DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 2012

WEDNESDAY, JUNE 22, 2011

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:39 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (chairman) presiding.

Present: Senators Inouye, Cochran, and Shelby.

NONDEPARTMENTAL WITNESSES

OPENING STATEMENT OF CHAIRMAN DANIEL K. INOUYE

Chairman INOUYE. First, I'd like to apologize to all of you for this lateness. Last night we were deluged with thunderstorms, and I live in Rockville, Maryland. It took me 2 hours to get in. No traffic lights, and American drivers without traffic lights.

So I'd like to welcome all of you to this hearing to receive testimony pertaining to the various issues related to defense appropriations requests. Because we have so many witnesses, I will have to remind the witnesses that they will be limited to 4 minutes apiece. I'm sorry about that.

At this point I'd like to recognize my vice chairman, Senator Cochran.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Mr. Chairman, thank you. It's a pleasure to join you in welcoming the witnesses to the hearing. We appreciate your interest in our work and it will make a contribution to helping improve our national security and the work we do here in supporting our military forces and related interests around the world.

Chairman INOUYE. Our first witness is Dr. Matthew King of the American Thoracic Society. Dr. King.

STATEMENT OF MATTHEW KING, M.D., ON BEHALF OF THE AMERICAN THORACIC SOCIETY

Dr. KING. Mr. Chairman, members of the subcommittee: Thank you for hearing me today. My name is Matt King. I'm a pulmonary physician in Nashville, Tennessee, and I've worked at both Vanderbilt University and the Nashville Veterans Administration (VA) Hospital with military personnel and veterans.

I'm testifying today on behalf of the American Thoracic Society, which is a medical professional organization dedicated to the pre-

vention, treatment, and cure of lung disease. Many of the members of the American Thoracic Society work in the military and with the VA, and as such we've become deeply concerned with the respiratory issues that some of our military personnel are suffering.

There is a real cause for concern here. As you may have read in the New York Times over the weekend, there have been several studies reporting a startling number of respiratory disorders in our military personnel returning from Iraq and Afghanistan. In fact, military personnel that have served in Iraq and Afghanistan are reporting severe respiratory diseases at a rate seven times higher than people who are serving elsewhere.

Studies have documented increases in asthma, fixed obstructive lung disease, allergic rhinitis, and several other rare pulmonary disorders. I personally have been involved in a study that's going to be published next month of 50 veterans returning from Iraq and Afghanistan that have a rare incurable pulmonary disease caused constrictive bronchiolitis. These patients often have normal pulmonary function tests, but, despite their normal tests, are having severe respiratory symptoms.

We don't know exactly why, but Iraq and Afghanistan veterans are exposed to a number of inhalational insults, ranging from dust storms to inhaled smoke from burn pits to aerosolized metal and chemicals from exploding improvised explosive devices (IEDs), blast overpressure or shock waves to the lung, outdoor allergens such as date pollen, and indoor allergens such as the mold aspergillus. We think many of these are contributing. We've identified many respiratory illnesses, but we really don't know the scope of the problem.

So there are several questions: What are the key causative agents? How many veterans are experiencing this disease? What is the best way to identify and treat the servicemen and women? Attention is needed to address these and other important questions.

The American Thoracic Society recommends the following steps: All service men and women should have pre- and post-deployment pulmonary function testing. The Department of Defense (DOD) and VA should support projects to establish a more comprehensive normative pulmonary function test database used to evaluate military men and women. The DOD and VA should jointly create and fund a program to study the respiratory exposures that may be contributing to these respiratory illnesses. Potential goals of this kind of research program could include identifying the exact agents to which people are exposed and that may be causing the illnesses, considering potential population-based and individual interventions that could prevent or at least reduce exposure to these causative agents, and supporting research and to improve prevention, detection, and treatments for deployment-related respiratory diseases.

Also, the DOD and VA should consider establishing centers of excellence to enhance research and clinical treatment of these service men and women that are returning with deployment-related respiratory illnesses.

Finally, we believe that the DOD and VA should create a standard administrative approach to determining respiratory disability for the Operation Iraqi Freedom and Enduring Freedom service personnel.

Thank you. The American Thoracic Society appreciates the opportunity to testify here. I'd be happy to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF DR. MATTHEW KING

The American Thoracic Society appreciates the opportunity to testify before the Senate Department of Defense Appropriations Subcommittee regarding the fiscal year 2012 budget.

The American Thoracic Society is a medical professional society of over 15.000 members who are dedicated to the prevention, detection, treatment and cure of respiratory, sleep and critical care related illnesses. Our physicians, nurses, respiratory therapists and basic scientists are engaged in research, education and advocacy to reduce the worldwide burden of respiratory diseases.

Many members of the American Thoracic Society service as researchers and clinicians in the U.S. military and at VA medical centers. As such, we are deeply concerned about the respiratory health of U.S. military personal.

And there is cause for concern.

A surprising number of returning service men and women from Iraq and Afghanistan are experiencing moderate to server respiratory diseases. There are several anecdotes of military personal who were elite athletes—marathon runners, road cyclists—before deployment are no longer able to complete the 2 mile physical readiness run. Even more puzzling, is in many cases, these service men and women have normal pulmonary function text values. Despite having normal pulmonary function test values, these service members severely de-saturate during exercise.

Physicians have described a new disease called Iraq-Afghanistan War lung injury (IAW–LI), among soldiers deployed to these countries as part of Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn. Not only do soldiers deployed to Iraq and Afghanistan suffer serious respiratory problems at a rate seven times that of soldiers deployed elsewhere, but the respiratory issues they present with show a unique pattern of fixed obstruction in half of cases, while most of the rest are clinically reversible new-onset asthma, in addition to the rare interstitial lung disease called nonspecific interstitial pneumonitis associated with inhalation of titanium and iron.

Iraq and Afghanistan veterans are faced with a barrage of respiratory insults, including: (1) dust from the sand, (2) smoke from the burn pits, (3) aerosolized metals and chemicals from exploded IEDs, associated with (4) blast overpressure or shock waves to the lung, (5) outdoor aeroallergens such as date pollen, and (6) indoor aeroallergens such as mold aspergillus. Researchers have experimentally exposed mouse models to samples of the dust taken from Iraq and Afghanistan and found that it produces extreme histological responses, underscoring the severe exposures that these soldiers undergo.

A case series study was recently presented at the American Thoracic Society international conference by Robert Miller, MD, of Vanderbilt University. Dr. Miller discussed a cohort of patients with constrictive bronchiolitis who were deployed in Iraq.

While clinicians and researchers have defined the condition, there is much we don't know. There are uncertainties regarding the number of service men and women who are experiencing deployment related respiratory illnesses. Complicating both clinical and research efforts is that fact that deployed troops do not receive pre and post deployment pulmonary function tests—in this case a simple spirometry test—that would help doctors know the extent of lung damage.

Further challenges include the spectrum of possible lung diseases that may be occurring from Southwest Asia exposures, such as asthma, constrictive bronchiolitis, acute eosinophilic pneumonia and rhinosinusitis, and the variability in exposures that may confer risk, including particulate matter from desert dusts, burn pits, vehicle exhaust and tobacco smoke.

Clinicians face a different set of challenges with this patient population, including the role of targeted medical surveillance in determining need for further respiratory diagnostic evaluation, and, importantly, the role of surgical lung biopsy in clinical diagnosis of post-deployment lung disease.

Attention is needed to address the respiratory illnesses suffered by returning service men and women. The ATS recommends the Department of Defense and the Department of Veterans Affairs take the following steps:

—The American Thoracic Society recommends all military personal deployed in combat receive a pre- and post-deployment pulmonary function test.

—Support projects to establish more comprehensive normative pulmonary function test values for military men and women.
—The Department of Defense and the Department of Veterans Affairs jointly create and fund a program to study respiratory exposures of servicemen and women deployed in Iraq and Afghanistan. Potential goals of this joint research program could include:
  —Identify likely agents responsible for respiratory illnesses of returning OEF and OIF personal;
  —Consider potential population based and individual interventions to prevent or reduce exposure to causative agents; and
  —Support research into improved prevention, detection and treatments for deployment-related respiratory disease.
—Establish Centers of Excellence to facilitate improved research and clinical treatment of service men and women experiencing severe deployment-related respiratory illnesses.
—The Department of Defense and the Department of Veterans Affair consider administrative standardized approaches to determining respiratory disability for deployment related respiratory illnesses.

The American Thoracic Society appreciates the opportunity to testify before the House Department of Defense Appropriations Subcommittee. We would be happy to answer any questions or provide follow up information.

Chairman INOUYE. Dr. King, I thank you very much. Will you share with this subcommittee the results of your testing, your findings?

Dr. KING. Of my personal study?

Chairman INOUYE. Yes.

Dr. KING. We have had 80 to 100 people from Fort Campbell in Kentucky referred to Vanderbilt University, where we've done extensive testing in patients, in whom we were unable to identify any other cause of potential respiratory symptoms. We did open-lung biopsies and found this constrictive bronchiolitis, which is an untreatable and irreversible condition, to which we speculate it is a reaction to some inhalational toxin experienced in Southwest Asia.

Chairman INOUYE. Thank you.

Senator Cochran.

Senator COCHRAN. I think we owe you a debt of gratitude and thanks for bringing this to our attention. I think you can be assured we'll look into it and try to make a decision that responds to the challenge.

Dr. KING. Thank you very much.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. No comments. I just want to hear the witnesses. Thank you, Mr. Chairman.

Chairman INOUYE. Thank you.

Our next witness is Ms. Dee Linde of the Dystonia Medical Research Foundation. Ms. Linde.

STATEMENT OF DEE LINDE, PATIENT ADVOCATE, DYSTONIA MEDICAL RESEARCH FOUNDATION

Ms. LINDE. Thank you, Mr. Chairman, and aloha nui loa to you.

Mr. Chairman and members of the Senate Defense Appropriations Subcommittee: Thank you for the opportunity to testify today. My name is Dee Linde and I am a dystonia patient and volunteer with the Dystonia Medical Research Foundation, or DMRS. As a veteran and former Navy petty officer, I am honored to testify before this subcommittee.

The DMRS is a patient-centered nonprofit organization dedicated to serving dystonia patients and their families. Dystonia is a neuro-

logical movement disorder that causes muscles to contract and spasm involuntarily. Dystonia is a chronic disorder whose symptoms vary in degrees of frequency, intensity, disability, and pain. Dystonia can be generalized or focal. Generalized dystonias affect all major muscle groups, resulting in twisting repetitive movements and abnormal postures. Focal dystonias affect a specific part of the body, such as the legs, arms, eyelids, or vocal cords.

Dystonia can be hereditary or caused by trauma, and it affects approximately 300,000 persons in the United States. At this time there is no cure for dystonia and treatment is highly individualized. Patients frequently rely on invasive therapies.

In 1995, after my Navy career, I started feeling symptoms for what would later be diagnosed as tardive dystonia, which is medication-induced dystonia. The symptoms started as uncontrollable shivering sensations. Over the next 2 years, the symptoms continued to worsen and I started feeling like I was being squeezed in a vise. My diaphragm was constricted and I couldn't breathe. I also had blepharospasm, a form of dystonia that forcibly shut my eyes, leaving me functionally blind even though there was nothing wrong with my vision.

My dystonia affected my entire upper body and for years my spasms wouldn't allow me to sit in a chair or sleep safely in bed with my husband. I spent those years having to sleep and even eat on the floor.

After I developed dystonia, I was forced to give up my private practice as a psychotherapist. Since I am a veteran, I receive all my medical care through the VA system. In 2000, I underwent surgery to receive deep brain stimulation (DBS). The neurosurgeon implanted leads into my brain that emit constant electrical pulses which interrupt the bad signals and help control my symptoms. Thanks to DBS, I have gone from being completely nonfunctional to having the ability to walk and move like a healthy individual. I'm happy to say that I am now almost completely symptom free.

The DMRS has received reports that the incidence of dystonia in the United States has noticeably increased since our military forces were deployed to Iraq and Afghanistan. A June 2006 article in Military Medicine titled "Post-Traumatic Shoulder Dystonia in an Active Duty Soldier" stated that: "Dystonia after minor trauma can be as crippling as a penetrating wound, with disability that renders the soldier unable to perform his duties."

Awareness of this disorder, dystonia, is essential to avoid mislabeling and possibly mistreating a true neurological disease. The Department of Defense peer-reviewed medical research program is the most essential program studying dystonia in military and veteran populations, and I myself was the consumer reviewer on this panel. This program is critical to developing a better understanding of the mechanisms connecting trauma and dystonia.

The dystonia community would like to thank the subcommittee for adding dystonia to the list of conditions eligible for study under the program in the fiscal year 2010 and 2011 defense appropriation bills. We urge the subcommittee to maintain dystonia as an eligible condition in the defense peer-reviewed medical research program in fiscal year 2012.

Thank you for allowing me the opportunity to address the subcommittee today.

Chairman INOUYE. Ms. Linde, I thank you very much for your testimony and we will do our best.

Ms. LINDE. Thank you.

Chairman INOUYE. Senator Cochran.

Senator COCHRAN. Mr. Chairman, I have nothing further to add. We appreciate your presence and your advice and observations for the benefit of the subcommittee.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Nothing to add either, but I appreciate all of you being here.

Ms. LINDE. Thank you.

Chairman INOUYE. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF DEE LINDE

Mr. Chairman and members of the Senate Appropriations Defense Subcommittee, thank you for the opportunity to testify today. My name is Dee Linde, and I am a dystonia patient and volunteer with the Dystonia Medical Research Foundation or "DMRF." I am also a former Navy service member and I am honored to testify before this subcommittee. The DMRF is a patient-centered, nonprofit organization dedicated to serving dystonia patients and their families. The DMRF works to advance dystonia research, increase dystonia awareness, and provide support for those living with the disorder.

Dystonia is a neurological movement disorder that causes muscles to contract and spasm involuntarily. Dystonia is not usually fatal, but it is a chronic disorder whose symptoms vary in degrees of frequency, intensity, disability, and pain. Dystonia can be generalized or focal. Generalized dystonia affects all major muscle groups, resulting in twisting repetitive movements and abnormal postures. Focal dystonia affects a specific part of the body such as the legs, arms, hands, neck, face, mouth, eyelids, or vocal chords. Dystonia can be hereditary or caused by trauma, and it affects approximately 300,000 persons in the United States. At this time, there is no cure for dystonia and treatment is highly individualized. Patients frequently rely on invasive therapies like botulinum toxin injections or deep brain stimulation (DBS) to help manage their symptoms.

In 1995, after my Navy career, I started feeling symptoms for what would later be diagnosed as tardive dystonia, which is medication-induced dystonia. The symptoms started as an uncontrollable shivering sensation that often prompted people to ask me if I was cold. Over the next 2 years, the symptoms continued to worsen and I started feeling like I was being squeezed: my diaphragm was constricted and I couldn't breathe. I also had belpharospasm which meant that my eyes would shut forcibly and uncontrollably, leaving me functionally blind even though there was nothing wrong with my vision.

The tardive dystonia affected my entire upper body and for years my spasms didn't allow me to sit in a chair, or sleep safely in the bed with my husband. As a family joke, my mother made my husband a nose guard to wear because I kept hitting him during the night. I spent those years having to sleep and even eat on the floor. Before I developed dystonia, I had my own private practice as a licensed psychotherapist which I had to give up as a result of my spasms.

Because I have other service-connected disabilities and am considered 100 percent unemployable, I receive care at the Veterans hospital in Portland, Oregon. In 2000, I underwent surgery to receive deep brain stimulation (DBS). The surgeons implanted leads into my basil ganglia which is the part of the brain that controls movement. The leads emit electric pulses that interrupt the bad signals that my brain is sending to my body and allow me to control my movement. Thanks to DBS, I have gone from being completely non-functional, to having the ability to walk and to move like a healthy individual. I am happy to say that I am now almost completely symptom free. The battery packs for the DBS are implanted under my clavical, and I used to return to the hospital every 2 years to surgically replace them. In 2010, I had the new rechargeable battery implanted. This battery lasts for 9 years, and now I literally "recharge my batteries" for 2.5 hours at the end of every week.

The DMRF has received reports that the incidence of dystonia in the United States has noticeably increased since our military forces were deployed to Iraq and Afghanistan. This recent increase is widely considered to be the result of a well-documented link between traumatic injuries and the onset of dystonia. A June 2006 article in Military Medicine, titled "Post-Traumatic Shoulder Dystonia in an Active Duty Soldier" reported on dystonia experienced by military personnel and stated that "Dystonia after minor trauma can be as crippling as a penetrating wound, with disability that renders the soldier unable to perform his duties . . . awareness of this disorder [dystonia] is essential to avoid mislabeling, and possibly mistreating, a true neurological disease." As military personnel remain deployed for longer periods, we can expect dystonia prevalence in military and veterans populations to continue to rise.

Although Federal dystonia research is conducted through a number of medical and scientific agencies, the Department of Defense (DOD) Peer-Reviewed Medical Research Program remains the most essential program studying dystonia in military and veteran populations. This program is critical to developing a better understanding of the mechanisms connecting trauma and dystonia. The DMRF would like to thank the Subcommittee for adding dystonia to the list of conditions eligible for study under the DOD Peer-Reviewed Medical Research Program in the fiscal year 2010 and 2011 Defense Appropriation bills. The DMRF is excited to report that dystonia researchers were granted two awards in fiscal year 2010. We urge the Committee to maintain dystonia as a condition eligible for study through the Peer-Reviewed Medical Research Program in fiscal year 2012.

Thank you again for allowing me the opportunity to address the Subcommittee today. I hope you will continue to include dystonia as a condition eligible for study under the DOD Peer-Reviewed Medical Research Program. Below is a poem that I composed during one of my most difficult moments, and I hope this poem provides greater insight to the hardships and loneliness faced in enduring this disorder.

DYSHARMONIA

The twitch [1] doctor says it's dystonia
Which is far from the likes of harmonia
The muscles don't work in dystonia
But how graceful they are in harmonia
I can walk down the street
Without two left feet
I can hold my head high
Not low like a geek
I can keep both my eyes wide open
And swallow my food without chokin'
But that's with harmonia
And I've got dystonia
Which leaves me just feelin'
Alonia

[1] twitch doctor = Movement Disorder Specialist.

Chairman INOUYE. Our next witness is Ms. Barbara Zarnikow, Interstitial Cystitis Association.

STATEMENT OF BARBARA ZARNIKOW, CO-CHAIR, INTERSTITIAL CYSTITIS ASSOCIATION

Ms. ZARNIKOW. Chairman Inouye, Ranking Member Cochran, and distinguished members of the Defense Subcommittee: Thank you for the opportunity to testify today, to present testimony today on interstitial cystitis, commonly known as "IC." I am Barbara Zarnikow from Buffalo Grove, Illinois. I am an IC patient and co-chair of the Interstitial Cystitis Association, a nonprofit organization which provides advocacy, research funding, and education for patients living with IC.

IC is a chronic debilitating condition characterized by recurring pain, pressure, and discomfort in the bladder and pelvic region. It is often associated with frequent and urgent urination. There is no known cause and it can take years to diagnose because it is often

misdiagnosed. There is not a test to diagnose IC, so it is diagnosed through the process of elimination of other diseases with similar symptoms.

IC affects an estimated 3 to 8 million women in the United States and is often believed to be primarily a women's disease. However, recent research shows that 1 to 4 million men suffer from IC as well. IC is a debilitating disease that has an impact on the quality of life similar to what's been reported by individuals suffering from end stage renal disease and rheumatoid arthritis. IC can cause patients to suffer from severe pain, sleep deprivation, high rates of depression, anxiety, and overall decline in quality of life. IC affects all aspects of a patient's life.

A study conducted between 1992 and 2002 found that approximately 1.4 percent of veterans served by the Veterans Health Administration were being treated for IC. The study also showed a 14 percent increase in patients being treated for IC in VHA during this same period.

IC is currently part of the Department of Defense peer-reviewed medical research program. This is so important because studies have shown that the incidence of IC in our population is much higher than previously thought.

A prime example of how IC can impact members of the military is former Navy Captain Gary Mowrey, retired, who was forced to cut his career short as a result of IC. Captain Mowrey was in the Navy for 25 years and has served as commander of the VAQ133 Squadron, operations officer on the USS *Dwight D. Eisenhower,* chief of the Enlisted Performance Division in the Bureau of Naval Personnel, and earned a Southwest Asia Service Medal with two stars for his service in Operation Desert Storm.

In 1994 he began to experience significant pelvic pain and could not always make it to the bathroom. He was not even able to sit through normal meetings. After months of unsuccessful antibiotic treatments for urinary tract infections, Captain Mowrey was diagnosed with IC, and shortly after retired due to the pain and limitations imposed by IC.

He then attempted to teach high school math, but had to retire from this position as well due to the pain, frequent urination, and fatigue associated with having to urinate 20 to 30 times each night. If you've ever had a bladder infection or know someone who has, imagine if that infection never went away and you had to live with these symptoms your entire life. That is IC.

On behalf of IC patients, including many veterans, we request IC continue to be eligible for the peer-reviewed medical research program for fiscal year 2012. Thank you for your time and consideration.

Chairman INOUYE. Ms. Zarnikow, I thank you very much on behalf of the subcommittee. We appreciate it very much.

