the subcommittee to include this funding in the fiscal year 2010 defense appropriations bill.

Thank you.

Chairman INOUE. Thank you very much, Mr. Dahlman.

[The statement follows:]

PREPARED STATEMENT OF GEORGE DAHLMAN

INTRODUCTION

Mr. Chairman and members of the committee, my name is George Dahlman, Senior Vice President, Public Policy for The Leukemia & Lymphoma Society. I am pleased to appear today and testify on behalf of the Society and the more than 900,000 Americans currently living with blood cancers and the 135,000 who will be diagnosed with one this year—recently some of whom have been right here in the Senate. Furthermore, every 10 minutes, someone dies from one of these cancers—leukemia, lymphoma, Hodgkin's disease and myeloma.

During its 60-year history, the Society has been dedicated to finding a cure for the blood cancers, and improving the quality of life of patients and their families. The Society has the distinction of being both the nation's second largest private cancer organization and the largest private organization dedicated to biomedical research, education, patient services and advocacy as they pertain to blood cancers.

Our central contribution to the search for cures for the blood cancers is providing a significant amount of the funding for basic, translational and clinical research. In 2009, we will provide approximately \$70 million in research grants. In addition to our research funding role, we help educate health care and school professionals as needed and provide a wide range of services to individuals with a blood cancer, their caregivers, families, and friends through our 64 chapters across the country. Finally, we advocate responsible public policies that will advance our mission of finding cures for the blood cancers and improving the quality of life of patients and their families.

We are pleased to report that impressive progress is being made in the effective treatment of many blood cancers, with 5-year survival rates doubling and even tripling over the last two decades. More than 90 percent of children with Hodgkin's disease now survive, and survival for children with acute lymphocytic leukemia and non-Hodgkin's lymphoma has risen as high as 86 percent.

Just 7 years ago, in fact, a new therapy was approved for chronic myelogenous leukemia, a form of leukemia for which there were previously limited treatment options, all with serious side-effects—5-year survival rates were just over 50 percent. Let me say that more clearly, if 8 years ago your doctor told you that you had CML, you would have been informed that there were limited treatment options and that you should get your affairs in order. Today, those same patients have access to this new therapy, called Gleevec, which is a so-called targeted therapy that corrects the molecular defect that causes the disease, and does so with few side effects. Now, 5-year survival rates are as high as 96 percent for patients newly diagnosed with chronic phase CML.

The Society funded the early research that led to Gleevec's approval, as it has contributed to research on a number of new therapies. We are pleased that we played a role in the development of this life-saving therapy, but we realize that our mission is far from realized. Many forms of leukemia, lymphoma and myeloma still present daunting treatment challenges. There is much work still to be done, and we believe that the research partnership between the public and private sectors—as represented in the Department of Defense's Congressionally Directed Medical Research Program—is an integral part of that important effort and should be further strengthened.

THE GRANT PROGRAMS OF THE LEUKEMIA & LYMPHOMA SOCIETY

The grant programs of the Society have traditionally been in three broad categories: Career Development Program grants, Translational Research Program grants, and Specialized Centers of Research Program grants. In our Career Development Program, we fund Scholars, Special Fellows, and Fellows who are pursuing careers in basic or clinical research. In our Translational Research Program, we focus on supporting investigators whose objective is to translate basic research discoveries into new therapies.

The work of Dr. Brian Druker, an oncologist at Oregon Health Sciences University and the chief investigator responsible for Gleevec's development, was supported by a Translational Research Program grant from the Society.

Our Specialized Centers of Research grant program is intended to bring investigators together to form new research teams focused on the discovery of innovative approaches to treating and/or preventing leukemia, lymphoma, and myeloma. The awards go to those groups that can demonstrate that their close interaction will create research synergy and accelerate our search for new and better treatments.

Dr. Druker is certainly a star among those supported by the Society, but our support in the biomedical field is broad and deep. Through the Society's research grant programs, we are currently supporting more than 380 investigators at 134 institutions in 34 States and 12 other countries.

Not content with these extensive efforts, the Society has launched a new Therapy Acceleration Program intended to proactively invest in promising blood cancer therapies that are in early stages of development by industry, but which may not have sufficient financial support or market potential to justify private sector investment. In addition, the Society will use this program to further facilitate the advancement of therapies in development by academic researchers who may not have the spectrum of resources or expertise to fulfill the potential of their discoveries. Directed early phase clinical trial support in this funding program will further advance new and better treatments for blood cancer treatments.

IMPACT OF HEMATOLOGICAL CANCERS

Despite enhancements in treating blood cancers, there are still significant research challenges and opportunities. Hematological, or blood cancers pose a serious health risk to all Americans. These cancers are actually a large number of diseases of varied causes and molecular make-up, and with different treatments, that strike men and women of all ages. In 2009, more than 130,000 Americans will be diagnosed with a form of blood-related cancer and almost 65,000 will die from these cancers. For some, treatment may lead to long-term remission and cure; for others these are chronic diseases that will require treatments across a lifetime; and for others a treatment options are still extremely limited. For many, recurring disease will be a continual threat to a productive and secure life.

A few focused points to put this in perspective:

- Taken together, the hematological cancers are fifth among cancers in incidence and fourth in mortality.
- Over 900,000 Americans are living with a hematological malignancy in 2009.
- Almost 65,000 people will die from hematological cancers in 2009, compared to 160,000 from lung cancer, 41,000 from breast cancer, 27,000 from prostate cancer, and 52,000 from colorectal cancer.
- Blood-related cancers still represent serious treatment challenges. The improved survival for those diagnosed with all types of hematological cancers has been uneven. The 5-year survival rates are:
 - Hodgkin's disease, 87 percent;
 - Non-Hodgkin's lymphoma, 64 percent;
 - Leukemias (total), 50 percent;
 - Multiple Myeloma, 33 percent;
 - Acute Myelogenous Leukemia, 21 percent.
- Individuals who have been treated for leukemia, lymphoma, and myeloma may suffer serious adverse consequences of treatment, including second malignancies, organ dysfunction (cardiac, pulmonary, and endocrine), neuropsychological and psychosocial aspects, and poor quality of life.
- For the period from 1975 to 2005, the incidence rate for non-Hodgkin's lymphoma increased by 79 percent (increasing 2.6 percent/year).
- Non-Hodgkin's lymphoma and multiple myeloma rank second and fifth, respectively, in terms of increased cancer mortality since 1973.
- Lymphoma is the third most common childhood cancer and the fifth most common cancer among Hispanics of all races. Recent statistics indicate both increasing incidence and earlier age of onset for multiple myeloma.
- Multiple myeloma is one of the top 10 leading causes of cancer death among African Americans.
- Hispanic children of all races under the age of 20 have the highest rates of childhood leukemias.
- Despite the significant decline in the leukemia and lymphoma death rates for children in the United States, leukemia is still the leading cause of death in the United States among children less than 20 years of age, in females between the ages of 20 and 39 and males between the ages of 60–79.

—Lymphoma is the fourth leading cause of death among males between the ages of 20 and 39 and the fifth leading cause of death for females older than 80. Overall, cancer is now the leading cause of death for U.S. citizens younger than 85 years of age, overtaking heart disease as the primary killer.

POSSIBLE ENVIRONMENTAL CAUSES OF HEMATOLOGICAL CANCERS

The causes of hematological cancers are varied, and our understanding of the etiology of leukemia, lymphoma, and myeloma is limited. Extreme radiation exposures are clearly associated with an increased incidence of leukemias. Benzene exposures are associated with increased incidence of a particular form of leukemia. Chemicals in pesticides and herbicides, as well as viruses such as HIV and EBV, apparently play a role in some hematological cancers, but for most cases, no environmental cause is identified. Researchers have recently published a study reporting that the viral footprint for simian virus 40 (SV40) was found in the tumors of 43 percent of NHL patients. These research findings may open avenues for investigation of the detection, prevention, and treatment of NHL. There is a pressing need for more investigation of the role of infectious agents or environmental toxins in the initiation or progression of these diseases.

IMPORTANCE TO THE DEPARTMENT OF DEFENSE

The Leukemia & Lymphoma Society, along with its partners in the American Society of Hematology, Aplastic Anemia & MDS International Foundation, International Myeloma Foundation, Lymphoma Research Foundation, and Multiple Myeloma Research Foundation, believe biomedical research focused on the hematological cancers is particularly important to the Department of Defense for a number of reasons.

First, research on blood-related cancers has significant relevance to the armed forces, as the incidence of these cancers is substantially higher among individuals with chemical and nuclear exposure. Blood cancers are linked to members of the military who were exposed to ionizing radiation, such as those who occupied Japan after World War II and those who participated in atmospheric nuclear tests between 1945–1962. Service members who contract multiple myeloma, non-Hodgkin's lymphoma, and leukemias other than chronic lymphocytic leukemia are presumed to have contracted these diseases as a result of their military service; hence, they are eligible to receive benefits from the Department of Veterans Affairs (VA).

Secondly, in-country Vietnam veterans who contract Hodgkin's disease, chronic lymphocytic leukemia, multiple myeloma, or non-Hodgkin's lymphoma are presumed to have contracted these diseases as a result of their military service and the veterans are eligible to receive benefits from the VA.

Thirdly, the Institute of Medicine (IOM) has found that Gulf War veterans are at risk for contracting a number of blood cancers. For instance, the IOM has found sufficient evidence of a causal relationship between exposure to benzene and acute leukemias. Additionally, the IOM has found there is sufficient evidence of an association between benzene and adult leukemias, and solvents and acute leukemias. Finally, the IOM has also found there is also limited or suggestive evidence of an association between exposure to organophosphorous insecticides to non-Hodgkin's lymphoma and adult leukemias; carbamates and Benzene to non-Hodgkin's lymphoma; and solvents to multiple myeloma, adult leukemias, and myelodysplastic syndromes—a precursor to leukemia.

Furthermore, research in the blood cancers has traditionally pioneered treatments in other malignancies. Cancer treatments that have been developed to treat a blood-related cancer are now used or being tested as treatments for other forms of cancer. Combination chemotherapy and bone marrow transplants are two striking examples of treatments first developed for treating blood cancer patients. More recently, specific targeted therapies have proven useful for treating patients with solid tumors as well as blood cancers.

From a medical research perspective, it is a particularly promising time to build a DOD research effort focused on blood-related cancers. That relevance and opportunity were recognized for a 6-year period when Congress appropriated \$4.5 million annually—for a total of \$28 million—to begin initial research into chronic myelogenous leukemia (CML) through the Congressionally Directed Medical Research Program (CDMRP). As members of the Subcommittee know, a noteworthy and admirable distinction of the CDMRP is its cooperative and collaborative process that incorporates the experience and expertise of a broad range of patients, researchers and physicians in the field. Since the Chronic Myelogenous Leukemia Research Program (CMLRP) was announced, members of the Society, individual patient advocates and leading researchers have enthusiastically welcomed the oppor-

tunity to become a part of this program and contribute to the promise of a successful, collaborative quest for a cure.

In spite of the utility and application to individuals who serve in the military, the CML program was not included in January's 2007 Continuing Resolution funding other fiscal year 2007 CDMRP programs. This omission, and the program's continued absence seriously jeopardizes established and promising research projects that have clear and compelling application to our armed forces as well as pioneering research for all cancers.

Recognizing that fact and the opportunity this research represents, a bipartisan group of 45 Members of Congress have requested that the program be reconstituted at a \$25 million level and be expanded to include all the blood cancers—the leukemias, lymphomas and myeloma. This would provide the research community with the flexibility to build on the pioneering tradition that has characterized this field.