[The statement follows:]

PREPARED STATEMENT OF BARBARA GORDON, RD, EXECUTIVE DIRECTOR, INTERSTITIAL CYSTITIS ASSOCIATION

Chairman Inouye, Ranking Member Cochran, and distinguished members of the Subcommittee, thank you for the opportunity to present information on Interstitial Cystitis (IC). The Interstitial Cystitis Association (ICA) provides advocacy, research funding, and education to ensure early diagnosis and optimal care with dignity for

people affected by IC. Until the biomedical research community discovers a cure for IC, our primary goal remains the discovery of more efficient and effective treatments to help patients live with the disease.

IC is a chronic condition characterized by recurring pain, pressure, and discomfort in the bladder and pelvic region. The condition is often associated with urinary frequency and urgency, although this is not a universal symptom. The cause of IC is unknown. Diagnosis is made only after excluding other urinary and bladder conditions, possibly causing 1 or more years of delay between the onset of symptoms and treatment. Men suffering from IC are often misdiagnosed with bladder infections and chronic prostatitis. Women are frequently misdiagnosed with endometriosis, inflammatory bowel disease (IBD), irritable bowel syndrome (IBS), vulvodynia, and fibromyalgia, which commonly co-occur with IC. When healthcare providers are not properly educated about IC, patients may suffer for years before receiving an accurate diagnosis and appropriate treatment.

Although IC is considered a "women's disease," scientific evidence shows that all demographic groups are affected by IC. Women, men, and children of all ages, ethnicities, and socioeconomic backgrounds develop IC, although it is most commonly found in women. Recent prevalence data reports that 3 to 8 million American women and 1 to 4 million American men suffer from IC. Using the most conservative estimates, at least 1 out of every 77 Americans suffer from IC, and further study may indicate prevalence rates as high as 1 out of every 28 people. Based on this information, IC affects more people than breast cancer, Alzheimer's diseases, and autism combined.

The effects of IC are pervasive and insidious, damaging work life and productivity, psychological well-being, personal relationships, and general health. Quality of life studies have found that the impact of IC can equal the severity of rheumatoid arthritis and end-stage renal disease. Health-related quality of life in women with IC is worse than in women with endometriosis, vulvodynia, or overactive bladder alone. IC patients have significantly more sleep dysfunction, higher rates of depression, increased catastrophizing, anxiety and sexual dysfunction.

Although IC research is currently conducted through a number of Federal entities, including the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC), the DOD's Peer-Reviewed Medical Research Program (PRMRP) remains essential. The PRMRP is an indispensable resource for studying emerging areas in IC research, such as prevalence in men, the role of environmental conditions such as diet in development and diagnosis, barriers to treatment, and IC awareness within the medical military community. Specifically, IC education and awareness among military medical professionals takes on heightened importance, as neither the President's fiscal year 2012 budget request nor the Centers for Disease Control and Preventions fiscal year 2011 Operating Plan include renewed funding for the CDC's IC Education and Awareness Program.

On behalf of ICA, and as an IC patient, I would like to thank the Subcommittee for including IC as a condition eligible for study under the DOD's PRMRP in the fiscal years 2010 and 2011 DOD Appropriations bills. The scientific community showed great interest in the program, responding to the initial grant announcement with an immense outpouring of proposals. We urge Congress to maintain IC's eligibility in the PRMRP in the fiscal year 2012 DOD Appropriations bill, as the number of current military members, family members, and veterans affected by IC is increasing.

Ms. ZARNIKOW. Thank you.

Senator COCHRAN. Thank you for your attendance. We appreciate your giving us this information and the observations you have about this problem.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. I thank the whole panel and I thank this woman who just gave this presentation. This is very interesting. It affects a lot of people. I know that.

Thank you, Mr. Chairman.

Ms. ZARNIKOW. It does affect a lot of people.

Chairman INOUYE. Thank you very much.

Ms. ZARNIKOW. Thank you.

Chairman INOUYE. Our next witness is Mr. Dane Christiansen, International Foundation for Functional Gastrointestinal Disorders.

STATEMENT OF DANE R. CHRISTIANSEN, DEVELOPMENT COORDINATOR, INTERNATIONAL FOUNDATION FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

Mr. CHRISTIANSEN. Chairman Inouye, Ranking Member Cochran, Senator Shelby, and the distinguished members of the Defense Appropriations Subcommittee: Thank you for the opportunity to present testimony. My name is Dane Christiansen and I am testifying on behalf of the International Foundation for Functional Gastrointestinal Disorders, or IFFGD. We request that the subcommittee include functional gastrointestinal disorders on the list of conditions deemed eligible for study through the Department of Defense peer-reviewed medical research program within fiscal year 2012 defense appropriations legislation.

Founded in 1991, IFFGD is a nonprofit patient-driven organization dedicated to helping individuals affected by functional gastrointestinal and motility disorders. The phrase "functional gastrointestinal disorder" or "functional GI disorder" refers to a family of conditions where the nerves, muscles, and related mechanisms of the digestive tract do not function properly. The result is multiple, persistent, and often painful symptoms, ranging from nausea and vomiting to altered bowel habit.

Over two dozen functional gastrointestinal disorders have been identified. Severity ranges from bothersome to disabling and life-altering. The conditions may strike anywhere along the GI tract. One thing they have in common is that little is understood about their underlying mechanisms and as a result little is understood about treatment.

The few treatments available reduce symptoms in some but not all patients. These conditions are chronic, costly from a healthcare standpoint, impair productivity, and exact a tremendous toll in terms of quality of life. The onset of a functional gastrointestinal disorders can be triggered by infection of the GI tract and/or severe stress. Deployed military personnel face an elevated chance of experiencing these risk factors.

The 2010 Institute of Medicine (IOM) report that looked at health effects of serving in the gulf war concluded that there is sufficient evidence for an association between deployment and symptoms consistent with functional gastrointestinal disorders. Functional gastrointestinal disorders are one of the hallmarks of what was previously described as gulf war syndrome.

The Veterans Administration recognizes a presumption of service connection for the purposes of soldiers with functional gastrointestinal disorders applying for disability benefits.

In order to better articulate the suffering associated with functional gastrointestinal disorders, I would like to be the voice of Dr. Brennan Spiegel, a physician who regularly sees military personnel affected by these conditions. I'm quoting now:

"Those of us in the VA are now witnessing a near-epidemic emerging and that is chronic GI symptoms, like abdominal pain, nausea, vomiting, and diarrhea. The stories are heartbreaking and compelling and they are constant and unrelenting. Imagine having the stomach flu. Now think about having that every day and being told that we can't treat it very well.

"Every Monday morning at the West Los Angeles VA Medical Center, our clinic cares for at least 5 to 10 patients with service-related GI symptoms. Recently, a soldier entered my VA exam room square-jawed and battle-tested. Within minutes, he was crying, averting eye contact, and trying to explain that his life came to a near halt after kicking in a door one day in Tikrit. His abdomen was burning while in the moment and he stifled nausea to get through the event. Then, when it was over, he broke from his troop and threw up. It's never stopped and that was 2 years ago.

"There are so many other stories like this. We're making progress, but we don't have good answers or good treatments."

Please consider including functional gastrointestinal disorders on the eligible conditions list for the DOD peer-reviewed medical research program within fiscal year 2012 defense appropriations legislation. This would allow researchers to begin working to better understand, diagnose, and treat these conditions, particularly as they impact veterans and active duty military personnel.

Thank you for your time and your consideration of this request.

[The statement follows:]

PREPARED STATEMENT OF NANCY J. NORTON, PRESIDENT AND CO-FOUNDER, INTERNATIONAL FOUNDATION FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

Thank you for the opportunity to present the views of the International Foundation for Functional Gastrointestinal Disorders (IFFGD) regarding functional gastrointestinal disorders (FGIDs) among service personnel and veterans. I am here today to request that that the Subcommittee include FGIDs as a condition eligible for study in the Department of Defense (DOD) Peer-Reviewed Medical Research Program in fiscal year 2012.

Established in 1991, IFFGD is a patient-driven nonprofit organization dedicated to assisting individuals affected by functional GI disorders, and providing education and support for patients, healthcare providers, and the public at large. Our mission is to inform and support people affected by painful and debilitating digestive conditions, about which little is understood and few (if any) treatment options exist. The IFFGD also works to advance critical research on functional GI and motility disorders, in order to provide patients with better treatment options, and to eventually find a cure.

FGIDs are disorders in which the movement of the intestines, the sensitivity of the nerves of the intestines, or the way in which the brain controls intestinal function is impaired. People who suffer from FGIDs have no structural abnormality which makes it difficult to identify their condition using X-rays, blood tests or endoscopies. Instead, FGIDs are typically identified and defined by the collection of symptoms experienced by the patient. For this reason, it is not uncommon for FGID suffers to have unnecessary surgery, medication, and medical devices before receiving a proper diagnosis. Examples of FGIDs include irritable bowel syndrome (IBS) and functional dyspepsia. IBS is characterized by abdominal pain and discomfort associated with a change in bowel pattern, such as diarrhea and/or constipation. Symptoms of functional dyspepsia usually include an upset stomach, pain in the belly, and bloating.

FGIDs can be emotionally and physically debilitating. Due to persistent pain and bowel unpredictability, individuals who suffer from this disorder may distance themselves from social events, work, and even may fear leaving their home. Stigma surrounding bowel habits may act as barrier to treatment, as patients are not comfortable discussing their symptoms with doctors. Because FGID symptoms are relatively common and not life-threatening, many people dismiss their symptoms or attempt to self-medicate using over-the-counter medications.

In April 2010, the National Academy of Sciences (NAS) published a report titled "Gulf War and Health, Volume 8: Update on the Health Effects of Serving in the Gulf War" which determined that there is sufficient evidence to associate deployment to the gulf war and FGIDs, including IBS and functional dyspepsia. According to the report, there have been a large number of FGID cases among gulf war veterans, and their symptoms have continued to be persistent in the years since that war. The NAS report focused on the incidence of GI disorders among veterans and

did not attempt to determine causality. However, the report provides compelling evidence linking exposure to enteric pathogens during deployment and the development of FGIDs. The NAS recommended that further research be conducted on this association.

The Department of Defense (DOD) Peer-Reviewed Medical Research Program conducts important research on medical conditions that impact veterans and active duty military personnel. Given the conclusions of the NAS report, and the report's recommendations for further research on the link between FGIDs and exposures experienced by veterans in the gulf war, FGIDs would make an appropriate addition to the eligible conditions list for the Defense Medical Research Program. Therefore, we ask that you include "functional gastrointestinal disorders" as a condition eligible for study in the fiscal year 2012 DOD Peer-Reviewed Medical Research Program.

Thank you again for the opportunity to address the Subcommittee today. I hope you agree that the evidence linking FGIDs to service in the gulf war is compelling, and that you will include "functional gastrointestinal disorders" as a condition eligible for study in the Department of Defense Peer-Reviewed Medical Research Program in fiscal year 2012.

IBS INFORMATION

IBS, one of the most common functional GI disorders, strikes all demographic groups. It affects 30 to 45 million Americans, conservatively at least 1 out of every 10 people. Between 9 to 23 percent of the worldwide population suffers from IBS, resulting in significant human suffering and disability. IBS as a chronic disease is characterized by a group of symptoms that may vary from person to person, but typically include abdominal pain and discomfort associated with a change in bowel pattern, such as diarrhea and/or constipation. As a "functional disorder", IBS affects the way the muscles and nerves work, but the bowel does not appear to be damaged on medical tests. Without a definitive diagnostic test, many cases of IBS go undiagnosed or misdiagnosed for years. It is not uncommon for IBS suffers to have unnecessary surgery, medication, and medical devices before receiving a proper diagnosis. Even after IBS is identified, treatment options are sorely lacking and vary widely from patient to patient. What is known is that IBS requires a multidisciplinary approach to research and treatment.

Chairman INOUYE. I thank you very much, Mr. Christiansen. Your request will be very seriously considered. Thank you.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, thank you for bringing the witnesses to the subcommittee today to let us hear about these situations. I think we have an obligation to look carefully into the suggestions of service connection between the events in their military deployment and the symptoms that are later discovered. I hope we have enough people who are willing to devote attention to this so we can figure out a way to find a cure or medicinal palliatives that make it better or in any other way possible to help restore them to good health.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. What are the, say, two most promising areas of research in this area to date, dealing with all of these issues?

Mr. CHRISTIANSEN. I am not a physician like Dr. King. I would hate to comment. But we do work extensively to support and encourage research whenever possible. There is a number of areas where we're learning more and more about gut flora and the type of bacteria that is normally within the gut and how something like a GI infection or eating food or drinking water from a country or an area where health conditions aren't up to par may throw that balance off, allow things, pathogens, to leak deeper into the gut than they would normally be, and that would explain why the conditions are chronic as opposed to it just goes through your system and then you're okay a couple weeks later. So looking at the gut flora is becoming more and more of a promising area.

I would also say—and this is a little bit off of functional gastrointestinal disorders directly, but it applies to this whole larger family of functional GI motility disorders, particularly as it applies to veterans and members of the military—that tremendous steps are being made in regenerative medicine, trying to actually regrow parts of the digestive system that may not be working. The anal sphincter is a perfect example. There is tremendous efforts underway to actually in a lab setting repair and regrow anal sphincters, and if this—for example, if there's a soldier who suffered an IED attack and significant pelvic floor damage, regenerative medicine could one day be at a point where he could get a new anal sphincter and return to a normal quality of life. So those are two areas I'd acknowledge off the top.

Senator SHELBY. Have there been studies to show that this is a higher rate of problems with military service personnel as opposed to the general population?

Mr. CHRISTIANSEN. Yes. The IOM report I previously cited, there was actually two IOM studies that looked at this. I'd be happy to share the results of those studies with the subcommittee. But it is—they had a very high threshold for acknowledging service connection and they found that the incidence was higher than it would be in the general population as a result of military service.

Senator SHELBY. Thank you.

Chairman INOUYE. I thank you very much. I'd like to thank the panel.

Our next panel consists of: Ms. Kathleen Moakler, National Military Family Association; Chief Master Sergeant John R. "Doc" McCauslin, Air Force Sergeants Association; Captain Charles D. Connor, U.S. Navy retired, American Lung Association; Mr. Rick Jones, National Association for Uniformed Services.

Our first witness, Ms. Kathleen Moakler. Welcome.

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

Ms. MOAKLER. Thank you, Chairman Inouye, Senator Cochran, Senator Shelby, for allowing us to speak with you this morning about military families, our Nation's families. We continue to share the concerns of military families with policymakers, as we have for over 40 years.

In the past several years, the National Military Family Association has done informal surveys with military families on our web site. In our most recent survey, when 1,200 family members responded on their top priorities, over 84 percent felt it was important that Congress and DOD focus on ensuring support programs meet the needs of families experiencing multiple deployments. Almost 80 percent felt that helping wounded service members and their families should be a top priority, and 78 percent felt that helping surviving families was an important priority.

We applaud the words of Defense Secretary Gates and Chairman Mullen before this subcommittee last week when they stressed the need for continued funding for military family programs and support of the wounded. Our association agrees that we will be dealing with the costs of these wars for years to come and we cannot afford

to shortchange our wounded warriors and our military families, who have sacrificed so much and will continue to sacrifice.

We also agree with Admiral Mullen that communities must join with DOD and the services to support service members, veterans, and military families in their midst. To help with that effort, our association has developed "Finding Common Ground," a toolkit for communities supporting military families that includes easily achievable action items and useful resources to guide anyone who wants to support military families, but doesn't know where to start. It can be downloaded for free at our website, militaryfamily.org.

Child care remains a concern for military families, as evidenced by a recent Pew Center on the States survey. We are pleased that, in addition to building new child development centers, DOD and the services are taking innovative steps to address these concerns by working to improve capacity in private child care agencies within States. But the need remains, especially for the families of the deployed National Guard and Reserve.

At our Operation Purple Healing Adventures Camp for families of the wounded, ill, and injured, families continue to tell us there is a tremendous need for child care services at or near military treatment facilities. Families need child care to attend medical appointments, especially mental healthcare appointments. Our association urges Congress to sustain funding and resources to meet the child care needs of military families, to include hourly, drop-in, and increased respite care across all services, for families of deployed service members and the wounded, ill, and injured, as well as those with special needs family members.

Our association also feels that funding to provide more dedicated resources, such as youth or teen centers, and enhanced partnerships with national youth-serving organizations, would be important ways to better meet the needs of our older youth and teens during deployment.

In 2009 the policy concerning the attendance of the media at the dignified transfer of remains at Dover Air Force Base was changed. Family members are now given the option of flying to Dover. In previous years only about 3 percent of family members attended this ceremony. Since the policy change, over 90 percent of families are sending members to Dover to attend. This is provided by the—the money for this is provided by the services and none of the costs have been funded. We would ask that funds be appropriated to cover the costs of this extraordinary expense.

Thank you for your long-term interest in support of—and support for military families. I look forward to any questions you may have.

[The statement follows:]

PREPARED STATEMENT OF KATHLEEN B. MOAKLER

The National Military Family Association is the leading nonprofit organization committed to improving the lives of military families. Our over 40 years of accomplishments have made us a trusted resource for families and the Nation's leaders. We have been at the vanguard of promoting an appropriate quality of life for active duty, National Guard, Reserve, retired service members, their families and survivors from the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration.

Association Volunteers and Representatives in military communities worldwide provide a direct link between military families and the Association staff in the Na-

tion's capital. These volunteers are our "eyes and ears," bringing shared local concerns to national attention.

The Association does not have or receive Federal grants or contracts.

Chairman Inouye and Distinguished Members of the Subcommittee, the National Military Family Association would like to thank you for the opportunity to present testimony for the record concerning the quality of life of military families—the Nation's families. In the 10th year of war, we continue to see the impact of repeated deployments and separations on our service members and their families. We appreciate your recognition of the service and sacrifice of these families. Your response through legislation to the increased need for support as situations have arisen has resulted in programs and policies that have helped sustain our families through these difficult times.

We recognize, too, the emphasis that the Administration is placing on supporting military families. The work of Mrs. Obama and Dr. Biden through the Joining Forces initiative in raising awareness of the sacrifices military families are making has been well received by the Nation and appreciated by our families. The American people are beginning to understand how 1 percent of our population in the United States is being called upon to bear 100 percent of the burden of defending our Nation, giving up years of family life together, and how they need the support of the other 99 percent of Americans to continue carrying that burden.

The recent Presidential Study Directive-9, which called on Federal agencies to outline how they are presently or could in the future support military families, reinforced Administration support as well. The vision of the study, as contained in the report Strengthening Our Military Families, Meeting America's Commitment, is, "to ensure that:

—The U.S. military recruits and retains the highest-caliber volunteers to contribute to the Nation's defense and security;

—Service members can have strong family lives while maintaining the highest state of readiness;

—Civilian family members can live fulfilling lives while supporting their service member(s); and

—The United States better understands and appreciates the experience, strength, and commitment to service of our military families.

This vision resonates with all that our Association has tried to work for during our 42 year history. We believe policies and programs should provide a firm foundation for families challenged by the uncertainties of deployment and transformation. Our Association cares about the health and resilience of military families. Innovative and evidence based approaches are essential to address the needs of military children. Families promote a service member's well-being. We realize support for service members and their families is not solely provided by the government. Communities also uphold the families.

Our Nation did not expect to be involved in such a protracted conflict. Our military families continue to require effective tools and resources to remain strong. We ask Congress, policymakers, non-government organizations, and communities to remain vigilant and respond in a proactive manner. Our Nation can express recognition for their sacrifices by promoting the well-being of military families.

In this statement, the National Military Family Association will expand on several issues of importance to military families: Family readiness, family health, and family transitions.

Family Readiness

Policies, programs and services must adapt to the changing needs of service members and families. Standardization in delivery, accessibility, and funding are essential. Educated and resourced families are able to take greater responsibility for their own readiness. Recognition should be given to the unique challenges facing families with special needs. Support should provide for families of all components, in every phase of military life, no matter where they live.

We appreciate provisions in the National Defense Authorization Acts and Appropriations legislation in the past several years that recognized many of these important issues. Excellent programs exist across the Department of Defense (DOD) and the Services to support our military families. There are redundancies in some areas and times when a new program was initiated before anyone looked to see if an existing program could be adapted to answer an evolving need. We realize all Americans will be asked to tighten their belts in this time of tighter budgets and some military family programs may need to be downsized or eliminated. We ask your support for programs that do work when looking for efficiencies, rewarding best practices and programs that are truly meeting the needs of families. While we understand that communities and non-government organizations may fill gaps in areas where gov-

ernment programs are lacking, we maintain DOD and the Department of Veterans Affairs (VA) still have a responsibility to provide an appropriate level of support for our service members, veterans, their families, and survivors. In this section we will highlight some of these best practices and identify needs.

Child Care

Child care remains a concern for military families, as evidenced by a recent Pew Center on the States survey (http://www.preknow.org/documents/2011_MilitaryFamiliesSurvey.pdf). We are pleased that in addition to building new Child Development Centers, DOD and the Services are taking innovative steps to address these concerns.

In December, DOD announced a new pilot initiative in 13 States aimed at improving the quality of child care within communities, which should translate into increased child care capacity for military families living in geographically dispersed areas. Last year, DOD contracted with SitterCity.com to help military families find caregivers and military subsidized child care providers. The military Services and the National Association of Child Care Resource and Referral Agencies (NACCRRA) continue to partner to provide subsidized child care to families who cannot access installation based child development centers.

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

We appreciate the requirement in the fiscal year 2010 National Defense Authorization Act calling for a report on financial assistance provided for child care costs across the Services and Components to support the families of service members deployed in support of a contingency operation and we look forward to the results.

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

Working with Youth

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

Through our Operation Purple® camps, our Association has begun to identify the cumulative effects multiple deployments are having on the emotional growth and well-being of military children and the challenges posed to the relationship between deployed parent, caregiver, and children in this stressful environment. Understanding a need for qualitative analysis of this information, we commissioned the RAND Corporation to conduct a longitudinal study on the experience of 1,500 families. RAND followed these families for 1 year, and interviewed the non-deployed caregiver/parent and one child per family between 11 and 17 years of age at three time points over the year. Recruitment of participants was extremely successful because families were eager to share their experiences. The research addressed three key questions:

—How are school-age military children faring?

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

—How are non-deployed caregivers handling deployment and what challenges do they face?

In January 2011, RAND released the report, "Views from the Homefront: The Experience of Youth and Spouses from Military Families" (http://www.rand.org/pubs/technical_reports/TR913.html), detailing the longitudinal findings. The research showed:

—Older teens reported more difficulties during deployment and reintegration.

—Girls reported more difficulties during reintegration.

—There were few differences on military characteristics, but reserve component youth reported more difficulties during deployment.
—Reserve component caregivers reported more challenges with deployment and reintegration.
—The total number of months away mattered more than the number of deployments.
—There is a direct correlation between the mental health of the caregiver and the well-being of the child.
—Quality of family communication mattered to both children and caregiver well-being.

What are the implications of these findings? Families facing longer deployments need targeted support—especially for older teens, girls and the reserve component. Support needs to be in place across the entire deployment cycle, including reintegration, and some non-deployed parents may need targeted mental health support. One way to address these needs would be to create a safe, supportive environment for older youth and teens. Dedicated installation Youth Centers with activities for our older youth would go a long way to help with this. Since many military families, especially those with older children, live off the installation, enhanced partnerships between DOD and national youth-serving organizations are also essential. DOD's current work with the 4–H program is an example of this outreach and support of military children in the community. DOD can encourage other organizations to share outreach strategies and work together to strengthen a network of support for military youth in their civilian communities. We must ensure, however, that, once we have encouraged these community organizations and services to engage with families, we also encourage installations and installation services to be collaborative and not set up roadblocks to interaction and support.

To address the issues highlighted by our research, our Association hosted a summit in May 2010, where we engaged with experts to develop research-based action items. Our Blue Ribbon Panel outlined innovative and pragmatic ideas to improve the well-being of military families, recognizing it is imperative solutions involve a broad network of government agencies, community groups, businesses, and concerned citizens.

We've published the recommendations from the summit in Finding Common Ground: A Toolkit for Communities Supporting Military Families. The toolkit is organized in a format similar to our Association's well-received Military Kids and Teens Toolkits. It contains cards for each of the intended communities—including Educators, Friends and Family, Senior leaders, Employers, and Health Care Providers—whose help is so important to military families. It also contains the summary document with the recommendations formulated by our Blue Ribbon Panel and summit participants.

Our goal was to create a user-friendly resource, with easily achievable action items and pertinent resources to guide everyone who wants to support military families, but may not know how. The toolkit lists concrete actions individuals, organizations, and communities can take to assist and support our military families. We hope that when someone receives a copy, they will go first to the card that most fits their relationship to military families and look for ideas and resources. We would like them to then take the time to explore other cards and the summit summary. While many of the suggested actions are simple, we've also presented some of the tougher things that require the building of partnerships and a longer-term focus. These actions are not exhaustive. It is our hope this toolkit will start conversations and stimulate action. Everyone can contribute—it doesn't need to be complicated or expensive. Just remembering to include military families in outreach is the beginning.

Our Association feels that funding to provide more dedicated resources, such as youth or teen centers and enhanced partnerships with national youth-serving organizations, would be important ways to better meet the needs of our older youth and teens during deployment.

Military Housing

In our recent study conducted by RAND, researchers found that living in military housing was related to fewer caregiver-reported deployment-related challenges. Fewer caregivers who lived in military housing reported their children had difficulties adjusting to parent absence (e.g., missing school activities, feeling sad, or not having peers who understand what their life is like) as compared to caregivers who rented homes. The study team explored the factors that determine a military family's housing situation in more detail. Among the list of potential reasons provided for the question, "Why did you choose to rent?" researchers found that the top three reasons parents/caregivers cited for renting included: military housing was not

available (31 percent), renting was most affordable (28 percent), and preference to not to invest in the purchase of a home (26 percent).

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

In the GAO Report "Military Housing: Enhancements Needed to Housing Allowance Process and Information Sharing among Services" GAO published in May 2011, GAO highlighted the military Services have consistently underestimated the amount needed to pay the basic allowance of housing by $820 million to $1.3 billion each year since 2006. Since the Services have underestimated the amount needed to pay the allowance, DOD has had to shift funds budgeted from other programs—which disrupts the funding to these program.

The key factor to underestimation is the timing of developing the budget process—it takes nearly 1 year to determine the rates. While this process is needed, it causes the Services to underestimate the true cost of the housing allowance. Rates are set in December—10 months after the President's budget is submitted to Congress and 2 months after the new fiscal year begins. In addition, changes in planned force structure (i.e. grow the force initiatives), and the increased use of mobilized reserve personnel (more personnel eligible to receive a housing allowance) present other challenges.

The same GAO report highlighted housing deficits ranging from 1 percent to 20 percent of the total demand at growth installations. While Military construction does not fall under the purview of this Committee, this Committee can help address the housing deficient by extending the use of the Temporary Lodging Expense Allowance. This allowance is designed to partially offset expenses when the service member occupies temporary quarters while relocating from one installation to another. Generally payable for up to 10 days—the Army has extended it up to 60 days at growth installations, such as Fort Drum and Fort Bliss.

We ask Congress to consider the importance of family well-being by addressing Basic Allowance for Housing (BAH) inequities.

We also ask for additional money to cover the housing allowance shortage.

We recommend that DOD provide the Services with the flexibility to extend the Temporary Lodging Expense Allowance at growth installations where there is a shortage of available housing.

Commissaries and Exchanges

The Military Personnel Subcommittee of the House Armed Services Committee (HASC) held two hearings this year to discuss the importance of sustaining Morale, Welfare, and Recreation (MWR) programs and the commissary and exchange systems. We maintain that these programs must not become easy targets for the budget cutters. The military resale hearing reinforced the importance of the commissary and exchange and stressed the need for them to remain fiscally sound without reducing the benefit to military families. Our Association feels strongly that these quality programs for military families should be preserved, especially during this era of increased budget austerity.

Our Association is concerned about one issue raised at the recent HASC resale hearing: the potential negative repercussions of the Tax Increase Prevention and Reconciliation Act of 2005 (TIPRA) on the military community. This legislation included a provision, Section 511, mandating Federal, State, and local governments to withhold 3 percent from payments for goods and services to contractors after December 31, 2010. While the implementation has been delayed until December 31, 2011, we believe this withholding requirement will have a direct impact on military families. We believe vendors who provide products sold in exchanges and commissaries will end up passing on the implementation costs to patrons and will be less willing to offer deals, allowances, promotions, and prompt payment discounts, which will thus diminish the value of the benefit for military families. The implementation costs for the exchange systems may also result in reduced dividends for

MWR programs, which already operate on tight budgets. Although our Association realizes this tax issue does not fall under the Senate Appropriations Committee's jurisdiction, we ask Congress to repeal Section 511 of TIPRA in order to protect this important benefit for military families. If full repeal is not possible, we urge Congress to exempt the Defense Commissary Agency, Exchanges and MWR programs from the withholding requirement. Military families, who have borne the burden of this war for nearly 10 years, should not have to incur additional costs at commissaries and exchanges due to the effects of this law, which will compromise their quality of life programs when they need them most.

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

Active duty and reserve component families have benefitted greatly from the addition of case lot sales. Our Association thanks Congress for allowing the use of proceeds from surcharges collected at these sales to help defray their costs. Case lot sales continue to be extremely well received and attended by family members not located near an installation. According to Army Staff Sgt. Jenny Mae Pridemore, quoted in the Charleston Daily Mail, "We don't have easy access to a commissary in West Virginia and with the economy the way it is everyone is having a tough time. The soldiers and the airmen really need this support." On average, case lot sales save families between 40 and 50 percent compared to commercial prices. This provides tremendous financial support for our remote families, and is a tangible way to thank them for their service to our Nation.

In addition to commissary benefits, the military exchange system provides valuable cost savings to members of the military community, while reinvesting their profits in essential MWR programs. Our Association strongly believes that every effort must be made to ensure that this important benefit and the MWR revenue is preserved, especially as facilities are down-sized or closed overseas.

Our Association urges Congress to continue to protect the commissary and exchange benefits, and preserve the MWR revenue all of which are vital to maintaining a health military community.

We also ask Congress to repeal Section 511 of TIPRA. If full repeal is not achievable, we urge Congress to exempt the Defense Commissary Agency, Exchanges and MWR programs from this withholding requirement.

National Guard and Reserve

Our Association has long recognized the unique challenges our National Guard and Reserve families face and their need for additional support. Reserve component families are often geographically dispersed, live in rural areas, have service members deployed as individual augmentees, and do not consistently have the same family support programs as their active duty counterparts. According to the research conducted for us by the RAND Corporation, spouses of service members in the National Guard and Reserves reported poorer emotional well-being and greater household challenges than their full-time active duty peers. Our Association believes that greater access to resources supporting National Guard and Reserve caregivers is needed to further strengthen our reserve component families.

We appreciate the great strides that have been made in recent years by both Congress and the Services to help support our reserve component families. Our Association would like to thank Congress for the fiscal year 2011 NDAA provision authorizing travel and transportation for members of the Uniformed Services and up to three designees to attend Yellow Ribbon Reintegration Program events, and for the provision enhancing the Yellow Ribbon Reintegration Program by authorizing service and State-based programs to provide access to all service members and their families. We appreciate your ongoing support of the Yellow Ribbon Reintegration Program and ask that you continue funding this quality of life program for reserve component families.

Our Association is gratified that family readiness is now seen as a critical component to mission readiness. We have long believed that robust family programs are integral to maintaining family readiness, for both our active duty and reserve component families. We are pleased the Department of Defense Reserve Family Readi-

ness Award recognizes the top unit in each of the Reserve Components that demonstrate superior family readiness and outstanding mission readiness.

Our Association asks Congress to continue funding the Yellow Ribbon Reintegration Program and stresses the need for greater access to resources supporting our Reserve Component caregivers.

Flexible Spending Accounts

Congress has provided the Armed Forces with the authority to establish Flexible Spending Accounts (FSA), yet the Service Secretaries have not established these important tax savings accounts for service members. We are pleased H.R. 791 and S. 387 have been introduced to press each of the seven Service Secretaries to create a plan to implement FSAs for uniformed service members. FSAs were highlighted as a key issue presented to the Army Family Action Plan at their 2011 Department of the Army level conference. FSAs would be especially helpful for families with out-of-pocket dependent care and healthcare expenses. It is imperative that FSAs for uniformed service members take into account the unique aspects of the military lifestyle, such as Permanent Change of Station (PCS) moves and deployments, which are not compatible with traditional FSAs. We ask that the flexibility of a rollover or transfer of funds to the next year be considered.

Our Association supports Flexible Spending Accounts for uniformed service members that account for the unique aspects of military life including deployments and Permanent Change of Station moves.

Financial Readiness

Ongoing financial literacy and education is critically important for today's military families. Military families are not a static population; new service members join the military daily. For many, this may be their first job with a consistent paycheck. The youthfulness and inexperience of junior service members makes them easy targets for financial predators. Financial readiness is a crucial component of family readiness. The Department of Defense Financial Readiness Campaign brings financial literacy to the forefront and it is important that financial education endeavors include military families.

Our Association looks forward to the establishment of the Office of Service Member Affairs this July. We encourage Congress to monitor the implementation of this office to ensure it provides adequate support to service members and their families. Military families should have a mechanism to submit a concern and receive a response. The new office must work in partnership with DOD.

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

We appreciate the increase to the Family Separation Allowance (FSA) that was made at the beginning of the war. In more than 10 years, however, there has not been another increase. We ask that the Family Separation Allowance be indexed to the Cost of Living Allowance (COLA) to better reflect rising costs for services.

Our Association asks Congress to increase the Family Separation Allowance by indexing it to COLA.

Family Health

When considering changes to the healthcare benefit, our Association urges policymakers to recognize the unique conditions of service and the extraordinary sacrifices demanded of military members and families. Repeated deployments, caring for the wounded, and the stress of uncertainty create a need for greater access to professional behavioral healthcare for all military family members.

Family readiness calls for access to quality healthcare and mental health services. Families need to be assured the various elements of their military health system are coordinated and working as a synergistic system. The direct care system of Military Treatment Facilities (MTFs) and the purchased care segment of civilian providers under the TRICARE contracts must work in tandem to meet military readiness requirements and ensure they meet access standards for all military beneficiaries.

Congress must provide timely and accurate funding for healthcare. DOD healthcare facilities must be funded to be "world class," offering state-of-the-art healthcare services supported by evidence-based research and design. Funding must also support the renovation of existing facilities or complete replacement of out-of-

date DOD healthcare facilities. As we close Walter Reed Army Medical Center and open the new Fort Belvoir Community Hospital and the new Walter Reed National Military Medical Center, as part of the National Capitol Region BRAC process, we must be assured these projects are properly and fully funded. We encourage Congress to provide any additional funding recommended by DOD and the Defense Health Board's BRAC Subcommittee's report.

Our Association recommends that DOD be funded to "world class", offering state-of-the-art healthcare services. Funding must also support renovation of existing facilities or replacement of out-of-date DOD healthcare facilities.

TRICARE Reimbursement

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. We are appreciative Congress passed the Medicare and Medicaid Extenders Act of 2010 (Public Law 111–309), which provided a 1-year extension of current Medicare physician payment rates until December 31, 2011. As the 112th Congress takes up Medicare legislation this year, we ask you to consider how this legislation will impact military healthcare, especially our most vulnerable populations, our families living in rural communities, and those needing access to mental health services.

While we have been impressed with the strides TMA and the TRICARE contractors are making in adding providers, especially mental health providers to the networks, we believe more must be done to persuade healthcare and mental healthcare providers to participate and remain in the TRICARE system, even if that means DOD must raise reimbursement rates. We frequently hear from providers who will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. National provider shortages in the mental health field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographic challenges, such as large military beneficiary populations in rural or traditionally underserved areas. Many mental health providers are willing to see military beneficiaries on a voluntary status. We need to do more to attract mental health providers to join the TRICARE network. Increasing reimbursement rates is just one way of enticing them.

Since TRICARE payments are linked to Medicare payments, we need Medicare reimbursement rates to be increased to improve access to providers.

DOD will need additional funding to offset proposed TRICARE savings through increasing TRICARE Prime Retiree enrollment fees and changes to the Pharmacy copays enacted by Congress.

Cost Saving Strategies in the 2012 Budget

We appreciate DOD's continued focus on cost savings strategies in the 2012 budget. DOD's proposed TRICARE changes include a change in enrollment fees for TRICARE Prime for under age 65 retirees and a change in pharmacy co-pays. DOD should also incur savings through better management of healthcare costs. Our Association has always supported a mechanism to provide for modest increases to TRICARE Prime enrollment fee for retirees under age 65. TRICARE Prime, the managed care option for military beneficiaries, provides guaranteed access, low out of pocket costs, additional coverage, and more continuity of care than the basic military health benefit of TRICARE Standard. The annual enrollment fee of $230 per year for an individual retiree or $460 for a family has not been increased since the start of TRICARE Prime in 1995.

We agree that DOD's proposed fiscal year 2012 increase of $5 per month per family and $2.50 per month per individual plan is indeed modest. We applaud DOD for deciding not to make any changes to the TRICARE benefit for active duty, active duty family members, medically retired service members, and survivors of service members and for not making any changes to the TRICARE Standard and TRICARE for Life (TFL) benefit.

We have some concerns regarding DOD's selection of a civilian-based index in determining TRICARE Prime retiree enrollment fee increases after 2012. Our Association has always supported the use of Cost of Living Allowance (COLA) as a yearly index tied to TRICARE Prime retiree enrollment fee increases. We believe if DOD thought the rate of $230 for individual and $460 for family was appropriate in 1995, then yearly increases tied to COLA would maintain that same principle. Our objection to the utilization of a civilian index is based on our concern that civilian healthcare experts cannot agree on an accurate index on which to base civilian healthcare yearly cost increases. The Task Force on the Future of Military Health Care "strongly recommended that DOD and Congress accept a method for indexing that is annual and automatic." However, the Task Force recommended "using a ci-

vilian-only rather than total cost (including civilian and MTF costs for Prime beneficiaries) because the Task Force and DOD have greater confidence in the accuracy of the civilian care data and its auditability." We ask Congress to adopt the Task Force's DOD accountability recommendation and require DOD to become more accurate and establish a common cost accounting system across the MHS. Until it can do so, however, we believe increases tied to COLA are the most fair to beneficiaries and predictable for DOD.

We do not support DOD's budget proposal to change the U.S. Family Health Plan (USFHP) eligibility, asking newly enrolled beneficiaries to transition from USFHP once they become Medicare/TRICARE for Life eligible. Our Association believes USFHP is already providing TMA's medical home model of care, maintaining efficiencies, capturing savings, and improving patient outcomes. Every dollar spent in preventative medicine is captured later when the onset of beneficiary co-morbid and chronic diseases are delayed. It is difficult to quantify the long-term savings not only in actual cost to the healthcare plan—and thus to the government—but to the improvement in the quality of life for the beneficiary. Removing beneficiaries from USFHP at a time when they and the system will benefit the most from their preventative and disease management programs would greatly impact the continuity and quality of care to our beneficiaries and only cost shift the cost of their care from one government agency to another. Almost all USFHP enrollees already purchase Medicare Part B in case they decide to leave the plan or spend long periods of time in warmer parts of the country. There must be another mechanism in which beneficiaries would be allowed to continue in this patient-centered program. USFHP also meets the Patient Protection and Accountability Care Act's definition of an Accountable Care Organization. They certainly have the model of care desired by civilian healthcare experts and should be used by DOD as a method to test best-practices that can be implemented within the direct care system.

Our Association understands the need for TRICARE to align itself with Medicare reimbursement payments. DOD's proposal to implement reimbursement payment for Sole Community Hospitals is another example of its search for efficiencies. According to TMA, 20 hospitals that serve military beneficiaries could be affected by this change. We appreciate the 4-year phased-in approach. However, our Association recommends Congress encourage TMA to reach out to these hospitals and provide waivers if warranted and provide oversight to ensure beneficiaries aren't unfairly impacted by this proposal.

Our Association approves of DOD's modest increase to TRICARE Prime enrollment fees for working age retirees.

We recommend that future increases to TRICARE Prime enrollment fees for working age retirees be indexed to retired pay cost of living adjustments and support legislative language in the House NDAA fiscal year 2012.

We recommend that Medicare-eligible beneficiaries using the USFHP be allowed to remain in the program and Congress should continue to fund this TRICARE option for beneficiaries.

We recommend Congress encourage TMA to reach out to Sole Community hospitals serving large numbers of military beneficiaries and provide waivers if warranted. Congress may need to provide additional funding to help offset this proposed reimbursement change by TMA.

Other Cost Saving Proposals

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 healthcare in a cost-effective manner.

—Creating a committee, similar in nature to the Medicare Payment Advisory Commission, to provide oversight of the DOD Military Health System (MHS) and make 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 within 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. This was recommended by the Defense Health Board in 2006 and 2009 and included in the U.S. House Armed Service Committee's fiscal year 2011 NDAA proposal and passed by the House of Representatives.

We are supportive of TMA's movement toward a medical home model of patient and family centered care within the direct and purchase care systems. An integrated healthcare model, where beneficiaries will be seen by the same healthcare team fo-

cused on well-being and prevention, is a well-known cost saver for healthcare expenditures. Our concern is with the individual Services' interpretation of the medical home model and its ability to truly function as designed. Our MTFs are still undergoing frequent provider deployments; therefore, the model must be staffed well enough to absorb unexpected deployments to theater, normal staff rotation, and still maintain continuity of providers within the medical home.

Our Association believes right-sizing to optimize MTF capabilities through innovating staffing methods; adopting coordination of care models, such as medical home; timely replacement of medical facilities utilizing "world class" and "unified construction standards;" and increased funding allocations, would allow more beneficiaries to be cared for in the MTFs. This would be a win-win situation because it increases MTF capabilities, which DOD asserts is the most cost effective. It also allows more families, who state they want to receive care within the MTF, the opportunity to do so. 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 healthcare practices. We encourage Congress to include the recommendations of the Task Force on the Future of Military Health Care in this year's fiscal year 2012 NDAA. These include:

—Restructuring TMA to place greater emphasis on its acquisition role.
—Examining and implementing strategies to ensure compliance with the principles of value-driven healthcare.
—Incorporating health information technology systems and implementing transparency of quality measures and pricing information throughout the MHS. (This is also a civilian healthcare requirement in the recently passed Patient Protection and Affordable Care Act.)
—Reassessing requirements for purchased care contracts to determine whether more cost effective strategies can be implemented.
—Removing systemic obstacles to the use of more efficient and cost-effective contracting strategies.