With all due respect to our colleagues fighting a broad range of malignancies that are represented in this program—and certainly not to diminish their significance—a cancer research program designed for application to military and national security needs would invariably include a strong blood cancer research foundation. DOD research on blood cancers addresses the importance of preparing for civilian and military exposure to the weapons being developed by several hostile nations and to aid in the march to more effective treatment for all who suffer from these diseases. This request clearly has merit for inclusion in the fiscal year 2010 legislation.

Furthermore, we respectfully request that funding be dedicated to a collaborative public-private effort between the U.S. Military Cancer Institute, The Leukemia & Lymphoma Society and a blue ribbon panel of scientific academicians.

The USMCI has over 9 million electronic medical records detailing the health histories of service men and women and their families. The military also has serum and tissue specimens from these individuals stored as a routine step in their health care. These records and samples, together, provide a unique base that can power blood cancer research relevant to the military environment and lifestyle in a way that is not possible for any other population.

A joint effort, tapping the expertise of both USMCI and LLS, represents a unique opportunity to identify valuable research opportunities and state-of-the-art technology that can address significant questions on the origins and diagnosis of blood cancers. For example:

- meta-analysis of the existing data may be used to gain insight into the exposure risks inherent in the military environment that may predispose the war fighter or their dependents to develop blood cancer.
- Gene profiling might be used to gauge the existing genetic risk for blood cancer in a given individual and may guide the delivery of healthcare and/or deployment decisions.
- Proteomic analysis of historically preserved serial blood samples from a military member diagnosed with blood cancer may reveal exposures related to development of the disease and drive decisions about safety precautions and protective gear.

The Leukemia & Lymphoma Society strongly endorses and enthusiastically supports this effort and respectfully urges the Committee to include this funding in the fiscal year 2010 Defense Appropriations bill.

We believe that building on the foundation Congress initiated over a 6-year period should not be abandoned and would both significantly strengthen the military's cancer program and accelerate the development of all cancer treatments. As history has demonstrated, expanding its focus into areas that demonstrate great promise; namely the blood-related cancers of leukemia, lymphoma and myeloma, would substantially aid the overall cancer research effort and yield great dividends.

Chairman INOUE. And now may I call upon the president of the Air Force Association, Lieutenant General Michael M. Dunn.

**STATEMENT OF LIEUTENANT GENERAL MICHAEL M. DUNN (RET.),
PRESIDENT/CHIEF EXECUTIVE OFFICER, AIR FORCE ASSOCIATION**

General DUNN. Thank you, Mr. Chairman.

Last but not least. Mr. Chairman, Mr. Vice Chairman, I'm honored to be with you today to talk about the fiscal year 2010 defense budget.

I represent 120,000 members of the Air Force Association, and I need to point out to this subcommittee that we are independent of

the Air Force, that the Air Force has not made any inputs, nor seen my statement or my remarks.

At this time I request my written statement be included in the record.

Chairman INOUE. Without objection.

General DUNN. Mr. Chairman, I have to tell this subcommittee I'm worried, at this point in history, about the future. The average age of Air Force aircraft is the oldest in its very short history—25 years old, one-quarter of a century. Some types of aircraft are over 50 years old, and, when they are eventually replaced, some are going to be over 90 years old.

To begin to replace the fleet, the Air Force has to buy about 165 aircraft per year, of all types. The 2010 budget request purchases only 81 aircraft, and 29 of them are unmanned aerial vehicles, and 13 are for the Air Force Academy.

This puts the Air Force on a replacement rate of about 100 years. Obviously, this is not a sustainable path. Costs to keep the fleet are rising—fleet ready—are rising, many aircraft have been grounded over the past few years, planes are breaking in unpredictable ways, and readiness rates are falling. Our men and women who serve deserve the very best we, as a Nation, can provide to them. We have to turn this around.

DOD has stated they need to rebalance the force to focus on irregular warfare (IW). The sad fact is, they have to do both—modernize and recapitalize, as well as focusing on IW.

I hope DOD is right about the future, that they won't face a strong opponent. But, the one thing certain about the future is we have been wrong over the type of opponent we will face. We did not anticipate the Japanese attacking the Hawaiian Islands in World War—to begin World War II for the United States; we did not anticipate the Korean War, Vietnam, the fall of the Soviet Union, Iraq's attack on Kuwait, 9/11, nor Operation Iraqi Freedom. To maintain that all wars in the future will be irregular wars is—well—not supported by the lessons of the past.

The decisions made by DOD and this Congress are ones we will live with for a long time. They are 30-year decisions. When the Nation terminates or delays seven aircraft production lines, the impact on our aerospace industry is devastating. And this is an industry that adds almost \$40 billion per year in positive trade balance. Engineers, design teams, and innovation will be lost, or hard or expensive to replace; tens of thousands of jobs will be lost. And these are high paying manufacturing jobs that benefit, not just local communities, but the Nation as a whole.

Mr. Chairman, I think you can see why I'm worried. This is not just about one system or another, this is about air power, our asymmetric advantage and the reason our past conflicts have so spectacular, with some of the lowest friendly casualty rates in the history of warfare. We have to nurture this capability for the future.

And thank you for your time, sir.

Chairman INOUE. Well, thank you very much, General Dunn.
[The statement follows:]

PREPARED STATEMENT OF MICHAEL M. DUNN

Ladies and gentleman of the Committee, I am honored to come before you today, representing the Air Force Association, to discuss your United States Air Force. I would like to begin my remarks by saluting our Airmen who strive every day to ensure that America's Air Force is second to none. These men and women are true heroes and we salute their dedication and determination, while also recognizing the sacrifices they make for our Nation.