Wounded Service Members Have Wounded Families

Our Association asserts that behind every wounded service member and veteran is a wounded family. It is our belief the government, especially the DOD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded, ill, and injured service member must also consider the needs of the spouse, children, parents of single service members and their siblings, and the caregivers. DOD and VA need to think proactively as a team and one system, rather than separately; and addressing problems and implementing initiatives upstream while the service member is still on active duty status.

Reintegration programs become a key ingredient in the family's success. For the past 3 years, we have piloted our Operation Purple® Healing Adventures camp to help wounded, ill, and injured service members and their families learn to play again as a family. We hear from the families who participate in this camp, as well as others dealing with the recovery of their wounded service members, that, even with Congressional intervention and implementation of the Services' programs, many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes all must focus on treating the whole family, with DOD and VA programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process. DOD, the VA, and non-governmental organizations must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

DOD and the VA must do more to work together both during the treatment phase and the wounded service member's transition to ease the family's burden. They must break down regulatory barriers to care and expand support through the Vet Centers the VA medical centers, and the community-based outpatient clinics (CBOCs). We recommend DOD partner with the VA to allow military families access to mental health services throughout the VA's entire network of care using the TRICARE benefit. Before expanding support services to families, however, VA facilities must establish a holistic, family centered approach to care when providing men-

tal health counseling and programs to the wounded, ill, and injured service member or veteran.

We remain concerned about the transition of wounded, injured, and ill service members and their families from active duty status to that of the medically retired. While we are grateful, DOD has proposed to exempt medically retired service members, survivors, and their families from the TRICARE Prime enrollment fee increases, we believe wounded service members need even more assistance in their transition. We continue to recommend that a legislative change be made to create a 3-year transition period in which medically retired service members and their families would be treated as active duty family members in terms of TRICARE fees, benefits, and MTF access. This transition period would mirror that currently offered to surviving spouses and would allow the medically retired time to adjust to their new status without having to adjust to a different level of TRICARE support.

Case Management.—Our Association still finds families trying to navigate a variety of complex healthcare systems alone, trying to find the right combination of care. Our most seriously wounded, ill, and injured service members, veterans, and their families are often assigned multiple case managers. Families often wonder which one is the "right" case manager. We believe DOD and the VA must look at whether the multiple, layered case managers have streamlined the process or have only aggravated it. We know the goal is for a seamless transition of care between DOD and the VA. However, we continue to hear from families, whose service member is still on active duty and meets the Federal Recovery Coordinator (FRC) requirement, who have not been told FRCs exist or that the family qualifies for one. We are awaiting the Government Accountability Office's (GAO) FRC report to determine how that program is working in caring for our most seriously wounded, ill, and injured service members and veterans and what can be done to improve the case management process.

Caregivers of the Wounded

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 healthcare 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 healthcare dollars in the long run. Their long-term psychological care needs must be addressed. Caregivers of the severely wounded, ill, and injured service members who are now veterans have a long road ahead of them. In order to perform their job well, they will require access to mental health services.

The VA has made a strong effort in supporting veterans' caregivers. DOD should follow suit and expand its definition, which still does not align with Public Law 111–163. We appreciate the inclusion in fiscal year 2010 NDAA of compensation for service members with assistance in everyday living and the refinement in fiscal year 2011 NDAA. The VA recently released their VA Caregiver Implementation Plan. Our Association had the opportunity to testify at a recent House Veterans' Affairs Committee hearing Implementation of Caregiver Assistance: Are we getting it right? about our concerns related to the VA's caregiver implementation plan. We believe the VA is waiting too long to provide valuable resources to caregivers of our wounded and injured service members and veterans who had served in Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND). The intent of the law was to allow caregivers to receive value-added benefits in a timely manner in order to improve the caregiver's overall quality of life and train them to provide quality of care to their service member and veteran. The VA's interpretation also has the potential to impact the DOD's Special Compensation for Service Members law passed as part of fiscal year 2010 NDAA and modified in fiscal year 2011. The one area of immediate concern is the potential gap in financial compensation when the service member transitions to veteran status. The VA's application process and caregiver validation process appear to be very time intensive. The DOD compensation benefit expires at 90-days following separation from active duty. Other concerns include:

—Narrower eligibility requirements than what the law intended;
—Lack of illness being covered, such as cancer from a chemical exposure;
—Delay in the caregiver's receipt of healthcare benefits if currently uninsured, respite care, and training; and
—Exclusion of non-medical care from the VA's caregiver stipend.

The VA's decision to delay access to valuable training may force each Service to begin its own training program. Thus, each Service's training program will vary in its scope and practice and may not meet VA's training objectives. This disconnect

could force the caregiver to undergo two different training programs in order to provide and care and receive benefits.

Our Association also believes the current laws do not go far enough. Compensation of caregivers should be a priority for DOD and the Secretary of Homeland Security. Non-medical care should be factored into DOD's compensation to service members. The goal is to create a seamless transition of caregiver benefit between DOD and the VA. We ask Congress to assist in meeting that responsibility. Congress will need to be ready to fully fund both DOD and VA caregiver benefit programs.

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

Relocation Allowance and Housing for Medically-Retired Single Service Members.—Active Duty service members and their spouses qualify through the DOD for military orders to move their household goods when they leave the military service. Medically retired service members are given a final PCS move. Medically retired married service members are allowed to move their family; however, medically retired single service members only qualify for moving their own personal goods.

Our Association suggests that legislation be passed to allow medically retired single service members the opportunity to have their caregiver's household goods moved as a part of the medical retired single service member's PCS move. This should be allowed for the qualified caregiver of the wounded service member and the caregiver's family (if warranted), such as a sibling who is married with children, or mom and dad. This would allow for the entire caregiver's family to move, not just the caregiver. The reason for the move is to allow the medically retired single service member the opportunity to relocate with their caregiver to an area offering the best medical care, rather than the current option that only allows for the medically retired single service member to move their belongings to where the caregiver currently resides. The current option may not be ideal because the area in which the caregiver lives may not be able to provide all the healthcare 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 FRC (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 healthcare, 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.

We ask Congress to allow medically retired service members and their families to maintain the active duty family TRICARE benefit for a transition period of 3 years following the date of medical retirement, comparable to the benefit for surviving spouses.

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.

Congress will need to fully fund training, compensation and other support programs for caregivers of the wounded, ill and injured because of the important role they play in the successful rehabilitation and care of the service member and veteran.

We request legislation funding medically retired single service members to have their caregiver's household goods moved as a part of their final PCS move.

Congress will need to fully fund DOD's Caregiver Compensation benefit for military service members and the VA's caregiver benefit for caregivers.

Senior Oversight Committee

Our Association is appreciative of the provision in the fiscal year 2009 NDAA continuing the DOD and VA Senior Oversight Committee (SOC) until December 2010. The DOD established the Office of Wounded Warrior Care and Transition Policy to take over the SOC responsibilities. The Office has seen frequent leadership and staff

changes and a narrowing of its mission. We urge Congress to put a mechanism in place to continue to monitor this Office for its responsibilities in maintaining DOD and VA's partnership and making sure joint initiatives create a seamless transition of services and benefits for our wounded, ill, and injured service members, veterans, their families, and caregivers.

Defense Centers of Excellence

A recent GAO report found the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury has been challenged by a mission that lacked clarity and by time-consuming hiring practices. DCoE has experienced a lack of adequate funding hampering their ability to hire adequate staff and begin to provide care for the patient population as they were created to address. These include the Vision Center of Excellence, Hearing Center of Excellence, and the Traumatic Extremity Injury and Amputation Center of Excellence. We recommend Congress immediately fund these Centers and require DOD to provide resources to effectively establish these Centers and meet DOD's definition of "world class" facilities.

The Defense Centers of Excellence is providing a transition benefit for mental health services for active duty service members, called inTransition. Our Association recommends this program be expanded to provide the same benefit to active duty spouses and their children. Families often complain about the lack of seamless transition of care when they PCS. This program will not only provide a warm hand-off between mental health providers when moving between and within Regions, but more importantly, enable mental health services to begin during the move, when families are between duty stations and most venerable.

We must educate those who care for our service members and veterans about the effects of Traumatic Brain Injury (TBI), Post-Traumatic Stress (PTS), Post-Traumatic Stress Disorder (PTSD), and suicide in order to help accurately diagnose and treat the service member/veteran's condition. These families are on the "sharp end of the spear" and are more likely to pick up on changes attributed to either condition and relay this information to their healthcare providers. Families need tools to help them deal with the daily issues that arise when living with and caring for a service member or veteran with TBI and/or PTS/PTSD. Programs are being developed by each Service. However, they are narrow in focus targeting line leaders and healthcare providers, but not broad enough to capture our military family members and the communities they live in. As Services roll out suicide prevention programs, we need to fund programs that include our families, communities, and support personnel. The Deployment Health Clinical Center (DHCC), an umbrella organization to DCoE, offers a 3 week PTSD course for service members and a separate 1-week course for their family members. These programs are making a difference in the quality of the service members and their families lives. Currently, the family member PTSD program is funded by a nonprofit organization. These programs need to continue; therefore, they need to be fully funded by Congress.

Our Association encourages all Congressional Committees with jurisdiction over military personnel and veterans matters to talk on these important issues. Congress, DOD, and VA can no longer continue to create policies in a vacuum and focus on each agency separately because our wounded, ill, and injured service members and their families need seamless, coordinated support from each.

We recommend Congress immediately fund the Vision Center of Excellence, Hearing Center of Excellence, and the Traumatic Extremity Injury and Amputation Center of Excellence and require DOD to provide resources to effectively establish these Centers and meet DOD's definition of "world class" facilities.

We recommend Congress fully fund DHCC's PTSD programs for service members and their family members s they may continue uninterrupted.

We recommend the "inTransition" program be expanded to provide the same benefit to active duty family members. This program would need to be funded to be expanded to include them.

Family Transitions

Policies and programs must provide training and support for families during the many transitions military families experience. Quality education for spouses and children, financial literacy, and spouse career progression need attention. When families experience a life-changing event, they require a responsive system to support them. Our Nation must continue to ensure our surviving family members receive the support they deserve.

Survivors

The Services continue to improve their outreach to surviving families. In particular, the Army's SOS (Survivor Outreach Services) program makes an effort to remind these families they are not forgotten. We most appreciate the special consid-

eration, sensitivity, and outreach to the families whose service members have committed suicide. We would like to acknowledge the work of the Tragedy Assistance Program for Survivors (TAPS) in this area as well. They have developed unique outreach to these families and held support conferences to help surviving family members navigate what is a very difficult time with many unanswered questions. 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. We believe Congress must grant authority to allow coverage of bereavement or grief counseling under the TRICARE behavioral health benefit. The goal is the right care at the right time for optimum treatment effect.

In 2009, the policy concerning the attendance of the media at the dignified transfer of remains at Dover AFB was changed. Primary next-of-kin (PNOK) of the service member who dies in theater is asked to make a decision shortly after they are notified of the loss as to whether or not the media may film the dignified transfer of remains of their loved one during this ceremony. Family members are also given the option of flying to Dover themselves to witness this ceremony. In previous years, only about 3 percent of family members attended this ceremony. Since the policy change, over 90 percent of families send some family members to Dover to attend. The travel of up to 3 family members and the casualty assistance officer on a commercial carrier are provided for. In the NDAA fiscal year 2010, eligible family member travel to memorial services for a service member who dies in theater was authorized. This is in addition to travel to the funeral of the service member. None of the costs associated with this travel has been funded for the Services. We would ask that funds be appropriated to cover the costs of this extraordinary expense.

Our Association recommends that grief counseling be more readily available to survivors as a TRICARE benefit.

We ask that funding be appropriated for the travel costs for surviving family members to attend the dignified transfer of remains in Dover and for eligible surviving family members to attend memorial services for service members who die in theater.

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 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 believe there needs to be DIC equity with other Federal survivor benefits. Currently, DIC is set at $1,154 monthly (43 percent of the Disabled Retirees Compensation). Survivors of Federal workers have their annuity set at 55 percent of their Disabled Retirees Compensation. Military survivors should receive 55 percent of VA Disability Compensation. We are awaiting the overdue report. We support raising DIC payments to 55 percent of VA Disability Compensation. When changes are made, we ask Congress to ensure that DIC eligibles under the old system receive an equivalent increase.

Imagine that you have just experienced the death of your spouse, a retired service member. In your grief, you navigate all the gates you must, fill out paperwork, notify all the offices required. Then, the overdrawn notices start showing up in your mailbox. Bills that you thought had been paid at the beginning of the month suddenly appear with "overdue" on them. Retirees are paid proactively, that is, they receive retired pay for the upcoming month i.e. on May 31, a retiree receives retired pay for the month of June. Presently, the government has the authority to take back the full month's pay from the retiree's checking account when that retiree dies. Payment for the number of days the retiree was alive in the month is subsequently returned to the surviving spouse. The VA, on the other hand, allows the surviving spouse to keep the last month of disability pay. We support H.R. 493, which would allow the surviving spouse or family to keep the last month of retired pay to avoid financial penalties caused by the decrease of funds in a checking account.

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 support H.R. 178 and S. 260, which both provide for that elimination.

We also request that SBP benefits be allowed to be paid to a Special Needs Trust in cases of disabled family members.

We ask that DIC be increased to 55 percent of VA Disability Compensation.

We support H.R. 493, "The Military Retiree Survivor Comfort Act", to provide for forgiveness of overpayments of retired pay paid to deceased retired members of the Armed Forces following their death.

Education of Military Children

Military families place a high value on the quality of their children's education. It is a leading factor in determining many important family decisions, such as volunteering for duty assignments, choosing to accompany the service member or staying behind, selecting where a family lives within their new community, deciding whether to spend their financial resources on private school, or considering homeschooling options. It can even impact a families' decision to remain in the Service.

Military families want quality education for their children just as their civilian counterparts do. It is important to remember that military families define "quality of education" differently. For military families, it is not enough for children to be doing well in their current schools they must also be prepared for the next location. Most military children will move at least twice during their high school years and most will attend six to nine different schools between kindergarten and 12th grade. Although the Interstate Compact on Educational Opportunity for Military Children is helping to alleviate many of the transition issues our families face when moving, it does not address the quality of education in our schools. Though many of our civilian schools are already doing an excellent job of educating and supporting our military children, we believe military children deserve a quality education wherever they may live. That is why our Association has spent over 40 years working to improve education for our military children and empowering parents to become their children's best advocate.

With more than 90 percent of military-connected students now attending civilian schools, our Association is pleased that the Department of Defense has completed a 90-day preliminary assessment of how to provide a world-class education for all of the 1.2 million school-aged children, not just those under the Department of Defense Education Activity's (DODEA) purview. Our Association was invited by Dr. Clifford L. Stanley, Under Secretary of Defense for Personnel and Readiness, to participate in the Education Review Debriefing and to offer our insights on the way ahead. We look forward to the final report and to working with DOD to support its implementation. We thank the Department of Defense for the educational support programs already available to military children, such as the tutoring program for deployed service member families, and DODEA's virtual high schools. Our Association believes these programs are making a difference and would be beneficial to all military families.

We were also pleased the President's landmark directive, "Strengthening Our Military Families," listed as one of its top priorities the need to ensure excellence in military children's education and their development. We greatly appreciate the Department of Education committing to making military families one of its priorities for its discretionary grant programs and for including our Association as a military stakeholder in finding ways to strengthen military families within the Reauthorization of the Elementary and Secondary Education Act.

Our Association thanks Congress for providing additional funding to civilian school districts educating military children through DODEA's Educational Partnership Grant Program. We are aware that DODEA's expanded authority to shares its

expertise, experience and resources to assist military children during transitions, to sharpen the expertise of teachers and administrators in meeting the needs of military children, and to provide assistance to local education agencies on deployment support for military children is set to expire in 2013. We ask Congress to extend the authority for the Educational Partnership Grant Program past 2013.

We strongly urge Congress to ensure it is providing appropriate and timely funding of Impact Aid through the Department of Education. We also ask that you allow school districts experiencing high levels of growth, due to military base realignment, to apply for Impact Aid funds using current student enrollment numbers rather than the previous year. In addition, we call on Congress to increase DOD Supplemental Impact Aid funding for schools educating large numbers of military connected students. Our Association has long believed that both Impact Aid programs are critical to ensuring that school districts can provide quality education for our military children.

We strongly urge Congress to ensure it is providing appropriate funding of Impact Aid through the Department of Education at authorized levels and to allow school districts experiencing high growth due to base realignments to apply for Impact Aid funds using current student enrollment numbers.

We ask Congress to increase the DOD supplement to Impact Aid to $60 million. We also ask Congress to extend the authority for the DODEA Educational Partnership Grant Program.

Spouse Education and Employment

We are pleased the NDAA fiscal year 2011 calls for a report on military spouse education programs. Our recent surveys and feedback we have received from military families indicates they appreciate in-state tuition and the Post 9/11 G.I. Bill transferability. Our Association would like to thank Congress for the enhancements made to the Post 9/11 G.I. Bill last session. We are especially pleased that spouses of active duty service members are now eligible for the book stipend and the authority to grant transferability has been extended to families of the Commissioned Corps of NOAA and the U.S. Public Health Service.

DOD's most-cited program success for military spouses is the Military Spouse Career Advance Account (MyCAA)—in its original form. In October 2010, MyCAA was significant revised and seasoned spouses who are no longer eligible feel their education pursuits are not supported by the Department of Defense. Many military spouses delay their education to support the service member's career. 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. Of particular interest, 33.5 percent of applicants from our 2011 scholarship applicant pool stated their education was interrupted because of the military lifestyle (frequent moves, TDYs, moving expenses, etc.) and 12.2 percent of those directly attributed the interruption to deployment of the service member. Military spouses remain committed to their education and need assistance from Congress to fulfill their educational pursuits. We ask Congress to push DOD to fully reinstate the MyCAA program to include all military spouses, regardless of their service member's rank and to ensure the funding is available for this reinstatement. We also ask Congress to work with the appropriate Service Secretaries to extend the MyCAA program to spouses of the Coast Guard, the Commissioned Corps of NOAA, and the U.S. Public Health Service.

The fiscal year 2011 NDAA report on military spouse education programs only addresses one aspect—education. In order to determine if the education programs are working, we recommend a report on spouse employment programs. The NDAA fiscal year 2010 created a pilot program to secure internships for military spouses with Federal agencies. Funding for the program continues through fiscal year 2011. A report on military spouse employment programs should include an assessment of the military spouse Federal internship program. Military spouses want more Federal employment opportunities. Should the pilot become a permanent program? We urge Congress to monitor the pilot to ensure spouses are able to access the program and eligible spouses are able to find Federal employment after successful completion of the internship. Our Association recommends Congress requests a report on military spouse employment programs.

To further spouse employment opportunities, we recommend an expansion to the Work Opportunity Tax Credit for employers who hire spouses of active duty and reserve component service members as proposed through the Military Spouse Employment Act, H.R. 687. This employer tax credit is one way to encourage corporate America to hire military spouses.

We also recommend providing a tax credit to military spouses to offset the expense of obtaining a career license or credential when the service member is relo-

cated to a new duty station. Military spouses are financially disadvantaged by government ordered moves when they are required to obtain a career license in a new State to practice in their profession. Many military spouses must maintain a career license in multiple States, costing hundreds of dollars. For example, a pharmacist can only reciprocate to another State from their original license, which requires a military spouse pharmacist to maintain a license in more than one State. When our Association asked military spouses to share their employment challenges with us, a military spouse of 26 years stated, "The very most frustrating part about the process, is that obtaining a license does not guarantee that I will find employment. I have been licensed in [Kentucky] for a full year and in that time have gotten one 6-hour shift of work. That one shift does not even begin to recover the expense of obtaining my license here." We recommend that Congress pass the Military Spouse Job Continuity Act or similar legislation to reduce the financial barrier licensed military spouses must overcome with each move in order to find employment.

Our Association urges Congress to recognize the value of military spouses by fully funding the MyCAA program for all military spouses, expand the Work Opportunity Tax Credit to include military spouses, and provide a tax credit to offset state license and credential fees.

Support for Special Needs Families

The NDAA fiscal year 2010 established the Office of Community Support for Military Families with Special Needs to enhance and improve DOD support around the world for military families with special needs, whether medical or educational. Our Association remains concerned that the Office has not received the proper resources to address the medical, educational, relocation, and family support resources our special needs families often require. This Office must address these various needs in a holistic manner in order to effectively implement change. The original intent of the legislation was to have the office reside in the Office of the Under Secretary of Defense for Personnel and Readiness in order to bring together all entities having responsibility for the medical, educational, relocation, and family support needs of special needs military family member. At present, however, the office comes under the jurisdiction of the Deputy Assistant Secretary of Defense for Military Community and Family Policy.

Case management for military beneficiaries with special needs is not consistent across the Services or the TRICARE Regions because the coordination care for the military family is being done by a non-synergistic healthcare system. Beneficiaries try to obtain an appointment and then find themselves getting partial healthcare within the MTF, while other healthcare is referred out into the purchased care network. Thus, military families end up managing their own care. Incongruence in the case management process becomes more apparent when military family members transfer from one TRICARE Region to another and when transferring within the same TRICARE Region. This incongruence is further exacerbated when a special needs family member is involved and they require not only medical intervention, but non-medical care as well. Families need a seamless transition and a warm handoff between and within TRICARE Regions and a universal case management process across the MHS. Each TRICARE Managed Care Support Contractor (MCSC) has created different case management processes. TRICARE leaders must work closely with their family support counterparts through the Office of Community Support for Military Families with Special Needs to develop a coordinated case management system that takes into account other military and community resources.