To borrow a phrase from General Schwartz, the United States Air Force is truly "all in." Whether deterring potential adversaries, striking strategic targets, gathering critical intelligence, delivering humanitarian relief supplies, evacuating wounded, airlifting cargo around the globe, enabling command and control, rescuing personnel behind enemy lines, or providing close air support, the Air Force is an invaluable national asset. Just looking at operations in Iraq and Afghanistan, the Air Force has flown nearly 60,000 sorties this year alone. In the real world, this translates into Airmen doing their very best 24/7 to fight and win on the front lines along with their joint team partners.

While we are certainly proud of the Air Force's current record, this success cannot be taken for granted. The Air Force has spent the past two decades engaged in continuous combat operations and is utilizing an aircraft fleet that averages nearly a quarter of a century in age—with some planes in the inventory dating back to the Eisenhower Administration.

The most obvious problem associated with this aging fleet is that old airplanes break more often and eventually are no longer airworthy. In the time since Desert Storm the average age of the Air Force fleet has increased by nearly a decade and the availability rate has dropped in a corresponding fashion. This means that since 1991 the percentage of time an aircraft is not broken and can fly a mission has fallen from 77 percent to 65 percent. Aside from these costly maintenance challenges, a number of dramatic airworthiness issues have also afflicted the Air Force fleet. In 2000 the service grounded one third of its KC-135 air refueling aircraft because of a faulty flight control component. In 2004 the Air Force discovered that many of its C-130s had major cracks in their wings. In 2007 an F-15 broke in two while on a training flight due to structural fatigue, grounding the entire fleet for months. In 2008 the entire T-38 fleet was grounded for an extended period because of an aging control surface fixture. Most recently, half of the A-10 fleet was grounded due to wing cracks and the C-130 fleet was also grounded due to a faulty bolt found in the wings of many of the aircraft. More problems are certain to arise as the age of the fleet continues to increase.

It is also important to consider that most next generation aircraft yield tremendous operational efficiencies that dramatically offset their higher per-unit acquisition cost and yield long-term savings. This performance increase was clearly demonstrated on the first night of Desert Storm when 20 new F-117 stealth fighters took the unprecedented step of attacking 28 separate targets. On the same night it took a combined force of 41 legacy non-stealth aircraft to strike one target—4 F/A-18s to defend against enemy aircraft, 3 drones to serve as decoys, 5 EA-6B aircraft to jam enemy radar, along with 4 F-4s and 17 F/A-18s to suppress enemy surface-to-air missiles so that 4 A-6s and 4 Tornados could strike one target. The full spectrum cost imposed by these legacy aircraft was tremendous—aircraft development and acquisition funding, operations and maintenance expenses, personnel bills, base access issues, etc. Viewed from this perspective, the encompassing price of new aircraft like the F-22 and F-35 is not so high.

The global threat environment is rapidly evolving and proliferation of modern weaponry is negating the survivability of the Air Force's legacy fleet. Over 30 nations operate fighter aircraft that equal or exceed the capabilities of the F-15 and F-16, whose designs respectively date back to the 1960s and 1970s. Nations such as Russia and China are also developing 5th generation fighters that will have F-22-like capabilities and will be bought in F-35-like quantities . . . and sold to other countries. Additionally, dozens of nations operate surface-to-air missiles that can easily shoot down aircraft such as the B-1, B-52, F-15, F-16, F-18, Predator, Global Hawk, and more. It is important to remember that in the final days of Vietnam the Air Force lost 15 B-52s in 12 days during Operation Linebacker II. Air defenses have advanced markedly since then but 47 percent of the long range strike fleet is comprised of these same B-52s. Had the U.S. Air Force been called upon to engage in the recent Georgian conflict, the B-2 and F-22 were the only aircraft in the U.S. inventory that would have survived in the threat environment. U.S. national security demands a broader array of effective capabilities than just 20 B-2s and 186 F-22s.

The fiscal year 2010 budget proposal currently under consideration by Congress fails to make necessary recapitalization investments and actually exacerbates the challenges facing several key mission sets. For example, the fiscal year 2010 budget proposal ends production of the F-22 at 187 aircraft even though the stated military requirement is for 243 airframes. A fleet comprised of 187 airframes yields a force of about 100 combat-ready aircraft, no attrition/reserve inventory, and too few aircraft to engage/deter in more than one operation at a time. All known analysis undertaken to this point has concluded such a limited fleet size entails high risk. Air dominance is the precondition for all successful U.S. military combat operations—this isn't just about the U.S. Air Force—it is essential for the entire joint team.

This year's budget also discontinues C-17 acquisition at 205 aircraft even though demand for airlift is so high that the Air Force is currently flying its C-17 airframes over 1,000 hours past what was originally programmed per year. Additional developments have seen the ground component grow by 92,000 Soldiers and Marines, increased reliance on airlift, to include leased Russian aircraft, to get equipment to Afghanistan and Iraq, and a decision to relocate many units back to CONUS. Each one of these developments suggests that the need for military airlift will increase. Closing the C-17 production line at 205 aircraft risks creating a high-demand low-density mission set.

Even though existing Combat Search and Rescue (CSAR) helicopters are rapidly nearing the end of their service lives, the budget cancels their replacement program. CSAR is a moral imperative. Our current enemies do not take prisoners of war. They welcome the opportunity to torture and kill their captives, making CSAR even more critical than before. In fact, the Air Force CSAR capabilities are in such high demand in Iraq and Afghanistan that the Weapons School has been closed so that a maximum number of assets can be surged forward.

The Next Generation Bomber program was also cancelled even though the current long range strike fleet averages over 40 years in age. While elements of the force are still capable in certain threat environments, the proliferation of advanced anti-access weaponry is curtailing when and where many of the legacy assets can successfully operate. Twenty B-2s are the only long range strike assets in the Air Force inventory that can penetrate high threat environments and survive. These aircraft are approaching 20 years in age, have not been in production since 1997, and have no viable replacements to backfill losses. During the Cold War, bombers were primarily viewed as nuclear deterrence assets. However, actual combat operations have demonstrated that long range conventional strike is an incredibly important tool. Modern long range bombers can penetrate air defense systems, respond rapidly to strike fleeting targets, and operate over long distances without excessive logistical support. The tactical strike fleet, while capable, simply does not have the range and payload capabilities to fulfill many of these missions.

The Airborne Laser (ABL) program was also curtailed even though nuclear weapons proliferation, combined with advances in delivery system technology, is yielding an increasingly dangerous world. Sufficient investment in robust missile defense capabilities is essential for the security of United States and its allies.

Cumulatively, these decisions will also have a tremendous impact on the defense industrial base. This sector is an invaluable strategic partner for the United States. Whether addressing problems through innovation, delivering high-quality products that enable our forces to attain victory, or developing solutions for future challenges, the industrial base is a critical national security asset. The United States is rapidly approaching the point where it will be limited to one major heavy aircraft production line (Boeing in Seattle, WA) and one advanced fighter production facility (Lockheed Martin in Fort Worth, TX). The proposed fiscal year 2010 budget cuts rapidly accelerate the decline of this sector. The barriers to entry are extraordinarily high within the military aerospace industrial base and once the Nation loses certain core competencies, they will be exceedingly difficult and costly to regenerate. For example, low observable (stealth) design teams are incredibly skilled in a highly nuanced field that does not lend itself to dual-use applications within the civilian aerospace sector. If projects are not forthcoming to maintain this skill set, then the country will face major challenges trying to regenerate such capabilities in the future. Additionally, the military aerospace sector will have an increasingly difficult time recruiting and retaining talent amidst these challenging times. Failing to build a viable and competent workforce for the next generation will have a dramatic impact on the national security options available to the Nation for the foreseeable future.

Clearly the United States Air Force is at a strategic crossroads. The Nation cannot realistically expect Airmen to successfully engage and survive in future campaigns if it does not equip them with modern and effective equipment. One of the key lessons from history is the importance of preparing for the full spectrum of operations. This country has failed to anticipate numerous critical events—Pearl Harbor,

Berlin Blockade, Cuban Missile Crisis, Soviet Invasion of Afghanistan, fall of the Shah in Iran, end of the Cold War, Iraq's invasion of Kuwait, 9/11, etc. Events in the modern world develop rapidly and the country has to respond quickly with the forces on hand. The days of WWII-like rapid wartime industrialization are gone. Aside from rudimentary supplies, effective weapons systems can no longer be developed in a matter of months and events are often decided by the time new items are fielded. This demands that the Nation prepare for a wide variety of contingencies. Otherwise, the lives of the men and women in uniform will be placed at undue risk as they struggle to achieve their respective objectives with inadequate tools. While airpower can operate with relative impunity in current operations, such access must not be taken for granted in the future. Current legacy systems will last a few more years, but eventually they will be retired. Most of the cuts involved in this budget kill the platforms that were intended to replace these legacy systems. The Chief of Staff of the Air Force has stated he needs to buy 165 aircraft per year in order to keep the average age of the fleet the same as it is now—a quarter of a century old. This budget only buys 81 aircraft—13 of which are for the Air Force Academy and 29 of which are UAVs. That puts the Air Force on a replacement rate of over 100 years. It is important that Congress and the American people fully appreciate the full ramifications of these decisions. We risk imposing drastic limitations on the strategic options available to the country for decades into the future.

ADDITIONAL SUBMITTED STATEMENT

Chairman INOUE. The subcommittee has received testimony from the National Military and Veterans Alliance and their testimony will be made part of the record.

[The statement follows:]

PREPARED STATEMENT OF THE NATIONAL MILITARY AND VETERANS ALLIANCE

The Alliance was founded in 1996 as an umbrella organization to be utilized by the various military and veteran associations as a means to work together towards their common goals. The Alliance member organizations are: American Logistics Association; American Military Retirees Association; American Military Society; American Retirees Association; American World War II Orphans Network; AMVETS (American Veterans); Armed Forces Marketing Council; Army and Navy Union; Catholic War Veterans; Gold Star Wives of America, Inc.; Japanese American Veterans Association; Korean War Veterans Foundation; Legion of Valor; Military Order of the Purple Heart; Military Order of the World Wars; Military Order of Foreign Wars; National Assoc. for Uniformed Services; National Gulf War Resource Center; Naval Enlisted Reserve Association; Naval Reserve Association; Paralyzed Veterans of America; Reserve Enlisted Association; Reserve Officers Association; Society of Military Widows; The Retired Enlisted Association; TREA Senior Citizens League; Tragedy Assist. Program for Survivors; Uniformed Services Disabled Retirees; Veterans of Foreign Wars; Vietnam Veterans of America; Women in Search of Equity.

These organizations have over three and a half million members who are serving our Nation or who have done so in the past, and their families.

INTRODUCTION

Mister Chairman and distinguished members of the Committee, the National Military and Veterans Alliance (NMVA) is very grateful for the invitation to testify before you about our views and suggestions concerning defense funding issues. The overall goal of the National Military and Veterans Alliance is a strong National Defense. In light of this overall objective, we would request that the committee examine the following proposals.

While the NMVA highlights the funding of benefits, we do this because it supports National Defense. A phrase often quoted “The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the Veterans of earlier wars were treated and appreciated by their country,” has been frequently attributed to General George Washington. Yet today, many of the programs that have been viewed as being veteran or retiree are viable programs for the young serving members of this war. This phrase can now read “The willingness with which our young people, today, are willing to serve in this war is how they perceive the veterans of this war are being treated.”

This has been brought to the forefront by how quickly an issue such as the treatment of wounded warriors suffering from Traumatic Brain Injury or Post Traumatic stress Disorder has been brought to the national attention.