We applaud the attention Congress and DOD have given to our special needs family members in the past 2 years and their desire to create robust healthcare, educational, and family support services for special needs family members. But, these robust services do not follow them when they retire. We encourage the Services to allow these military families the opportunity to have their final duty station be in an area of their choice, preferably in the same State in which they plan to live after the service member retires, to enable them to begin the process of becoming eligible for State and local services while still on active duty. We also suggest the Extended Care Health Option (ECHO) be extended for 1 year after retirement for those family members already enrolled in ECHO prior to retirement. More importantly, our Association recommends if the ECHO program is extended, it must be for all who are eligible for the program because we should not create a different benefit simply based on medical diagnosis.

The Office of Community Support is beginning a study on Medicaid availability for special needs military family members. Our Association is anxiously awaiting this report's findings. We will be especially interested in the types of value-added services individual State Medicaid waivers offer their enrollees and whether State budget difficulties are making it more difficult for military families to qualify for

and participate in waiver programs. This information will provide yet another avenue to identify additional services ECHO may include in order to help address our families' frequent moves and their inability to often qualify for these additional value-added benefits in a timely manner.

There has been discussion over the past several years by Congress and military families regarding the ECHO program. 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 request a GAO report to determine if the ECHO program is working as it was originally designed and if it has been effective in addressing the needs of this population. We also hear from our ECHO eligible families that they could benefit from additional programs and healthcare services to address their special needs. We request a DOD pilot study to identify what additional service(s), if any, our special needs families need to improve their quality of life, such as cooling vests, diapers, and some nutritional supplements. We recommend families have access to $3,000 of additional funds to purchase self-selected items, programs, and/or services not already covered by ECHO. DOD would be required to authorize each purchase to verify the requested item, program, or service is appropriate. The pilot study will identify gaps in coverage and provide DOD and Congress with a list of possible extra ECHO benefits for special needs families. We need to make the right fixes so we can be assured we apply the correct solutions. Our Association believes the Medicaid waiver report, the GAO report, along with the pilot study will provide DOD and Congress with the valuable information needed to determine if the ECHO program needs to be modified in order to provide the right level of extra coverage for our special needs families. We also recommend a report examining the impact of the war on special needs military families.

We ask Congress to request a GAO report to determine if the ECHO program is working as it was originally designed and if it has been effective in addressing the needs of this population.

We request Congress fund a DOD pilot study to identify what additional service(s), if any, our special needs families need to improve their quality of life.

We recommend that the Extended Care Health Option (ECHO) program be extended for 1 year after retirement for those already enrolled in ECHO prior to retirement.

We also recommend a report examining the impact of the war on our special needs families.

Families on the Move

A Permanent Change of Station (PCS) move to an overseas location can be especially stressful for our families. 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 extracurricular 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.

Travel allowances and reimbursement rates have not kept pace with the out-of-pocket costs associated with today's moves. In a recent PCS survey conducted by our Association, more than 50 percent of survey respondents identified uncovered expenses related to the move as their top moving challenge. Military families are authorized 10 days for a housing hunting trip, but the cost for trip is the responsibility of the service member. Families with two vehicles may ship one vehicle and travel together in the second vehicle. The vehicle will be shipped at the service member's expense and then the service member will be reimbursed funds not used to drive the second vehicle to help offset the cost of shipping it. Or, families may drive both vehicles and receive reimbursement provided by the Monetary Allowance in Lieu of

Transportation (MALT) rate. MALT is not intended to reimburse for all costs of operating a car but is payment in lieu of transportation on a commercial carrier. Yet, a TDY mileage rate considers the fixed and variable costs to operate a vehicle. Travel allowances and reimbursement rates should be brought in line with the actually out-of-pocket costs borne by military families.

Our Association supports the Service Members Permanent Change of Station Relief Act, S. 472 and believes it will reduce some of the additional moving expenses incurred by many military families.

Our Association requests that Congress authorize the shipment of a second vehicle to an overseas location (at least Alaska and Hawaii) on accompanied tours, and that Congress address the out-of-pocket expenses military families bear for government ordered moves.

Military Families—Our Nation's Families

Military families have been supporting their warriors in time of war for 10 years. DOD and the military Services, with the help and guidance of Congress have developed programs and policies to respond to their changing and developing needs over this time. Families have come to rely on this support. They appreciate the spotlight of recognition that has been shone on their experience by the First Lady and Dr. Biden. They are heartened by the new sense of cooperation between government agencies in coordinating support. They know that it is up to them to make use of the tools and programs provided to become more resilient with each deployment. Congress provides the authorization and funding for these tools and programs. Even in a time of austere budgets, our Nation needs to sustain this support in order to maintain readiness. Our military families deserve no less.

Chairman INOUYE. I thank you very much, Ms. Moakler.

Senator Cochran.

Senator COCHRAN. I'm curious, what's the estimated cost of the reimbursement if the Congress desired to or decided to respond to that request?

Ms. MOAKLER. I don't know, because it depends on how long, how far the family is coming from. But right now the units themselves are taking that money out of hide, out of their family support funds.

Senator COCHRAN. Thank you.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, just an observation. I know Ms. Moakler is her as an advocate and she's got a great record of family support. I believe this subcommittee has a good record of support for our military through the appropriation, and their families, which we think are very important to the wellbeing and the readiness of our soldiers.

Ms. MOAKLER. We agree.

Senator SHELBY. Thank you.

Chairman INOUYE. Thank you very much.

Our next witness, Chief Master Sergeant John McCauslin, Air Force Sergeants Association.

STATEMENT OF CHIEF MASTER SERGEANT JOHN R. "DOC" McCAUSLIN, CHIEF EXECUTIVE OFFICER, AIR FORCE SERGEANTS ASSOCIATION

Sergeant MCCAUSLIN. Good morning, Chairman Inouye, Ranking Member Cochran, Senator Shelby, and other members of this subcommittee. On behalf of the 110,000 members of the Air Force Sergeants Association, thanks for this opportunity to offer our views of our members on the fiscal year 2012 priorities. This morning I will briefly cover some specific areas we urge your subcommittee to provide funding for.

Let me begin with healthcare. In coordination with the Military Coalition and governmental agencies, we want to ensure that our military members and their families continue to receive a cost-effective sustainable healthcare benefit, and we greatly appreciate the past efforts of you and this subcommittee to make that happen.

Last week the Senate Armed Services Committee marked the National Defense Authorization Act and we were greatly disappointed that the bill permits TRICARE fee increases. Before seeking increases in military healthcare, we would urge that you consider all funding options relative to adequate and sustainable healthcare for our military and their families and get full detailed justification for the raise of such from DOD.

The care of those who have borne the horrors and hazards of battle needs your constant attention. More than 42,000 service members have been wounded in action since the conflicts began. Thousands more suffer from the unseen wounds of war. We support full funding for the care of wounded warriors, including moneys for research and treatment of traumatic brain injuries, post-traumatic stress disorder, and all those other war-related issues.

On a related matter, this Nation owes those heroes an everlasting gratitude and compensation that extends well beyond their time in the military. It calls attention to the importance of proper documentation of care received on the battlefield and their recovery afterward. DOD and VA have made great strides in recent years developing a joint electronic health record. But it's imperative that this work continue until that job is done. This is one that actually saves the taxpayers money.

We also urge continued funding of military base pay, so that annual military pay raises exceed the ECI index by at least one-half of 1 percent, and we support targeted pay raises for midgrade enlisted personnel who have recently assumed increased responsibility. The bottom line here is regular military pay raises must be maintained by DOD so that we can continue to recruit and retain the very best and brightest.

Another hot button issue is the homelessness and unemployment of our veterans. The VA has estimated that 25 percent of all homeless individuals in the United States are veterans. According to the Bureau of Labor Statistics, the estimated jobless rate among male veterans ages 18 to 24 was more than 30 percent just last month, compared to 18 percent among civilians of the same age and gender group. This is an absolute shame. DOD and VA recently agreed to tackle this issue jointly, so we encourage you to provide enough resources to make that happen.

Caring for survivors of military members is always a matter of concern. Those with military survivor plan annuities should be able to also receive VA's dependency and indemnity compensation payments without offset. The special survivors indemnity allowance created by Congress in 2008 to minimize those losses is appreciated, but it only restores a fraction of the nearly $1,200 surviving spouses lose each month. We as a Nation must be able to do better than that.

We would like to thank Senator Bill Nelson for introducing S. 260 and the 38 Senators, 8 of which are on your subcommittee, sir, who have co-sponsored this important legislation. You may recall

that in the 111th Congress there were 62 co-sponsors in the Senate to fix this. It's high time we act.

Another precious asset is, the National Guard and Air Force Reserve currently have to wait until they reach age 60 before they draw their retirement pay. They are currently over 50 percent of our mission completion, yet subject to this holding situation. A provision in last year's NDAA allows the reserve components to shave off some time of their minimum retired age in exchange for equal periods of active duty service in combat zones. We are nowhere near resolving this issue and appreciate your continued attention.

Mr. Chairman, that's all I have today. On behalf of our association, I thank you and the members of your subcommittee for their dedication to those of us who serve.

[The statement follows:]

PREPARED STATEMENT OF JOHN R. "DOC" MCCAUSLIN

Chairman Inouye, Ranking Member Cochran, and distinguished members of the Defense subcommittee, on behalf of the 111,000 members of the Air Force Sergeants Association, thank you for this opportunity to offer the views of our members on the military personnel programs that affect those serving (and who have served) our Nation. This hearing will address issues critical to those serving and who have served our Nation.

AFSA represents active duty, guard, reserve, retired, and veteran enlisted Air Force members and their families, and this year marks our 50th Anniversary in doing so. Your continuing efforts toward improving the quality of their lives make a real difference, and our members are grateful. In this statement, I will list several specific goals that we hope this committee will consider funding in fiscal year 2012 on behalf of current and past enlisted members and their families. The content of this statement reflects the views of our members as they have communicated them to us. As always, we are prepared to present more details and to discuss these issues with your staffs.

BASIC MILITARY PAY

Tremendous progress has been made in recent years to close the gap between civilian sector and military compensation. AFSA appreciates these steady efforts and we hope they will continue. We believe linking pay raises to the employment cost index (ECI) is essential to recruiting and retaining the very best and brightest volunteers.

The President's fiscal year 2012 budget proposal calls for a 1.6 percent pay increase for active duty service members—the minimum amount by law. AFSA believes that the formula for determining annual pay increases to be ECI + 0.5 percent until the gap is completed eliminated. If we want to continue having an all volunteer force, we must continue on the path to close the aforementioned pay gap!

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, healthcare, 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 3 years and I can assure you that the demand for adequate child care is a top priority among our Airmen and their families. The availability of on base Child Development Centers (CDC) plays a critical role in each military family's decision whether or not to remain in the service. So I urge Congress to dedicate the funding necessary to build more CDCs and eliminate the space deficit that exists today.

HEALTHCARE

Like many Military and Veterans Service Organizations (MSO/VSO's), AFSA wants to ensure that past, present and future service members and families receive the inexpensive, high quality healthcare benefit that they so richly deserve. And we are concerned with repeated attempts by DOD to shift healthcare costs onto the back of retirees—particularly how they are perceived by active duty service members, many of whom have fought in Iraq and Afghanistan over the past 10 years.

As Abraham Lincoln correctly observed, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their nation."

To date, Congress has rejected the Pentagons proposed raids on earned medical benefits, and we greatly appreciate your work which allowed that to happen.

This year the Pentagon is once again asking for higher fees and their current plan would raise enrollment fees for "working age" retirees and their families who use TRICARE Prime would increase by 13 percent in fiscal year 2012. The National Health Expenditure index, produced by the Centers for Medicare and Medicaid Services, would be used beginning in fiscal year 2013, to determine annual enrollment fee increases thereafter.

Co-pays for prescription drugs obtained at retail pharmacies would also rise under DOD's plan—from $3 to $5 for generics, $9 to $12 for brand name, and $22 to $25 for non-formulary medications at retail pharmacies. Non-formulary medications obtained through TRICARES Home Delivery would also increase to $25 from $22.

At first glance, the increases DOD is proposing appear modest but we view them as the "foot in the door" which will provide the impetus for a long line of future TRICARE program changes. Regrettably, the House recently chose to include, or rather exclude, language in its version of the fiscal year 2012 National Defense Authorization Act (H.R. 1540) which would allow DOD's plan to move forward. It does however, limit increases in fiscal year 2013 and beyond to the rate of the annual COLA.

AFSA does not discount the country's current fiscal dilemma, or the need to get the Federal budget under control. Nor is it is an issue of sacrificing a little more so everyone shares a greater portion of the load. The question is should they pay more before lesser priority programs are cut first? No one has sacrificed more then the men and women who have worn or are wearing the Nation's uniform. We simply believe it is unwise to raise TRICARE fees at a time when we have thousands of men and women in harms way overseas. What kind of message are we sending to them? Many of the individuals that would be affected by the proposed increases were promised free lifetime healthcare by DOD's recruiters to entice them to enlist, and career counselors to induce them to reenlist. Right, wrong, or indifferent, a decision to increase fees at this time would likely be viewed as another breech of promises made by the government. This in turn could adversely affect the services quality recruiting and retention efforts.

I urge this Subcommittee to ensure continued, full funding for Defense Health Program. Before seeking increases in enrollment fees, deductibles or co-payments, DOD should pursue any and all options to contain the growth of healthcare spending in ways that do not disadvantage beneficiaries and provide incentives to promote healthy lifestyles.

Again, we appreciate your consistent support in recent years to protect beneficiaries from disproportional healthcare fee increases.

Support Judicious VA–DOD Sharing Arrangements

We encourage this Subcommittee to fund programs that eliminate waste and increase efficiency between DOD and VA.

AFSA supports the judicious use of VA–DOD sharing arrangements involving network inclusion in the DOD healthcare program, especially when it includes consolidating physical examinations at the time of separation. It makes no sense to order a full physical exam on your retirement from the military and then within 30 days the VA has ordered their own complete physical exam with most of the same exotic and expensive exams.

The decision to begin this process represents a good, common-sense approach that should eliminate problems of inconsistency, save time, and take care of veterans in a timely manner. These initiatives will save funding dollars. AFSA recommends that Congress closely monitor the collaboration process to ensure these sharing projects actually improve access and quality of care for eligible beneficiaries. DOD beneficiary participation in VA facilities must never endanger the scope or availability of care for traditional VA patients, nor should any VA–DOD sharing arrangement jeopardize access and/or treatment of DOD health services beneficiaries. One example of a successful joint sharing arrangement is the clinic with ambulatory care services being in Colorado Springs, Colorado. This will aid the large number of veterans remaining in the area and support the increases in Colorado Springs as a result of BRAC initiatives. The VA and DOD each have a lengthy and comprehensive history of agreeing to work on such projects, but follow-through is lacking. "We urge these committees to encourage joint VA–DOD efforts, but ask you to exercise close oversight to ensure such arrangements are implemented properly."

CARING FOR SURVIVORS

Support of Survivors.—AFSA commends this committee for previous legislation, which allowed retention of Dependency and Indemnity Compensation (DIC), burial entitlements, and VA home loan eligibility for surviving spouses who remarry after age 57. However, we strongly recommend the age 57 DIC remarriage provision be reduced to age 55 to make it consistent with all other Federal survivor benefit programs.

We also endorse the view that surviving spouses with military Survivor Benefit Plan (SBP) annuities should be able to concurrently receive earned SBP benefits and DIC payments related to their sponsor's service-connected death.

We strongly recommend the Subcommittee fund Senator Bill Nelson's (D-FL) bill, S. 260 which would eliminate this unfair offset.

Survivors of retirees who draw the final full month's retired pay for the month in which retirees die should not have to pay this compensation back. This is however, what current law requires.

At a time when the surviving spouse and family members are trying to put their lives back together, DOD comes and takes the money back. Not some of it; all of it. The entire month. Weeks later, the proportionate amount of retired pay may be returned to the spouse but the damage has already been done.

AFSA believes it is wrong to subject survivors to this kind of "financial nit-picking" at a tragic time lives. If there's ever a time for the Government to give a military beneficiary a tiny break, surely this is it. And we encourage this subcommittee to provide sufficient funding to remove this requirement from the books.

Other Survivor issues included in our Top Priorities are:

—Permit the member to designate multiple SBP beneficiaries with a presumption that such designations and related allocations of SBP benefits must be proportionate to the allocation of retired pay.

—Provide for eligibility for housing loans guaranteed by the Department of Veterans Affairs for the surviving spouses of certain totally disabled veterans.

DEBT COMMISSION PROPOSALS

Oppose the following Debt commission recommendations:

—Freeze Federal salaries, bonuses and other comp for 3 years including military non-combat pay;

—Reduce spending on base support and facility maintenance;

—Integrate military kids into local schools in the United States;

—Use highest 5 years for civil svc and military retiree pay;

—Reform military retiree system to vest after 10 years and defer collection to age 60; and

—Full 20+ years of military retired pay starts age 57.

Work Toward a Consistent Funding Formula and Program Permanence.—This association believes that the parameters of who will be served, what care will be provided, the facilities needed, and the full funding to accomplish those missions should be stabilized as mandatory obligations. If that were so, and Congress did not have to go through redefinition drills as economic philosophies change, the strength of the

economy fluctuates, and the numbers of veterans increases or decreases—these committees and this Nation would not have to re-debate obligations and funding each year. We believe that these important programs should be beyond debate and should fall under mandatory rather than discretionary spending.

The following are a few of the Debt Commission issues recognized in our Top Priorities:

—Make adjustments to the Household Goods (HHG) weight allowances that take into consideration the number of family members;
—If advantageous to the Government, reimburse transportation expenses for PCSing members to take their POVs to a location other than a commercial storage facility;
—Resist DOD/DECA efforts to reduce the benefit that negatively alter current pricing policies, or provide the benefit to non-military beneficiaries;
—Resist the Base Exchange merger process to prevent degradation of the benefit; and
—Monitor/scrutinize housing privatization efforts to preclude adverse impact on all military members.

AIR NATIONAL GUARD AND RESERVE RETIREMENT

Reduce the earliest Guard and Reserve retirement compensation age from 60 to 55.—Legislation was introduced in previous years to provide a more equitable retirement for the men and women serving in the Guard and Reserves. This proposed legislation would have reduced the age for receipt of retirement pay for Guard and Reserve retirees from 60 to 55. Active duty members draw retirement pay the day after they retire. Yet, Guard and Reserve retirees currently have to wait until they reach age 60 before they can draw retirement pay.

Provide Concurrent Retirement and Disability Pay (CRDP) For Service Incurred Disabilities.—National Guard and Reserve with 20 or more good years are currently able to receive CRDP, however, they must wait until they are 60 years of age and begin to receive their retirement check. This policy must be changed, and along with the reduction in retirement age eligibility, is a benefit our Guard and Reserve deserve. They have incurred a service connected disability and we must provide concurrent retirement and disability pay to them.

Many Guard/Reserve retirees have spent more time in a combat zone than their active duty counterparts. The DOD has not supported legislation to provide Guard/Reserve men and women more equitable retirement pay in the past. Additional requirements and reliance has been placed on the Guard/Reserve in recent years. It is time to recognize our men and women in uniform serving in the Guard and Reserve and provide them a more equitable retirement system.

Provide employer and self-employed tax credits and enhance job security.—AFSA supports legislation to allow the work opportunity credit to small businesses, which hire members of the Reserve Components. We encourage this Subcommittee to provide the funding necessary to make this happen.

Award Full Veterans Benefit Status to Guard and Reserve Members.—It is long overdue that we recognize those servicemembers in the Guard and Reserve who have sustained a commitment to readiness as veterans after 20 years of honorable service to our country. Certain Guard and Reserve members that complete 20 years of qualifying service for a reserve (non-regular) retirement have never been called to active duty service during their careers. At age 60, they are entitled to start receiving their reserve military retired pay, Government healthcare, and other benefits of service including some veterans' benefits. But, current statutes deny them full standing as a "veteran" of the armed forces and as a result they are not entitled to all veteran benefits. Our goal, along with our TMC partners, is to support pending legislation that will include in the definition(s) of "veteran" retirees of the Guard/Reserve components who have completed 20 years or more of qualifying service, but are not considered to be veterans under the current statutory definitions.

EDUCATION PROGRAMS

There's no escaping the fact that college costs are rising. As the gap between the cost of an education and value of the Montgomery GI Bill (MGIB) widened, the significance of the benefit became less apparent. For that reason, the Post-9/11 GI Bill is a giant step forward. However, we must make sure that the new Post-9/11 GI Bill 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 remaining technical corrections to the Post-9/11 GI Bill. Examples that standout are active duty not receiving the $1,000 an-

nual book stipend, Title 32 credit for Guard and Reserve service, and BAH for those veterans or retirees taking on-line college courses full-time.

Providing in-State tuition rates at federally supported State universities and colleges.—Regardless of residency requirements, is an important goal for AFSA due to the rise in servicemembers and their families returning to institutions to further their education and other numerous PCS moves involved with the CONUS.

Ensure full funding for the mission of the Impact Aid Program.—Impact Aid Program is to disburse payments to local educational agencies that are financially burdened by Federal activities and to provide technical assistance and support services.

Preserve Tuition Assistance.—The discretionary Air Force Tuition Assistance (TA) Program is an important quality of life program that provides tuition and fees for courses taken by active duty personnel. The program is one of the most frequent reasons given for enlisting and re-enlisting in the Air Force.

Implement the Interstate Compact!.—The Interstate Compact on Educational Opportunity for Military Children works to correct the inequalities that military children face as they transfer from one school (system) to another due to deployments or permanent change of station moves by their servicemember parent.

By implementing this Compact, States can work together to achieve cohesive education goals and assure military students are well prepared for success after high school graduation. We encourage your strong support for those who serve this Nation and ask that you take necessary measures to pass this Act in your State and implement this important program. The States that thus far are absent from supporting the "sense of the Senate" are Nebraska, Massachusetts, Vermont, West Virginia, Minnesota, New Hampshire, and Wyoming.

Repeal or Greatly Modify the Uniformed Services Former Spouses Protection Act (USFSPA—Public Law 97–252).—AFSA urges this Subcommittee to support some fairness provisions for the USFSPA. While this law was passed with good intentions in the mid 1980s, the demographics of military service and their families have changed. As a result, military members are now the only U.S. citizens who are put at a significant disadvantage in divorce proceedings.

Because of the USFSPA, the following situations now exist:

—A military member is subject to giving part of his/her military retirement pay (for the rest of his/her life) to anyone who was married to him/her during the military career regardless of the duration of the marriage.

—The divorce retirement pay separation is based on the military member's retirement pay—not what the member's pay was at the time of divorce (often many years later).

—A military retiree can be paying this "award" to multiple former spouses.

—It takes a military member 20 years to earn a retirement; it takes a former spouse only having been married to the member (for any duration, no matter how brief) to get a portion of the member's retirement pay.

—Under this law, in practice judges award part of the member's retirement pay regardless of fault or circumstances.

—There is no statute of limitations on this law; i.e., unless the original divorce decree explicitly waived separation of future retirement earnings, a former spouse who the military member has not seen for many years can have the original divorce decree amended and "highjack" part of the military member's retirement pay.

—The former spouse's "award" does not terminate upon remarriage of the former spouse.

—The "award" to a former spouse under this law is above and beyond child support and alimony.

—The law is considered unfair, illogical, and inconsistent. The member's military retired pay which the Government refers to as "deferred compensation" is, under this law, treated as property rather than compensation. Additionally, the law is applied inconsistently from State to State.

—In most cases, the military retiree has no claim to part of the former spouse's retirement pay.

—Of all U.S. citizens, it is unconscionable that military members who put their lives on the line are uniquely subjected to such an unfair and discriminatory law.

—While there may be unique cases (which can be dealt with by the court on a case-by-case basis) where a long-term, very supported former spouse is the victim, in the vast majority of the cases we are talking about divorces that arise which are the fault of either or both parties—at least half of the time not the military member. In fact, with the current levels of military deployments, more and more military members are receiving "Dear John" and "Dear Jane" letters while they serve.

—This is not a male-vs.-female issue. More and more female military members are falling victim to this law. These are just a few of the inequities of this law. We believe this law needs to be repealed or, at the least, greatly modified to be fairer to military members. We urge the Subcommittee to support any funding requirement that may be necessary to take action on this unfair law—for the benefit of those men and women who are currently defending the interests of this nation and its freedom.

CONCLUSION

Chairman Inouye, Ranking Member Cochran, in conclusion, I want to thank you again for this opportunity to express the views of our members on these important issues as you consider the fiscal year 2012 budget. We realize that those charged as caretakers of the taxpayers' money must budget wisely and make decisions based on many factors. As tax dollars dwindle, the degree of difficulty deciding what can be addressed, and what cannot, grows significantly.

AFSA contends that it is of paramount importance for a nation to provide quality healthcare and top-notch benefits in exchange for the devotion, sacrifice, and service of military members. So, too, must those making the decisions take into consideration the decisions of the past, the trust of those who are impacted, and the negative consequences upon those who have based their trust in our Government? We sincerely believe that the work done by your committees is among the most important on the Hill. On behalf of all AFSA members, we appreciate your efforts and, as always, are ready to support you in matters of mutual concern.

The Air Force Sergeants Association looks forward to working with you in this 112th Congress.

Chairman INOUYE. I can assure you that the matter of the unemployed and homeless will be a very high priority. Thank you very much.

Sergeant MCCAUSLIN. Thank you, Senator.

Chairman INOUYE. Senator Cochran.

Senator COCHRAN. Thank you for bringing these facts and figures to our attention. It occurs to me that we need to give this our best consideration. I think you can be assured that that will happen.

Sergeant MCCAUSLIN. Thank you, sir.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, just an observation. Sergeant, Mr. McCauslin——

Sergeant MCCAUSLIN. Yes, sir.

Senator SHELBY [continuing]. You speak well for the Sergeants Association. There are a lot of you, but you had a distinguished military record yourself. I was just reading that. You're to be commended. You're a good spokesman for them. Thank you. We respect that.

Sergeant MCCAUSLIN. Thank you, sir.

Chairman INOUYE. Thank you very much, Sergeant.

Our next witness is Captain Connor, American Lung Association. Captain.

STATEMENT OF CAPTAIN CHARLES D. CONNOR, UNITED STATES NAVY (RETIRED), PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN LUNG ASSOCIATION

Captain CONNOR. Thank you very much, Senator. It's a pleasure to be here. Mr. Chairman, with your permission, I would like to pass on the greetings of two of your admirers in Honolulu I met with last week, Dr. Michael Chun and Aaron Mahi. I'm passing on their greetings to you this morning.

I'm, as you said, a retired Navy captain. I'm President and CEO of the American Lung Association. The American Lung Association has been around for more than 100 years and our mission is to

save lives by improving lung health and fighting lung disease. We do this through three big things: research, advocacy, and educational programs.

I'd like to take a few seconds of the subcommittee's time to talk about three big things today: the terrible burden on the military caused by tobacco use and the need for DOD to start combatting it; to ask your consideration for restoring funding for the peer-reviewed lung cancer research program to $20 million; and third, to discuss briefly what you've heard about this morning already, which is the threat posed by our soldiers in Iraq and Afghanistan to toxic pollutants in the air.

Firstly, let me address tobacco use if I may. Tobacco use, as you well know, is the leading cause of preventable death in the United States today. Not surprisingly, it is also a very significant problem in our military as well. DOD has made some small progress, but much, much more needs to be done. Currently the smoking rate for civilians in America is about 20 percent. It's about 30 percent in the military, 30.5 exactly, and we think the combat arms people in deployed status, it's probably much higher than that. The highest smoking rates in the military are for those people between 18 and 25, especially soldiers and marines.

More than one in seven active duty personnel begin smoking after they join the military. So it's a very, very severe problem.

The use of tobacco is a severe compromiser of readiness and performance. Studies have shown that smoking is the best predictor of training failure and it's also been shown to increase soldiers' chances of physical injury and hospitalization. Now, you may have been surprised, as I was, to see the Secretary of Defense in the last year for the first time in my recollection complain about the cost of military healthcare. The biggest driver of healthcare is tobacco use. So the Pentagon spends over $1.6 billion of appropriated funds in treating tobacco-related medical care, increased hospitalization, and lost days of work.

Just 2 years ago, the Institute of Medicine issued a big thick report I could have brought today entitled "Tobacco Use in the Military and Veterans Population." The panel found that tobacco control does not have a very high priority in the military—that's what we think as well—and that it will take a long time to get the military off tobacco. They suggested as long as 20 years.

So the American Lung Association believes now is the time to attack this problem if it's going to take that long, and DOD is overdue in announcing how it intends to implement those recommendations.

Two other things briefly in the minute I have left. We strongly support the lung cancer research program in the congressionally directed medical research program. We urge you to restore it to its original intent and the $20 million. The original intent was for competitive research grants and priority given to deployment of integrated components to identify, treat, and manage early curable lung cancer.

Last, I will not repeat what you've heard already today, but we are extremely concerned about the respiratory disease of soldiers and marines coming back from theater. We recommend DOD immediately begin to find alternatives to burning trash for waste dis-

posal and to make burn pits more efficient. We also urge DOD to take steps to minimize troop exposure to pollutants and to further monitor pollution efforts. We think military people should be measured for respiratory illness before they go to theater and then coming back, so that we can compare apples to apples, so to speak, without comparing military respiratory disease with the civilian population. So I think there's some attention that needs to be paid to that.

Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF CHARLES D. CONNOR

Mr. Chairman and members of the Committee, the American Lung Association is honored to present this testimony to the Senate Appropriations Subcommittee on Defense. The American Lung Association was founded in 1904 to fight tuberculosis and today, our mission is to save lives by improving lung health and preventing lung disease. We accomplish this through research, advocacy and education.

The American Lung Association wishes to call your attention to three issues for the Department of Defense's (DOD) fiscal year 2012 budget: the terrible burden on the military caused by tobacco use and the need for the Department to aggressively combat it; the importance of restoring funding for the Peer-Reviewed Lung Cancer Research Program to $20 million; and the health threat posed by soldiers' exposure to toxic pollutants in Iraq and Afghanistan.

First, the American Lung Association is concerned about the use of tobacco products by the troops. The effects of both the health and performance of our troops are significantly hindered by the prevalence of smoking and use of smokeless tobacco products. As a result, we urge the Department of Defense to immediately implement the recommendations in the Institute of Medicine's 2009 Report, Combating Tobacco Use in Military and Veteran Populations.

Next, the American Lung Association recommends and supports restoring funding to $20 million for the Peer-Reviewed Lung Cancer Research Program (LCRP) within the Department of Defense Congressionally Directed Medical Research Program (CDMRP). Finally, the American Lung Association is deeply concerned about the respiratory health of our soldiers in Iraq and Afghanistan. We urge the DOD to immediately find alternatives to using burn pits, to track the incidence of respiratory disease related to service, and to take other steps that will improve the lung health of soldiers.

Combating Tobacco Use

Tobacco use remains the leading cause of preventable death in the United States and not surprisingly, is a significant problem within the military as well. The DOD has made some small progress, including its recent smokefree policy on submarines, but significantly more will need to be done to reduce the billion dollar price tag that comes with military personnel using tobacco products.

The 2008 Department of Defense Survey of Health Behaviors among Active Duty Personnel found that smoking rates among active duty personnel have essentially remained steady since 2002. However, smoking rates among deployed personnel are significantly higher and, alarmingly, more than one in seven (15 percent) of active duty personnel begin smoking after joining the service.

Currently, the smoking rate for active duty military is 30.5 percent, with smoking rates highest among personnel ages 18 to 25—especially among soldiers and Marines. The Department of Veterans Affairs estimates that more than 50 percent of all active duty personnel stationed in Iraq smoke.[1] The use of tobacco compromises military readiness and the performance of our men and women in the armed forces. Studies have found that smoking is one of the best predictors of training failure, and it has also been shown to increase soldiers' chances of physical injury and hospitalization.[2] Tobacco use not only costs the DOD in troop readiness and health—

[1] Hamlett-Berry, KW, as cited in Beckham, JC et al. Preliminary findings from a clinical demonstration project for veterans returning from Iraq or Afghanistan. Military Medicine. May 2008; 173(5):448–51.

[2] Institute of Medicine. Combating Tobacco Use in Military and Veteran Populations. 2009; 3–4.

it also costs the DOD money. The Pentagon spends over $1.6 billion on tobacco-related medical care, increased hospitalization and lost days of work.[3]

In 2009, the prestigious Institute of Medicine (IOM) issued a report entitled, Combating Tobacco Use in Military and Veteran Populations. The panel found "tobacco control does not have a high priority in DOD or VA." This report, which was requested by both departments, issued a series of recommendations, which the American Lung Association fully supports and asks this Committee to ensure are implemented.

The IOM recommendations include commonsense approaches to eliminating the use of tobacco in the U.S. military. Some of the IOM's recommendations include:

—Phase in tobacco-free policies by starting with military academies, officer-candidate training programs, and university-based reserve officer training corps programs. Then the IOM recommends new enlisted accessions be required to be tobacco-free, followed by all active-duty personnel;
—Eliminate tobacco use on military installations using a phased-in approach;
—End the sales of tobacco products on all military installations. Personnel often have access to cheap tobacco products on base, which can serve to start and perpetuate addictions;
—Ensure that all DOD healthcare and health promotion staff are trained in the standard cessation treatment protocols;
—Ensure that all DOD personnel and their families have barrier-free access to tobacco cessation services.

A recent investigation conducted by American Public Media[4] highlights that the discount price for tobacco products on base is significantly more—in some cases 20 percent—than the 5 percent permitted under law. The easiest way to end this problem is to end tobacco sales on all military installations.

The American Lung Association recommends that the Department of Defense implement all recommendations called for in the 2009 IOM report. The IOM has laid out a very careful, scientifically based road map for the DOD to follow and the American Lung Association strongly urges the Committee to ensure that the report's recommendations be implemented without further delay.

Peer Reviewed Lung Cancer Research Program

The American Lung Association strongly supports the Lung Cancer Research Program (LCRP) in the Congressionally Directed Medical Research Program (CDMRP) and its original intent to research the scope of lung cancer in our military.

In fiscal year 2011, LCRP received $12.8 million. We urge this Committee to restore the funding level to the fiscal year 2009 level of $20 million. In addition to the reduced funding, the American Lung Association is troubled by the change in governance language of the LCRP authorized by the Congress in fiscal year 2010. We request that the 2012 governing language for the LCRP be returned to its original intent, as directed by the 2009 program: "These funds shall be for competitive research . . . . Priority shall be given to the development of the integrated components to identify, treat and manage early curable lung cancer".

Troubling Lung Health Concerns in Iraq and Afghanistan

The American Lung Association is extremely troubled by reports of soldiers and civilians who are returning home from Iraq and Afghanistan with lung illnesses including asthma, chronic bronchitis and sleep apnea. Several new studies discussed below show that the airborne particle pollution our troops breathe in these areas may cause or contribute to these problems.

A recent DOD study found that air in several Middle East locations contained high concentrations of desert sand, as well as particles that likely came from human-generated sources—especially trash burned in open pits and diesel exhaust. Breathing particulate matter causes heart attacks, asthma attacks, and even early death. People most at risk from particulate matter include those with underlying diseases such as asthma, but the health impact of particle pollution is not limited to individuals with pre-existing chronic conditions. Healthy, young adults who work outside—such as our young men and women in uniform—are also at higher risk. Data from a 2009 study of soldiers deployed in Iraq and Afghanistan found that 14 percent of them suffered new-onset respiratory symptoms, a much higher rate than their non-deployed colleagues. In a review of the DOD studies, the National Academy of Sciences National Research Council (NRC) concluded that troops deployed

[3] Institute of Medicine. Combating Tobacco Use in Military and Veteran Populations. 2009; 56.
[4] Herships, Sally. "Military underprices tobacco more than law allows." American Public Media. http://marketplace.publicradio.org/display/web/2011/06/01/pm-military-underprices-tobacco-more-than-law-allows/. Accessed June 3, 2011.

in the Middle East are "exposed to high concentrations" of particulate matter associated with harm "affecting troop readiness during service" and even "occurring years after exposure."[5]

Several studies, released in May at the American Thoracic Society 2011 International Conference, show mounting evidence for the importance of solving these problems. One large study showed that asthma rates in soldiers deployed to Iraq are higher than in soldiers deployed elsewhere. The study also showed that soldiers who served in Iraq had more serious asthma—i.e., lower lung function—than non Iraq personnel. In fact, records show that 14 percent of medic visits in Iraq are for respiratory issues, which is a higher percentage than from the previous Iraq war.[6]

There are several probable causes for this alarming prevalence of respiratory disease in our current war arenas. The most obvious cause is exposure to dust. There are multiple kinds of dust from multiple sources in the Middle East. Measurements show that the amount of harmful particles in the air is over 600 percent higher than the levels considered acceptable for public health in the United States. More significant sources of toxic air pollution are burn pits, which are lit with jet fuel and sometimes burn continuously for years. This method of disposing of trash can be incredibly harmful to soldiers who work in the pits' vicinity. Major explosions, IEDs, and fungus can also cause harmful respiratory effects.[7]

While we know these problems exist, it is also clear that the DOD needs to do a better job at identifying and tracking them. Respiratory disease is difficult to detect, especially in personnel who are younger, healthier and more athletic than the general population. Military personnel need to be tested for respiratory and lung function pre-deployment so that doctors can make useful comparison with post-deployment results, instead of comparing soldiers to the population average. Another possible solution is to use non-traditional measures to detect problems—such as ability to complete a 2-mile run, as suggested by one researcher.[8]

To protect the troops from the hazards discussed and resulting lung disease, the American Lung Association recommends that DOD begin immediately to find alternatives to burning trash for waste disposal and/or make burn pits more efficient. We also strongly urge DOD to take steps to minimize troop exposure to pollutants and to further monitor pollution levels. Military doctors also must develop better ways to measure and track lung disease in military personnel, including taking baseline measures prior to deployment and creating a national registry to track all veterans who were exposed to these pollutants while in Iraq and Afghanistan. These problems are pervasive throughout the military, and DOD officials need to take leadership roles in creating positive change.

Conclusion

Mr. Chairman, in summary, our Nation's military is the best in the world and we should do whatever necessary to ensure that the lung health needs of our armed services are fully met. Our troops must be protected from tobacco and unsafe air pollution and the severe health consequences. Thank you for this opportunity.

Chairman INOUYE. I thank you very much, Captain. I'm one of the one out of seven. I began smoking after I got in, but I quit. But all of us received in our K rations a pack of four cigarettes free. That's how we learned.

Senator Cochran.

Senator COCHRAN. We appreciate very much your being here today and bringing this reminder to our attention. It's something that we need to work hard on and I hope we can be successful. It seems to me that this is probably the most preventable kind of medical problem that we can work on and the chairman has cer-

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[5] National Academy of Sciences, National Research Council. Review of the Department of Defense Enhanced Particulate Matter Surveillance Program Report. 2010. http://www.nap.edu/catalog/12911.html. Accessed June 7, 2011.

[6] Szema, Anthony M. Overview of Exposures And New Onset Asthma In Soldiers Serving In Iraq And Afghanistan. As presented at American Thoracic Society 2011 International Conference, May 18, 2011.

[7] Szema, Anthony M. Overview Of Exposures And New Onset Asthma In Soldiers Serving In Iraq And Afghanistan. As presented at American Thoracic Society 2011 International Conference, May 18, 2011.

[8] Miller, Robert. Constrictive Bronchiolitis Among Soldiers Exposed To Burn Pits, Desert Dust And Fires In Southwest Asia. As presented at American Thoracic Society 2011 International Conference, May 18, 2011.

tainly indicated a willingness to cooperate, so I think you can look forward to cooperation from this subcommittee.

Captain CONNOR. Thank you.

Mr. Vice Chairman, if I may, I'd like to leave behind a very recent article from the American Journal of Public Health, which fully reveals the extent to which the tobacco industry has got its hands in the Senate and the House. We actually have enshrined into law, if you can believe it, obstacles to DOD attacking the smoking problem. So with your permission, I'd like to leave that behind.

Chairman INOUYE. Without objection, it will be made part of the record.

[The information follows:]

[From the American Journal of Public Health, March 2011]

FORCING THE NAVY TO SELL CIGARETTES ON SHIPS: HOW THE TOBACCO INDUSTRY AND POLITICIANS TORPEDOED NAVY TOBACCO CONTROL

(Naphtali Offen, Sarah R Arvey, Elizabeth A Smith, Ruth E Malone)

In 1986, the U.S. Navy announced the goal of becoming smoke-free by 2000. However, efforts to restrict tobacco sales and use aboard the USS *Roosevelt* prompted tobacco industry lobbyists to persuade their allies in Congress to legislate that all naval ships must sell tobacco. Congress also removed control of ships' stores from the Navy. By 1993, the Navy abandoned its smoke-free goal entirely and promised smokers a place to smoke on all ships. Congressional complicity in promoting the agenda of the tobacco industry thwarted the Navy's efforts to achieve a healthy military workforce. Because of military lobbying constraints, civilian pressure on Congress may be necessary to establish effective tobacco control policies in the armed forces. (Am J Public Health. 2011;101:404–411. doi: 10.2105/AJPH.2010.196329)

At more than 30 percent,[1] [2] the prevalence of smoking in the military is 50 percent higher than is the civilian rate, with a 40 percent prevalence among those aged 18 to 25 years[3] and nearly 50 percent among those who have been in a war zone.[2] [4] From 1998 to 2005, tobacco use in the military increased 7.7 percent, from 29.9 percent to 32.2 percent, reversing the decline of prior decades.[4] A tobacco-friendly military culture persists, including the availability of cheap tobacco products,[5] liberal smoking breaks,[6] and easily accessible smoking areas.[6] [7] Smoking damages health and readiness[8] [9] [10] [11] and increases medical and training

[1] Bray RM, Hourani LL. Substance use trends among active duty military personnel: findings from the United States Department of Defense Health Related Behavior Surveys, 1980–2005. *Addiction.* 2007;102(7):1092–1101.

[2] Volkow ND. Director's perspective: substance abuse among troops, veterans, and their families. *NIDA Notes.* 2009; 22(5):1092–1101.

[3] Bray RM, Hourani LL, Olmsted DLR, et al. 2005 Department of Defense survey of health related behaviors among active duty military personnel: a component of the Defense Lifestyle Assessment Program (DLAP). December 2006. Prepared by RTI International. Report No. DAMD 17–00–2–0057. Available at: http://www.ha.osd.mil/special_reports/2005_Health_Behaviors_Survey_1-07.pdf. Accessed May 10, 2010.