In a long war, recruiting and retention becomes paramount. The National Military and Veterans Alliance, through this testimony, hopes to address funding issues that apply to the veterans of various generations.

FUNDING NATIONAL DEFENSE

NMVA is pleased to observe that the Congress continues to discuss how much should be spent on National Defense. The Alliance urges the President and Congress to increase defense spending to 5 percent of Gross Domestic Product during times of war to cover procurement and prevent unnecessary personnel end strength cuts.

PAY AND COMPENSATION

Our serving members are patriots willing to accept peril and sacrifice to defend the values of this country. All they ask for is fair recompense for their actions. At a time of war, compensation rarely offsets the risks.

The NMVA requests funding so that the annual enlisted military pay raise exceeds the Employment Cost Index (ECI) by at least half of a percent.

Further, we hope that this committee continues to support targeted pay raises for those mid-grade members who have increased responsibility in relation to the overall service mission. Pay raises need to be sufficient to close the civilian-military pay gap.

NMVA would apply the same allowance standards to both Active and Reserve when it comes to Aviation Career Incentive Pay, Career Enlisted Flyers Incentive Pay, Diving Special Duty Pay, Hazardous Duty Incentive Pay and other special pays.

The Service chiefs have admitted one of the biggest retention challenges is to recruit and retain medical professionals. NMVA urges the inclusion of bonus/cash payments (Incentive Specialty pay IPS) into the calculations of Retirement Pay for military health care providers. NMVA has received feedback that this would be incentive to many medical professionals to stay in longer.

G-R Bonuses.—Guard and Reserve component members may be eligible for one of three bonuses, Prior Enlistment Bonus, Reenlistment Bonus and Reserve Affiliation Bonuses for Prior Service Personnel. These bonuses are used to keep men and woman in mission critical military occupational specialties (MOS) that are experiencing falling numbers or are difficult to fill. During their testimony before this committee the Reserve Chiefs addressed the positive impact that bonuses have upon retention. This point cannot be understated. The operation tempo, financial stress and civilian competition for jobs make bonuses a necessary tool for the DOD to fill essential positions. The NMVA supports expanding and funding bonuses to the Federal Reserve Components.

Reserve/Guard Funding.—NMVA is concerned about ongoing DOD initiatives to end “two days pay for one days work,” and replace it with a plan to provide 1/30 of a Month’s pay model, which would include both pay and allowances. Even with allowances, pay would be less than the current system. When concerns were addressed about this proposal, a retention bonus was the suggested solution to keep pay at the current levels. Allowances differ between individuals and can be affected by commute distances and even zip codes. Certain allowances that are unlikely to be paid uniformly include geographic differences, housing variables, tuition assistance, travel, and adjustments to compensate for missing health care. The NMVA strongly recommends that the reserve pay system “two days pay for one days work,” be funded and retained, as is.

EDUCATIONAL ISSUES

MGIB-SR Enhancements

Practically all active duty and Selected Reserve enlisted accessions have a high school diploma or equivalent. A college degree is the basic prerequisite for service as a commissioned officer, and is now expected of most enlisted as they advance beyond E-6. Officers to promote above O-4 are expected to have a post graduate degree. The ever-growing complexity of weapons systems and support equipment requires a force with far higher education and aptitude than in previous years.

Both political parties are looking at ways of enhancing the GI bill. There are suggested features in legislation be suggested by both sides. At a minimum, the GI bill needs to be viewed as more than a recruiting and retention incentive. Education is

a means to help reintegrate our returning veterans into society. A recent survey by military.com, of returning military veterans, found that 81 percent didn't feel fully prepared to enter the work force, and 76 percent of these veterans said they were unable translate their military skills into civilian proficiencies.

Transferability of educational benefits to spouses and children are another key aspect that should be included in a GI Bill enhancement. In addition, for those with existing degrees and outstanding debts, the GI Bill stipend, should be allowed to pay-off outstanding student loans.

No enhancement can be accomplished without funding. This should be viewed as an investment rather than an expense. The original GI bill provided years of economic stimulus, returning seven dollars for every dollar invested in veterans.

The National Military and Veterans Alliance asks this subcommittee to support funding for suggested GI Bill funding.

The Montgomery G.I. Bill for Selective Reserves (MGIB-SR) will continue to be an important recruiting and retention tool. With massive troop rotations the Reserve forces can expect to have retention shortfalls, unless the government provides enhances these incentives as well.

The problem with the current MGIB-SR is that the Selected Reserve MGIB has failed to maintain a creditable rate of benefits with those authorized in Title 38, Chapter 30. MGIB-SR has not even been increased by cost-of-living increases since 1985. In that year MGIB rates were established at 47 percent of active duty benefits. The MGIB-SR rate is 28 percent of the Chapter 30 benefits. Overall the allowance has inched up by only 7 percent since its inception, as the cost of education has climbed significantly.

The NMVA requests appropriations funding to raise the MGIB-SR and lock the rate at 50 percent of the active duty benefit. Cost: \$25,000,000/first year, \$1,400,000,000 over 10.

FORCE POLICY AND STRUCTURE

War Funding

The Alliance thanks the committee for the war funding amended to the Supplemental Appropriations Act 2008, H.R. 2642. While the debate on Iraqi policy is important, the Alliance would like to stress that resulting legislation should be independent and not included as language in any Defense Appropriation bill. Supporting the troops includes providing funding for their missions.

NMVA supports the actions by this subcommittee to put dollars for the War back into the Emergency Supplemental.

End Strength

The NMVA concurs with funding increases in support of the end strength boosts of the Active Duty Component of the Army and Marine Corps that have been recommended by Defense Authorizers. New recruits need to be found and trained now to start the process so that American taxpayer can get a return on this investment. Such growth is not instantaneously productive. Yet, the Alliance is concerned with continued end strength cuts to the other services: the Air Force and the Navy. Trying to pay the bills by premature manpower reductions may have consequences.