[4] Institute of Medicine. *Combating Tobacco Use in Military and Veteran Populations.* Washington, DC: National Academic Press; 2009.

[5] Smith EA, Blackman VS, Malone RE. Death at a discount: how the tobacco industry thwarted tobacco control policies in U.S. military commissaries. *Tob Control* 2007;16(1):38–46.

[6] Haddock CK, Hoffman KM, Peterson A, et al. Factors which influence tobacco use among junior enlisted in the United States Army and Air Force: a formative research study. *Am J Health Promot.* 2009;23(4):241–246.

[7] Jahnke SA, Haddock CK, Poston WS, Hoffman KM, Hughey J, Lando HA. A qualitative analysis of the tobacco control climate in the U.S. military. *Nicotine Tob Res.* 2010;12(2):88–95.

[8] Dept of the Navy, Office of the Secretary. SECNAV instruction 5100.13E, Navy and Marine Corps tobacco policy. Available at: http://www. mccsmiramar.com/pdfs/5100_13E.pdf. Accessed March 3, 2010.

[9] Conway T, Cronan T. Smoking, exercise, and physical fitness. *Prev Med.* 1992;21(6):723–734.

[10] Zadoo V, Fengler S, Catterson M. The effects of alcohol and tobacco use on troop readiness. *Mil Med.* 1993;158(7): 480–484.

[11] Conway TL. Tobacco use and the United States military: a longstanding problem. *Tob Control.* 1998;7(3):219–221.

costs.[12] [13] [14] [15] In addition to short-term effects, such as impairment to vision and hearing, long-term consequences include lung and other cancers, cardiovascular disease, chronic obstructive pulmonary disease, and problematic wound healing.[4] The U.S. Department of Defense spends more than $1.6 billion annually on tobacco-related health care and absenteeism.[4]

In addition to compromised military readiness and Department of Defense expenses, a tobacco-friendly military culture takes a societal toll—economic and human—long after military personnel return to civilian life. The Department of Veterans Affairs spent $5 billion in 2008 treating veterans with chronic obstructive pulmonary disease, a diagnosis most often associated with smoking.[4] Lifelong smokers have a 50 percent chance of dying prematurely.[4] Most costs must be borne by the veteran: in 1998, Congress denied disability pensions to tobacco-sickened veterans who began to smoke during their service, initially labeling smoking in the military as "willful misconduct." [16]

Department of Defense Directive 1010.10, issued in 1986, established a baseline "policy on smoking in the DOD [Department of Defense] occupied buildings and facilities." [17] The policy emphasized a healthy military that discouraged smoking and designated authority to the services and to individual commanders to set specific policies.[18] However, subsequent attempts to set such policies achieved limited results,[19] [20] in part because of the tobacco industry's influence on Congress.[5] [18]

The industry successfully lobbied Congress to prevent the military from raising the prices of tobacco products sold in military stores,[5] and to ensure that in-store tobacco promotions would not be prohibited.[18] Congress also prevented the army from implementing a stronger tobacco control policy than that set by Directive 1010.10, although the directive was intended to be a policy floor upon which the services could expand.[18] To achieve its goals, Congress privately pressured military tobacco control advocates,[18] publicly scolded them,[5] interfered with funding for military programs,[5] and passed laws preventing the establishment of recommended tobacco control policies.[5] [16]

We examined an attempt by a former captain of the USS *Theodore Roosevelt* to ban smoking on the aircraft carrier and showed how tobacco industry lobbyists, working through their allies in the U.S. Congress, were successful in stymieing his efforts and forcing the Navy to sell cigarettes on all ships.

METHODS

As part of a larger project examining tobacco industry influence on the U.S. military, we searched internal tobacco industry documents released following the Master Settlement Agreement.[21] Data were collected from the University of California, San Francisco Legacy Tobacco Documents Library (available at: http://legacy.library.ucsf.edu) and Tobacco Documents Online (available at: http://tobaccodocuments.org). Initial search terms included "Navy/smokefree" and "Navy/cigarettes"; we used a snowball approach to locate additional material.[22] We also

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[12] Helyer AJ, Brehm WT, Perino L. Economic consequences of tobacco use for the Department of Defense, 1995. *Mil Med.* 1998;163(4):217–221.

[13] Klesges RC, Haddock CK, Chang CF, Talcott GW, Lando HA. The association of smoking and the cost of military training. *Tob Control.* 2001;10(1):43–47.

[14] Dall TM, Zhang Y, Chen YJ, et al. Cost associated with being overweight and with obesity, high alcohol consumption, and tobacco use within the military health system's TRICARE prime-enrolled population. *Am J Health Promot.* 2007; 22(2):120–139.

[15] Woodruff SI, Conway TL, Shillington AM, Clapp JD, Lemus H, Reed MB. Cigarette smoking and subsequent hospitalization in a cohort of young U.S. Navy female recruits. *Nicotine Tob Res.* 2010; 12(4):365–373.

[16] Offen N, Smith EA, Malone RE. "Willful misconduct": how the U.S. government prevented tobacco-disabled veterans from obtaining disability pensions. *Am J Public Health.* 2010;100(7):1166–1173.

[17] Taft WH. Department of Defense Directive 1010.10 Health Promotion. March 11, 1986. Philip Morris collection. Bates no. 2047563159/3166. Available at: http://legacy.library.ucsf.edu/tid/des52e00. Accessed October 23, 2006.

[18] Arvey S, Malone RE. Advance and retreat: tobacco control policy in the U.S. military. *Mil Med.* 2008;173(10):985–991.

[19] Smith EA, Malone RE. Tobacco targeting of military personnel: "The plums are here to be plucked." *Mil Med.* 2009;174(8):797–806.

[20] Smith EA, Malone RE. "Everywhere the soldier will be": wartime tobacco promotion in the U.S. military. *Am J Public Health.* 2009;99(9):1595–1602.

[21] National Association of Attorneys General. Master Settlement Agreement. Available at: http://www.naag.org/upload/1109185724__1032468605__cigmsa.pdf. Accessed July 7, 2009.

[22] Malone RE, Balbach ED. Tobacco industry documents: treasure trove or quagmire? *Tob Control.* 2000;9(3):334–338.

searched the LexisNexis database for media coverage,[23] the Library of Congress Thomas database of legislative history,[24] and the U.S. Code collection at Cornell University Law School,[25] and conducted Internet searches for supplemental documents. We attempted to interview all principals in this case study and spoke with the former captain of the USS *Roosevelt*, Admiral Stanley Bryant (November 9, 2009) and former Navy Master Chief Petty Officer James Herdt (January 14, 2010), both of whom advocated for the USS *Roosevelt* policy change. We also interviewed former Secretary of the Navy John Dalton (October 22, 2009), who opposed the policy. Otherwise unattributed quotations from these individuals are taken from the interviews. Our inability to secure other interviews is a limitation of this study. We analyzed approximately 340 industry documents and 80 documents from other sources using an interpretive approach, chronologically organizing our findings as a descriptive case study.[26] [27]

RESULTS

Following Directive 1010.10, some Navy leaders began to propose policies to reduce smoking among their personnel. As early as 1986, Chief of Naval Operations James Watkins (1982–1986) proposed a tobacco-free Navy,[28] a goal reiterated in 1990 by the Navy surgeon general, Vice-Admiral James Zimble (1987–1990).[29] In February 1992, the Navy issued Instruction 6100.2, emphasizing tobacco-use prevention, cessation, and the protection of nonsmokers from secondhand smoke.[30] As a result, a number of ships restricted tobacco sales by limiting the number of brands carried, raising prices, or not selling tax-free cigarettes.[31] Some ships restricted smoking to limited venues,[31] tobacco-related promotional activities were curtailed at one Navy exchange,[32] and naval hospitals ashore went smoke-free.[33] In early 1993, Navy Surgeon General Donald Hagen (1991–1995) asked the Office of the Secretary of Defense to end tobacco product price subsidies in commissaries and exchanges in all service branches, arguing that low cigarette prices contributed to high rates of smoking in the military.[34] By late 1993, the Office of the Secretary of Defense had not responded.[35] [36] (Cigarette prices in commissaries remained low, and only in 1996 were they marginally increased, at the instigation of an Assistant Secretary of Defense.)[5]

USS Roosevelt Bans Smoking

Shortly after assuming command of the aircraft carrier *Theodore Roosevelt*, Captain Stanley W. Bryant announced that the ship would become entirely smoke-free by July 1993, including an end to cigarette sales in the ship's store. Motivated by

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[23] LexisNexis Academic Web site. Available at: http://www.lexisnexis.com/us/lnacademic. Accessed September 20, 2008.

[24] Library of Congress Thomas Web page. Available at: http://thomas.loc.gov/home/multicongress/multicongress.html. Accessed September 20, 2008.

[25] Cornell University Law School US Code collection. Available at: http://www.law.cornell.edu/uscode. Accessed September 13, 2008.

[26] Hill MR. *Archival Strategies and Techniques*. Newbury Park, CA: Sage Publications; 1993.

[27] Yin RK. *Case Study Research Design and Methods*. Thousand Oaks, CA: Sage Publications; 1994.

[28] Taylor M, Stump D. Sailors are under the "smoking gun." September 6, 1995. Philip Morris collection. Bates no. 2048895176/5180. Available at: http://legacy.library.ucsf.edu/tid/yre35c00. Accessed January 16, 2008.

[29] Zimble JA. I am writing to strongly object to Camel cigarette advertising that includes naval vessels and aircraft in the background. June 11, 1990. RJ Reynolds collection. Bates no. 507471512. Available at: http://legacy.library.ucsf.edu/action/document/view?tid=eso24d00. Accessed January 24, 2007.

[30] Dept of the Navy, Office of the Chief of Naval Operations. OPNAV Instruction 6100.2, Health Promotion Program. Available at: http://www-nehc.med.navy.mil/bumed/tcat/tobacco/opnav%206100.2.pdf. Accessed March 3, 2010.

[31] Glennie L. Navy ship smoking restrictions. May 18, 1992. Philip Morris collection. Bates no. 2023176786. Available at: http://legacy.library.ucsf.edu/tid/trs95e00. Accessed April 15, 2008.

[32] O'Rourke R. Dept of the Navy, Sale and use of tobacco products. June 19, 1992. Philip Morris collection. Bates no. 2076220349/0350. Available at: http://legacy.library.ucsf.edu/tid/bqc62c00. Accessed April 28, 2009.

[33] Navy News & Undersea Technology. First steps to a smoke-free Navy are under way. May 14, 1990. Philip Morris collection. Bates no. 2023175502. Available at: http://legacy.library.ucsf.edu/tid/oqx83e00. Accessed April 8, 2008.

[34] Hagen DF. Tobacco use reduction. March 24, 1993. Philip Morris collection. Bates no. 2023172986. Available at: http://legacy.library.ucsf.edu/tid/iuc85e00. Accessed December 6, 2006.

[35] Juliana J. Key issues: DOD smoking policies. May 6, 1993. Available at: http://tobaccodocuments.org/nysa__ti__s1/TI03081755.html. Accessed April 8, 2008.

[36] Linehan K. Washington outlook for 1994. December 29, 1993. Philip Morris collection. Bates no. 2025774681/4698. Available at: http://legacy.library.ucsf.edu/tid/vho14e00. Accessed January 5, 2008.

a recently released report that secondhand smoke caused cancer in nonsmokers, Bryant felt obliged to act. He said, "I'm the commanding officer of these kids and I can't have them inhaling secondhand smoke. I wouldn't put them in the line of fire. I'm not going to put them in the line of smoke." Navy Surgeon General Hagen and Chief of Naval Operations Admiral Frank B. Kelso (1990–1994) supported Bryant's efforts.[37] [38]

The *Roosevelt* left port in March 1993 for 6 months at sea, having informed the crew in advance of the impending policy change. Cigarettes were removed from the ship's store, but chew tobacco was available because, according to Bryant, "although it's bad for the person, it doesn't adversely affect the other crew members." Crewmen were allowed to bring cigarettes aboard and would be able to smoke them in the few lavatories set aside for that purpose until the ban went into effect July 4. Thereafter, they would be able to smoke only in ports of call. Those lavatories were among the only spaces on board where the air was vented directly to the outside and not recirculated; however, maintaining smoking in the lavatories was untenable because measurements of the air quality in the lavatories showed high levels of toxicity and the smoke strayed to nearby berths.

According to Bryant, crew reaction was mixed: many nonsmokers expressed support, and some smokers complained. Command Master Chief James Herdt, who served as the highest-ranking enlisted person under Bryant, said the new policy was opposed by an "incredibly small group of people." When a crew member asked Bryant how he could take away his right to smoke, Bryant told him the military regulates the length of hair and fingernails, how one dresses, and other such matters that many things, such as conjugal privileges and alcohol consumption, are prohibited on ship; and that smoking cigarettes, like drinking alcohol and smoking marijuana, affected the health and welfare of the rest of the crew. Bryant reported that few infractions occurred and that he received many letters from his crew's family members thanking him for protecting their loved ones from smoke and making it easier for smokers to quit.

Tobacco Industry Reaction

Philip Morris and the Tobacco Institute, the industry's lobbying arm, observed that Navy Instruction 6100.2 represented a policy shift from accommodating both smokers and nonsmokers to privileging nonsmokers. One Philip Morris military sales executive said, "We are very concerned that the Navy appears to be getting to the point where they are mandating non-smoking."[31] His colleague, Rita O'Rourke, noted that Instruction 6100.2 established that "where conflicts arise between the rights of smokers and rights of the nonsmokers, those of the nonsmokers shall prevail."[39] She called attention to permission given to commanders to punish violations, and argued that the provision forced smokers to quit.[39] With the emergence of stricter policies than Department of Defense Directive 1010.10, O'Rourke wondered whether to suggest that the Department of Defense revisit the issue, although that would risk a decision that "all Services . . . become smoke-free."[40]

Bryant's tobacco control measures on the Roosevelt elicited particular industry concern. In a list of suggested talking points, Tobacco Institute counsel Jim Juliana told colleagues that the policy constituted "discrimination," a denial of freedom of choice, and a breach of contract. He argued,

> People are recruited and granted certain privileges and rights which now seem to be denied in the middle of their service to their country.[35]

(Bryant noted that when recruits ledge an oath to the Constitution, "it doesn't say a damn thing about smoking.") Juliana argued that the Roosevelt was home as well as workplace and suggested that tobacco products would be smuggled aboard and "used illegally and unwarranted and unnecessary punitive actions" would result.[35]

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[37] Law Offices of Shook. Hardy & Bacon. Report on recent ETS and IAQ developments. August 6, 1993. Lorillard collection. Bates no. 87806034/6062. Available at: http://legacy.library.ucsf.edu/tid/tzb40e00. Accessed April 15, 2008.

[38] Tobacco Institute. Executive summary. August 6, 1993. Tobacco Institute collection. Bates no. TICT0004527/4528. Available at: http://legacy.library.ucsf.edu/tid/lgc42f00. Accessed April 28, 2009.

[39] O'Rourke R. Department of the Navy violations of Department of Defense Directive 1010.10. March 6, 1993. Philip Morris collection. Bates no. 2023172961/2965. Available at: http://legacy.library.ucsf.edu/tid/ouc85e00. Accessed November 17, 2006.

[40] O'Rourke R. DOD-sale and use of tobacco products. March 16, 1993. Philip Morris collection. Bates no. 2023172957/2959. Available at: http://legacy.library.ucsf.edu/tid/muc85e00. Accessed October 17, 2006.

Congressional Hearing

Only a month after the Roosevelt went smoke-free, the Morale, Welfare, and Recreation (MWR) Panel of the House Armed Services Committee (HASC) took up the issue of tobacco control in the Navy, and the USS *Roosevelt* in particular.[41] The panel had oversight of MWR activities offered to sailors, such as entertainment and sports programs. MWR was funded by profits from the ships' stores. Tobacco-friendly politicians challenged Rear Admiral Commander John Kavanaugh of Navy Exchange Command on the Navy's tobacco control policies, using many of the arguments suggested in a memo prepared by Juliana. For example, Representative Herbert Bateman (R-VA) characterized not being able to smoke aboard ship as a "trauma" for crew.[41] He likened Navy smoking restrictions to the failed national policy of Prohibition (although alcohol use is prohibited on Navy ships).[42] Representative John Tanner (D-TN), thought it was "entirely appropriate to perhaps restrict smoking for the convenience of those who object violently."[41] "But," he added, "somebody is banning a legal commodity."[41] He wondered if lottery tickets or hair spray might be next.[41] Representative Solomon Ortiz (D-TX), chair of the panel, assured Kavanaugh that forcing sailors to remain smoke-free for months-long deployments would "cause problems."[41]

The panel was most concerned about eliminating cigarette sales in the ship's store. Will Cofer, MWR Panel staff member and long-time tobacco industry ally,[43] contended that the *Roosevelt* policy prohibiting sales had "created a black market within the Navy of selling cigarettes from one ship to another ship." He said, "[S]ome GIs are selling cigarettes at inflated prices to guys on the ship that can't buy cigarettes."[41] (Bryant and Herdt acknowledged there was some profiteering on the *Roosevelt* when cigarettes were removed from the ship's store, but said that it was minimal.)

The real question about sales, however, involved the profits from the ship's stores. These profits supported MWR activities, and eliminating tobacco sales would reduce funding for them. Representative Bateman found it "incredible" that implementing a smoke-free base policy wouldn't "impact revenues generated from the sale of tobacco products on that base." Kavanaugh acknowledged that "profits and sales will be reduced," assuring the panel that there had been "no move to take cigarettes out of Navy exchanges," and that only 2 out of the Navy's "500 some ships" had banned sales.[41] Representative Martin Lancaster (D-NC) questioned Kavanaugh about allowing local-level leaders to implement site-specific policy, expressing concern about how MWR funds would be equitably distributed among units that profited from tobacco sales and those that did not.[41]

Under congressional pressure, Kavanaugh said that he would report the panel's concerns to the Office of the Secretary of the Navy and the Chief Naval Officer.[41] After Kavanaugh delivered the message that the MWR Panel was very disturbed by Captain Bryant's decision, the Navy sent the panel an official response, stating, "The Navy's smoking policy, for both afloat and ashore commands, is under review by Navy leadership."[41]

During the first 3 Congresses of the 1990s, the percentage of members of the MWR Panel who accepted contributions from the tobacco industry was higher than the congressional average. Although MWR Panel members received about 15 percent more industry money than other members during the first 2 Congresses of the 1990s, they accepted 93 percent more than all House members during the 103rd Congress (1993–1994), when this issue was considered (Table 1). In total, the tobacco industry contributed at least $4.4 million to members of the House during these 3 Congresses.[44]

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[41] Exchange operations and activities: hearing before the Morale, Welfare, and Recreation Panel of the Committee on Armed Services, House of Representatives, 103rd Congress (1993).

[42] Moore RS, Ames GM, Cunradi CB. Physical and social availability of alcohol for young enlisted naval personnel in and around home port. *Subst Abuse Treat Prev Policy.* 2007;2:17.

[43] Gaillard RC. Project Breakthrough. March 24, 1994. RJ Reynolds collection. Bates no. 509721550/1552. Available at: http://legacy.library.ucsf.edu/tid/ofz63d00. Accessed February 17, 2010.

[44] Center for Responsive Politics. Tobacco: Money to Congress. Available at: http://www.opensecrets.org/industries/summary.php?cycle=1990&ind=A02. Accessed May 12, 2010.

TABLE 1.—CAMPAIGN CONTRIBUTIONS FROM THE TOBACCO INDUSTRY TO MEMBERS OF THE MORALE, WELFARE AND RECREATIONAL (MWR) PANEL OF THE HOUSE OF REPRESENTATIVES' COMMITTEE ON ARMED SERVICES

[Amounts in dollars]

	Contributions			
	1990 [1]	1992 [2]	1994 [3]	Career
MWR Panel recipient:				
Neil Abercrombia (D-HI)	.....	500	1,500	9,500
Herbert H. Bateman (R-VA)	8,100	8,450	5,260	41,548
Earl Hutto (D-FL)	.....	.....	.....	.....
John R. Kasich (R-OH)	500	500	1,500	9,500
H. Martin Lancaster (D-NC)	18,200	22,198	44,720	85,118
Donald H. Machtley (R-RI)	1,750	.....	.....	1,750
Solomon P. Ortiz (D-TX)	1,000	500	6,000	33,000
Owen B. Pickett (D-VA	2,850	2,000	6,500	25,750
Bob Stump (R-AZ)	2,000	3,500	2,500	15,250
John S. Tanner (D-TN)	5,700	4,700	5,500	157,700
Robert A. Underwood (D-GU)	.....	.....	.....	.....
Total contributions received	40,100	42,348	73,480	379,116
Average donation received by all MWR Panel members	3,645	3,850	6,680	.....
Average donation received by all House members	3,118	3,393	3,458	.....

[1] MWR Panel members received on average 16.9 percent more than all House members.
[2] MWR Panel members received on average 13.5 percent more than all House members.
[3] MWR Panel members received on average 93.2 percent more than all House members.