Manning Cut Moratorium

The NMVA would also like to put a freeze on reductions to the Guard and Reserve manning levels. A moratorium on reductions to End Strength is needed until the impact of an operational reserve structure is understood. Many force planners call for continuation of a strategic reserve as well. NMVA urges this subcommittee to at least fund to last year's levels.

SURVIVOR BENEFIT PLAN (SBP) AND SURVIVOR IMPROVEMENTS

The Alliance wishes to deeply thank this Subcommittee for your funding of improvements in the myriad of survivor programs.

However, there is still an issue remaining to deal with: Providing funds to end the SBP/DIC offset.

SBP/DIC Offset affects several groups. The first is the family of a retired member of the uniformed services. At this time the SBP annuity the servicemember has paid for is offset dollar for dollar for the DIC survivor benefits paid through the VA. This puts a disabled retiree in a very unfortunate position. If the servicemember is leaving the service disabled it is only wise to enroll in the Survivor Benefit Plan (perhaps being uninsurable in the private sector). If death is service connected then the survivor loses dollar for dollar the compensation received under DIC.

SBP is a purchased annuity, available as an elected earned employee benefit. The program provides a guaranteed income payable to survivors of retired military upon the member's death. Dependency and Indemnity Compensation (DIC) is an indemnity program to compensate a family for the loss of a loved one due to a service connected death. They are different programs created to fulfill different purposes and needs.

A second group affected by this dollar for dollar offset is made up of families whose service member died on active duty. Recently Congress created active duty SBP. These service members never had the chance to pay into the SBP program. But clearly Congress intended to give these families a benefit. With the present offset in place the vast majority of families receive no benefit from this new program, because the vast numbers of our losses are young men or women in the lower paying ranks. SBP is completely offset by DIC payments.

Other affected families are service members who have already served a substantial time in the military. Their surviving spouse is left in a worse financial position than a younger widow. The older widows will normally not be receiving benefits for her children from either Social Security or the VA and will normally have more substantial financial obligations (mortgages, etc). This spouse is very dependent on the SBP and DIC payments and should be able to receive both.

The NMVA respectfully requests this Subcommittee fund the SBP/DIC offset.

CURRENT AND FUTURE ISSUES FACING UNIFORMED SERVICES HEALTH CARE

The National Military and Veterans Alliance must once again thank this Committee for the great strides that have been made over the last few years to improve the health care provided to the active duty members, their families, survivors and Medicare eligible retirees of all the Uniformed Services. The improvements have been historic. TRICARE for Life and the Senior Pharmacy Program have enormously improved the life and health of Medicare Eligible Military Retirees their families and survivors. It has been a very successful few years. Yet there are still many serious problems to be addressed:

Wounded Warrior Programs

As the committee is aware, Congress has held a number of hearings about the controversy at Walter Reed Army Medical Center. The NMVA will not revisit the specifics. With the Independent Review Group and the Dole/Shalala Commission recommending the closure of Walter Reed, an emphasis needs to be placed on the urgency of upgrades at Bethesda, and the new military treatment hospital at Fort Belvoir. NMVA hopes that this committee will financially support the studies that measure the adequacy of this plan.

The Alliance supports continued funding for the wounded warriors, including monies for research and treatment on Traumatic Brain Injuries (TBI), Post Traumatic Stress Disorder, the blinded, and our amputees. The Nation owes these heroes an everlasting gratitude and recompense that extends beyond their time in the military. These casualties only bring a heightened need for a DOD/VA electronic health record accord to permit a seamless transition from being in the military to being a civilian.

Full Funding for the Defense Health Program

The Alliance applauds the Subcommittee's role in providing adequate funding for the Defense Health Program (DHP) in the past several budget cycles. As the cost of health care has risen throughout the country, you have provided adequate increases to the DHP to keep pace with these increases.

Full funding for the defense health program is a top priority for the NMVA. With the additional costs that have come with the deployments to Southwest Asia, Afghanistan and Iraq, we must all stay vigilant against future budgetary shortfalls that would damage the quality and availability of health care.

With the authorizers having postponed the Department of Defense's suggested fee increases, the Alliance is concerned that the budget saving have already been adjusted out of the President's proposed budget. NMVA is confident that this subcommittee will continue to fund the DHP so that there will be no budget shortfalls.

The National Military and Veterans Alliance urges the Subcommittee to continue to ensure full funding for the Defense Health Program including the full costs of all new programs.

TRICARE Pharmacy Programs

NMVA supports the continued expansion of use of the TRICARE Mail Order pharmacy.

To truly motivate beneficiaries to a shift from retail to mail order adjustments need to be made to both generic and brand name drugs co-payments. NMVA recommends that both generic and brand name mail order prescriptions be reduced to zero \$\$ co-payments to align with military clinics.

Ideally, the NMVA would like to see the reduction in mail order co-payments without an increase in co-payments for Retail Pharmacy.

The National Military and Veterans Alliance urges the Subcommittee to adequately fund adjustments to co-payments in support of recommendations from Defense Authorizers.

TRICARE Standard Improvements

TRICARE Standard grows in importance with every year that the Global War on Terrorism continues. A growing population of mobilized and demobilized Reservists depends upon TRICARE Standard. A growing number of younger retirees are more mobile than those of the past, and likely to live outside the TRICARE Prime network.

An ongoing challenge for TRICARE Standard involves creating initiatives to convince health care providers to accept TRICARE Standard patients. Health care providers are dissatisfied with TRICARE reimbursement rates that are tied to Medicare reimbursement levels. The Alliance is pleased by Congress' plan to prevent near-term reductions in Medicare reimbursement rates, which will help the TRICARE Program.

Yet this is not enough. TRICARE Standard is hobbled with a reputation and history of low and slow payments as well as what still seems like complicated procedures and administrative forms that make it harder and harder for beneficiaries to find health care providers that will accept TRICARE. Any improvements in the rates paid for Medicare/TRICARE should be a great help in this area. Additionally, any further steps to simplify the administrative burdens and complications for health care providers for TRICARE beneficiaries hopefully will increase the number of available providers.

The Alliance asks the Defense Subcommittee to include language encouraging continued increases in TRICARE/Medicare reimbursement rates.

TRICARE Retiree Dental Plan (TRDP)

The focus of the TRICARE Retiree Dental Plan (TRDP) is to maintain the dental health of Uniformed Services retirees and their family members. Several years ago we saw the need to modify the TRDP legislation to allow the Department of Defense to include some dental procedures that had previously not been covered by the program to achieve equity with the active duty plan.

With ever increasing premium costs, NMVA feels that the Department should assist retirees in maintaining their dental health by providing a government cost-share for the retiree dental plan. With many retirees and their families on a fixed income, an effort should be made to help ease the financial burden on this population and promote a seamless transition from the active duty dental plan to the retiree dental plan in cost structure. Additionally, we hope the Congress will enlarge the retiree dental plan to include retired beneficiaries who live overseas.

The NMVA would appreciate this Committee's consideration of both proposals.

NATIONAL GUARD AND RESERVE HEALTH CARE

Funding Improved TRICARE Reserve Select

It is being suggested that the TRICARE Reserve Select healthcare plan be changed to allow the majority of Selected Reserve participate at a 28 percent copayment level with the balance of the premium being paid by the Department of Defense.

NMVA asks the committee to continue to support funding of the TRICARE Reserve Select program.

Mobilized Health Care—Dental Readiness of Reservists

The number one problem faced by Reservists being recalled has been dental readiness. A model for healthcare would be the TRICARE Dental Program, which offers subsidized dental coverage for Selected Reservists and self-insurance for SELRES families.

In an ideal world this would be universal dental coverage. Reality is that the services are facing challenges. Premium increases to the individual Reservist have caused some junior members to forgo coverage. Dental readiness has dropped. The Military services are trying to determine how best to motivate their Reserve Component members but feel compromised by mandating a premium program if Reservists must pay a portion of it.

Services have been authorized to provide dental treatment as well as examination, but without funding to support this service. By the time many Guard and Reserve are mobilized, their schedule is so short fused that the processing dentists don't have time for extensive repair.

The National Military Veterans Alliance supports funding for utilization of Guard and Reserve Dentists to examine and treat Guardsmen and Reservists who have substandard dental hygiene. The TRICARE Dental Program should be continued, because the Alliance believes it has pulled up overall Dental Readiness.

Demobilized Dental Care

Under the revised transitional healthcare benefit plan, Guard and Reserve who were ordered to active duty for more than 30 days in support of a contingency and have 180 days of transition health care following their period of active service.

Similar coverage is not provided for dental restoration. Dental hygiene is not a priority on the battlefield, and many Reserve and Guard are being discharged with dental readiness levels much lower than when they were first recalled. At a minimum, DOD must restore the dental state to an acceptable level that would be ready for mobilization, or provide some subsidize for 180 days to permit restoration from a civilian source.

Current policy is a 30-day window with dental care being space available at a priority less than active duty families.

NMVA asks the committee for funding to support a DOD's demobilization dental care program. Additional funds should be appropriated to cover the cost of TRICARE Dental premiums and co-payment for the 6 months following demobilization if DOD is unable to do the restoration.

OTHER GUARD AND RESERVE ISSUES

Ensure adequate funding to equip Guard and Reserve at a level that allows them to carry out their mission. Do not turn these crucial assets over to the active duty force. In the same vein we ask that the Congress ensure adequate funding that allows a Guardsman/Reservist to complete 48 drills, and 15 annual training days per member, per year. DOD has been tempted to expend some of these funds on active duty support rather than personnel readiness.

The NMVA strongly recommends that Reserve Program funding remain at sufficient levels to adequately train, equip and support the robust reserve force that has been so critical and successful during our Nation's recent major conflicts.

While Defense Authorizers provided an early retirement benefit in fiscal year 2008, only those who have served in support of a contingency operation since 28 January 2008 are eligible, nearly 6 years and 4 months after Guard and Reserve members first were mobilized to support the active duty force in this conflict. Over 600,000 Reservists have served during this period and were excluded from eligibility. The explanation given was lack of mandatory funding offset. To exclude a portion of our warriors is akin to offering the original GI Bill to those who served after 1944.

NMVA hopes that this subcommittee can help identify excess funding that would permit an expanded early retirement benefit for those who have served.

ARMED FORCES RETIREMENT HOMES

Following Hurricane Katrina, Navy/Marine Corps residents from AFRJ-Gulfport were evacuated from the hurricane-devastated campus and were moved to the AFRH-Washington, D.C. campus. Dormitories were reopened that are in need of refurbishing.

NMVA urges this subcommittee to continue funding upgrades at the Washington, D.C. facility, and to continue funding to rebuild the Gulfport facility.

CONCLUSION

Mr. Chairman and distinguished members of the Subcommittee the Alliance again wishes to emphasize that we are grateful for and delighted with the large steps forward that the Congress has affected the last few years. We are aware of the continuing concern all of the subcommittee's members have shown for the health and welfare of our service personnel and their families. Therefore, we hope that this subcommittee can further advance these suggestions in this committee or in other positions that the members hold. We are very grateful for the opportunity to submit these issues of crucial concern to our collective memberships. Thank you.

CONCLUSION OF HEARINGS

Chairman INOUE. I'd like to thank all of you for your testimony this morning. The subcommittee will take all issues seriously, I can assure you. And if you do have documents to support your testimony, please submit them.

With that, the meeting will stand in recess, subject to the call of the Chair.

Thank you.

[Whereupon, at 11:40 a.m., Thursday, June 18, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]