Congress Retaliates

Tobacco industry observers interpreted the outcome of the HASC MWR Panel hearing as favorable to the industry. Internal industry communique's described various members of the panel as supportive of the industry's position and noted that "the military commanders who appeared before the panel stated that they would not support eliminating sales of tobacco products and would make their opposition known to officials."[45]

However, industry reports were overly optimistic. Just 3 days after the hearing, the Tobacco Institute learned that Admiral Kelso had endorsed Bryant's decision to ban smoking and cigarette sales aboard the USS *Roosevelt*. The Institute reported to tobacco companies that

> Several Members of Congress believe they were betrayed by this decision and intend to take legislative action including the removal of all Naval ship stores from the commissary system, thus eliminating the subsidy and forcing price increases on all other products.[38]

Command Master Chief Herdt of the USS *Roosevelt* received a shipboard call from the highestranking enlisted person in the Navy, Master Chief Petty Officer John Hagan, urging a reversal of the ban. Hagan had been summoned to the office of a HASC MWR congressman, who chastised him severely about the nosmoking policy. Hagan reportedly said he had never been treated so abusively in his role as Master Chief Petty Officer. Nonetheless, Herdt and Bryant decided to continue the nosmoking policy.

A month after the hearing, in September 1993, Representative Owen Pickett (D-VA) and Representative Ortiz sponsored an amendment to the Defense Authorization Act for Fiscal Year 1994, stripping Federal subsidies from Navy ships' stores and requiring that they all sell tobacco products.[46] The amendment did not contain obviously pro-tobacco language, but merely revised the applicable section to replace the word "may" with "shall," thus reading: "(c) ITEMS SOLD.—Merchandise sold by ship stores afloat shall include items in the following categories . . ." and listed "to-

[45] [Philip Morris.] House panel voices opposition to DOD efforts to establish "smoke-free" military. August 9, 1993. Philip Morris collection. Bates no. 2047992778/2785. Available at: http://legacy.library.ucsf.edu/tid/rgi57d00. Accessed January 25, 2008.

[46] Tobacco Institute. Executive summary. September 17, 1993. Lorillard collection. Bates no. 87686227/6228. Available at: http://legacy.library.ucsf.edu/tid/txt21e00. Accessed April 15, 2008.

bacco products" as one among many items that must be made available.[47] The law does not mention specific tobacco products.

The amendment also transferred "the authority over all ships [sic] stores from ship captains to the Navy Exchange Command (NEXCOM)."[48] This transfer meant that oversight would now reside in "the Morale Welfare, and Recreation (MWR) Panel of the House Armed Services Committee."[49]

The tobacco industry reported that the legislation was prompted by the Navy's tobacco control efforts. Philip Morris observed that "Congressional intervention reversed the imposition of a 'smokefree' policy aboard Navy ships."[36] The Tobacco Institute noted that the Chief of Naval Operations angered Congressman Pickett and others by "reneging on his promise to reverse the order by the Commanding Officer of the USS *Roosevelt* banning smoking and tobacco sales aboard ship."[46]

Navy Response

Before the Defense Authorization Act had been approved and signed by the President, the Navy implemented a new service-wide policy that prevented local-level personnel from banning smoking entirely.[50] On October 21, 1993, Secretary of the Navy John Dalton issued the "Smoking policy for Department of Navy controlled spaces," effective January 1, 1994, which described exactly where designated smoking spaces would be established on ships or submarines.[50]

Dalton sent Ortiz a copy of the policy.[51] He wrote, "Appreciating your interest in the issue of smoking aboard Navy ships, I am pleased to advise you that . . . I have approved a policy that will be applicable to all Navy ships."[51] He continued, "Tobacco products will be sold in ship's stores and will be priced similarly to those sold in Navy Exchanges ashore." The new policy addressed only smoking regulations and not sales, suggesting that Dalton may have raised the sales issue in his cover letter and implemented the policy in an effort to forestall the adoption of the Pickett-Ortiz amendment. Ortiz immediately shared the victory with his tobacco industry allies, faxing the documents to Philip Morris just "minutes after" receiving Dalton's letter and policy memo.[52]

A naval press release characterized the policy as protecting people from "involuntary exposure to environmental tobacco smoke"[53] rather than reinstating smoking areas on ships that had eliminated them. The media thus reported Dalton's policy as a crackdown on smoking, as opposed to a capitulation to members of the HASC MWR Panel.[54] When interviewed, Dalton was unable to recall additional details of the incident.

Despite Dalton's policy, the Pickett-Ortiz amendment passed. The Navy tried to argue for amending it, contending that it would "increase the cost of merchandise to sailors, reduce funding for their ship's morale, welfare, and recreation (MWR) programs and result in a less efficient program."[55] In response, Pickett inserted lan-

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[47] Cornell University Law School U.S. Code collection. Title 10, Subtitle C, Part IV, Chapter 651, § 7604 ships' stores: sale of goods and services. Available at: http://www.law.cornell.edu/uscode/html/uscode10/usc__sec__10__00007604—000-.html. Accessed August 14, 2009.

[48] Scott GR. Sale of tobacco products on ships stores. April 7, 1994. Philip Morris collection. Bates no. 2073010489. Available at: http://legacy.library.ucsf.edu/tid/xps57c00. Accessed January 16, 2008.

[49] [Philip Morris.] Washington Report: Defense Authorization Bill conferees adopt provision requiring ship stores to sell tobacco products. November 29, 1993. Philip Morris collection. Bates no. 2046215439/5445. Available at: http://legacy.library.ucsf.edu/tid/vuh92e00. Accessed January 16, 2008.

[50] Dept of the Navy. Smoking policy for Department of the Navy (DoN) controlled spaces. October 22, 1993. Philip Morris collection. Bates no. 2023172656/2658. Available at: http://legacy.library.ucsf.edu/tid/jtt14e00. Accessed December 1, 2006.

[51] Dalton JH. Letter from John Dalton to Solomon Ortiz. October 21, 1993. Philip Morris collection. Bates no. 2023172654. Available at: http://legacy.library.ucsf.edu/tid/suc85e00. Accessed December 7, 2006.

[52] Scott G. Navy smoking policy. October 22, 1993. Philip Morris collection. Bates no. 2023172653. Available at: http://legacy.library.ucsf.edu/tid/ruc85e00. Accessed January 25, 2008.

[53] Navy announces new smoking policy [press release]. Washington, DC: U.S. Navy; October 21, 1993. Available at: http://www.navy.mil/navydata/news/mednews/med93/med93041.txt. Accessed November 9, 2009.

[54] Morris P. Navy cracks down on smoking with uniform new regulations. November 17, 1993. Philip Morris collection. Bates no. 2048159074/9146. Available at: http://legacy.library.ucsf.edu/tid/xrs65e00. Accessed April 24, 2008.

[55] Roark D. Impact on afloat sailors by converting ships stores from appropriated to non-appropriated funding. April 6, 1994. Philip Morris collection. Bates no. 2073010490. Available at: http://legacy.library.ucsf.edu/tid/wps57c00. Accessed April 10, 2008.

guage into the act delaying the date of implementation for 1 year, which successfully thwarted the Navy's attempt to repeal the law.[56]

In September 1995, the Navy newspaper Soundings reported that the Navy had "thrown in the towel" and abandoned plans to become smoke-free by 2000.[28] The Navy was reported to have "conceded" that the goal was "unrealistic."[28] Instead, it established a goal to reduce smoking rates to 35 percent, the equivalent civilian rate at the time.[28] As of 2005, the smoking prevalence in the Navy was 32 percent,[4] still more than 50 percent above the corresponding civilian rate of 21 percent.

Tobacco Industry Confidence

Internal industry communique's with wording such as "the provision we put through last year"[57] reveal the extent to which the industry was confident of the power it wielded. At the end of 1993, one Philip Morris executive wrote, "We are continuing to stimulate congressional opposition to efforts to restrict the sale of tobacco products in the military."[36] Another Philip Morris employee wrote in 1994, "We will be working with the MWR Panel to attempt to ensure that the Pickett-Ortiz provision is not repealed."[48] Industry lobbyists enjoyed access to key committee members.[40]

Kelso visited the *Roosevelt* when it was deployed in the Mediterranean in August 1993 and told Bryant he was doing the right thing in banning smoking. However, when the *Roosevelt* returned to port in September 1993, Kelso told Bryant he was taking "immense heat" from every corner, including Congress and the Secretary of the Navy, for Bryant's actions and that all ships, including the *Roosevelt*, would have to accommodate smokers by providing a dedicated smoking area. In retrospect, Bryant was grateful that Kelso had put off overriding the *Roosevelt*'s smokefree policy until after its deployment. Bryant said, "I'm taking care of my crew. Who's going to take me to task for that? And in fact, the military did not." He added, "You've got to do what you think is right. For the most part, the media and Congress respect that, but then you've got big money and the tobacco industry that work against it."

DISCUSSION

In this case, the tobacco industry's influence over Congress clearly has harmed sailors in 2 ways. Foremost, sailors have been left exposed to secondhand smoke while deployed, compromising their safety and health. Congressional action mandating cigarette sales also ensured that this exposure would continue; the Navy could not in the future adopt strong tobacco control policies without congressional approval, since doing so would likely be difficult—and obviously hypocritical—to enforce a smokefree ship while still selling cigarettes. For instance, smoking on submarines continued to be allowed until it was prohibited at the end of 2010.[58] [59] Second, an opportunity to denormalize smoking was lost, and a tobacco-friendly atmosphere was maintained.

The tobacco industry appears to have had significant influence on Navy tobacco control efforts. Between 1988 and 1994, nearly 70 percent of Members of Congress received tobacco industry money,[44] which has been found to be associated with legislative support for tobacco industry positions.[60] [61] [62] House MWR Panel members, many of whom represented tobacco States, accepted on average more and larger campaign contributions than other Housemembers. Certainly the industry and its consultants believed their actions resulted in reversing the smoke-free policies aboard the USS *Roosevelt*.

The U.S. military is one of the most powerful institutions in the world. Its mission, the protection of the country, requires personnel at peak readiness and performance; hence, military training stresses physical and mental fitness. The ulti-

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[56] U.S. Congress. Sec. 382. Ships' stores. May 4, 1994. Philip Morris collection. Bates no. 2073010557. Available at: http://legacy.library.ucsf.edu/tid/fps57c00. Accessed April 15, 2008.

[57] Scott GR. DOD—cigarettes. May 5, 1994. Philip Morris collection. Bates no. 2073010555. Available at: http://legacy.library.ucsf.edu/tid/hps57c00. Accessed April 10, 2008.

[58] U.S. Navy. Smoking to be extinguished on submarines. Available at: http://www.navy.mil/search/display.asp?story__id=52488. Accessed May 12, 2010.

[59] Shanker T. To protect health of nonsmokers, Navy bans tobacco use on its submarine fleet. The New York Times. June 21, 2010:A16. Available at: http://www.nytimes.com/2010/06/21/us/21smoking.html. Accessed June 24, 2010.

[60] Luke DA, Krauss M. Where there's smoke there's money: tobacco industry campaign contributions and U.S. Congressional voting. *Am J Prev Med.* 2004; 27(5):363–72.

[61] Glantz SA, Begay ME. Tobacco industry campaign contributions are affecting tobacco control policymaking in California. *Journal of the American Medical Association.* 1994;272(15):1176–82.

[62] Monardi F, Glantz SA. Are tobacco industry campaign contributions influencing State legislative behavior? *Am J Public Health.* 1998;88(6):918–23.

mate responsibility for maintaining this force lies with Congress, which retains essential civilian oversight of the military. Such oversight, however, leaves military policy vulnerable to other interests.

A consistent pattern of congressional interference with military tobacco control efforts suggests several lessons for advocates. First, the industry-scripted response to military tobacco control policy that positions tobacco use as a "right" to be defended by Congress must be countered. Military readiness requires restrictions on activities or characteristics that interfere with fitness. All branches of the military, for example, set healthy weight parameters for recruits [63]; restricting tobacco use is no more a violation of rights than is requiringmaintenance of appropriate weight.

Second, congressional intervention has largely taken place out of public view; the MWR Panel's actions ultimately took the form of small, seemingly technical changes to a comprehensive and necessary piece of legislation. It is likely that most Members of Congress were unaware of these amendments and their long-term impact on the health of Navy personnel. Such action is in keeping with other pro-tobacco legislative efforts, such as the passage of an amendment to the 1986 defense authorization bill requiring military commissaries to sell tobacco and forbidding them to raise prices.[5] Directing public attention to such legislation, and making its proponents justify it in public, will likely be a necessary part of changing military tobacco control policy.

Finally, civilian public health organizations must play a stronger role in these efforts. The public may believe that the military is resistant to tobacco control; however, multiple studies have demonstrated that advocates at all levels of tobacco control in the military find themselves or their services to be the target of political attacks.[5] [18] Because all active-duty military personnel are constrained by the structural controls on their lobbying activity, their ability to respond to these attacks is limited. A coalition of public health, tobacco control, and veterans' service groups and health-focused congressional allies needs to organize to achieve effective military tobacco control policies. Such a coalition could shine a light on congressional actions that thwart military tobacco control efforts and facilitate those that help the military achieve the goal recently called for by the Institute of Medicine: a tobacco-free military.[4]

This coalition could reframe military tobacco control issues. Veterans might be particularly effective at debunking the idea that military personnel deserve the freedom to smoke by talking about years of postservice addiction that began in a tobaccofriendly military.[16] Similar reframing should be used in advocating for clean indoor air for all military personnel. Tobacco-sickened veterans could help drive home the point that military policy lags behind civilian policy in the percentages of people fully protected by proven, effective tobacco control policies recommended for use globally,[64] including smoke-free spaces and high tobacco taxes. Members of the services assume unavoidable risks as part of the military mission, but exposure to cigarette smoke should not be one of them.

Senator COCHRAN. Thank you.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Have there been studies comparing, say, the returning veterans' respiratory and lung problems, say, with the ones that came out of the Gulf in 1991?

Captain CONNOR. Senator Shelby, I would like to research that and get right back to you with a full answer to that.

Senator SHELBY. Would you do that for the record?

Captain CONNOR. We certainly will get right back to you on that.

[The information follows:]

I wanted to thank you and the Senate Appropriations Subcommittee on Defense for allowing me the opportunity to testify on June 22 about lung health and the military. I also wanted to follow up with some information regarding questions you asked me about lung health problems in veterans and steps the Department of Defense (DOD) has taken regarding tobacco.

First, you asked me if there were any data comparing the lung health of veterans of the 1991 gulf war to veterans of the current conflict. Researchers and doctors are

[63] 10 Steps to joining the military: height and weight charts. Available at: http://www.military.com/Recruiting/Content/0,13898,rec_step07_hw,00.html. Accessed May 3, 2010.

[64] World Health Organization. WHO Framework Convention on Tobacco Control. Available at: http://www.who.int/tobacco/framework/en. Accessed February 26, 2010.

beginning to address this question. The evidence thus far shows that veterans of the first gulf war had a variety of respiratory problems, which we are likely to find in veterans of the current war. However, there are also differences in the toxins personnel were exposed to, and in length of time they were exposed. As you know, the first gulf war was much shorter than the current one. We are still learning how these differences affect the lung health of today's troops.

There is certainly enough evidence to warrant concern for our current troops and action from DOD. One study conducted by Vanderbilt University suggests that certain exposures during the current conflict have caused serious cases of constrictive bronchiolitis, a condition associated with damage or destruction of over 50 percent of small airways.[1] In a review of DOD studies, the National Academy of Sciences' National Research Council (NRC) concluded that troops deployed in the Middle East are "exposed to high concentrations" of particulate matter associated with harm "affecting troop readiness during service" and even "occurring years after exposure."[2] Much more surveillance and research is needed, which is why I urged in my testimony that DOD be required to develop better ways to measure and track lung disease in military personnel, including taking baseline measures prior to deployment and creating a national registry to track all veterans who were exposed to pollutants while in Iraq and Afghanistan.

I also wanted to follow-up with you regarding your question about what the DOD has done so far to help tobacco users in the military quit. As I shared in my testimony, the Institute of Medicine (IOM) found that the Pentagon spends $1.6 billion annually on tobacco-related medical care, increased hospitalization and lost days of work. While there have been some efforts—notably the "Quit Tobacco, Make Everyone Proud" website[3]—they have not been enough, especially in light of the severity of the problem. Access to tobacco cessation programs and medication varies among bases and military branches. And despite urgings from the Institute of Medicine report on the subject,[4] and a requirement in the Duncan Hunter National Defense Authorization for Fiscal Year 2009,[5] TRICARE still does not cover treatments to help tobacco users quit.

The American Lung Association recommends that the Department of Defense implement all recommendations called for in the 2009 IOM report Combating Tobacco Use in Military and Veterans Populations that I discussed in my testimony. The IOM has laid out a very careful, scientifically based road map for the DOD to follow and the American Lung Association strongly urges the Committee to ensure that the report's recommendations be implemented without further delay.

Senator SHELBY. Second, what is the Department of Defense doing to discourage smoking? As the chairman noted, they used to promote smoking, I guess, or help, aid, and abet it. What are they doing to discourage it, because a lot of the young people, not just soldiers but in our college campuses, a lot of them smoke. A lot of them quit. A lot of them quit too late.

Captain CONNOR. Right. It's a two-part question, what are they doing to prevent it and stop it; and then what are they doing to help people get off cigarettes.

Senator SHELBY. Right.

Captain CONNOR. There are some smoking cessation efforts which we believe could be better resourced. We don't feel they're doing nearly enough to prevent it. The study that I referred to has very excellent concrete recommendations, like let's suggest all officers not smoke. When kids come into boot camp, they can't smoke. So we could start by grandfathering that starting today, saying,

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[1] Robert F. Miller, MD. Vanderbilt University Medical Center. Testimony before the United States Senate Committee on Veterans' Affairs. "Airway injury in U.S. soldiers following service in Iraq and Afghanistan" October 8, 2009.

[2] National Academy of Sciences, National Research Council. Review of the Department of Defense Enhanced Particulate Matter Surveillance Program Report. 2010. http://www.nap.edu/catalog/12911.html. Accessed June 7, 2011.

[3] www.ucanquit2.org.

[4] Institute of Medicine. *Combating Tobacco Use in Military and Veteran Populations. 2009.* http://www.nap.edu/catalog.php?record__id=12632.

[5] http://www.dod.gov/dodgc/olc/docs/2009NDAA__PL110–417.pdf.

okay, when you get through boot camp, guess what, you can't go back smoking.

So there's a number of things that could be done to attack this problem over time. Nobody's suggesting that the knife come down tomorrow and say no smoking. But I think steps could be taken to arrest this problem and stop it from growing.

Senator SHELBY. I think all of us know that the more you smoke the less you're going to run, probably the fewer miles you're going to march, the fewer minutes you can do exercise, too. That's just common sense.

Captain CONNOR. That's right. The other thing, you've got the military exchanges are making money from the cigarettes. That's a big issue, too. Then there's a reluctance of combat commanders that we hear about from the health people in DOD, a reluctance to deprive troops of something that they say affects their morale and things like that.

Senator SHELBY. Thank you.

Chairman INOUYE. Thank you very much, Captain.

The next witness is Mr. Rick Jones, National Association for Uniformed Services.

STATEMENT OF RICK JONES, LEGISLATIVE DIRECTOR, NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

Mr. JONES. Chairman Inouye, Vice Chairman Cochran, Senator Shelby: Thank you very much.

The National Association for Uniformed Services is concerned about the investment we're making in our defense. As hard as you work, too often we still depend on aging fleets of aircraft, ships, and vehicles across the services. We must continue to drive toward modernization and that means investment.

The message our members ask me to bring is simple and direct: Anyone who goes into harm's way under the flag of the United States needs to be deployed with the best our Nation can provide. Our troops in the field depend on America's support. Critical funding provides them the margins they need for success.

TRICARE, the provision of quality, timely healthcare, is considered one of the most important non-cash earned benefits afforded those who serve a career in the military. Our service members and their families make great sacrifices for all of us. The TRICARE benefit reflects the commitment of a Nation to those who serve, and it deserves your wholehearted support.

Our fiscal situation, of course, requires shared sacrifice. But our military and our military retirees should bear no more than their share. For those who give their career to a uniformed service, our organization asks you to provide full funding for the securing of their earned benefit.

It's our understanding that certain leaders in Congress have agreed with the Department of Defense regarding a 13 percent increase in TRICARE fees paid by military retirees. NAUS does not agree and, after hearing for more than a year the Secretary of Defense and the Chairman of the Joint Chiefs say that rising costs of retiree healthcare was crippling our Nation's national security, we read that the House Appropriations Committee intends to use $330 million of unexecuted money in the TRICARE health program

for funding additional congressionally directed medical research programs, many of which are outside traditional battlefield medicine and/or duplicate subjects covered by the National Institutes of Health. It's not appropriate. Our folks might be outraged when they hear this, that their healthcare they'll have to pay more for, but the money's going for additional research in areas unrelated to the military.

My association urges you to provide adequate funding for military construction and family housing accounts. The funds for base allowance and housing should ensure that those serving our country are able to afford to live in quality housing.

Walter Reed. Another matter of great interest to our members is the plan to realign the National Capital area's military health programs. While we herald this development, we're hearing that things may not be quite in order or ready by the September BRAC deadline. The deadline may have to be extended and we hope that you'll take a look at that to make sure that our wounded warriors don't fall through the cracks in this transfer from the old Walter Reed to the new Bethesda facility.

DOD prosthetic research. My organization and association encourages the subcommittee to ensure that funding for DOD prosthetic research is adequate to support the full range of programs needed to meet current and future challenges facing wounded warriors.

Post-traumatic stress and traumatic brain injury are indeed signature injuries and they deserve your support.

We would also ask that the Armed Forces Retirement Home receive your attention. We encourage both the home in Washington, DC, and the home in Gulfport, Mississippi, give your attention to both of those for adequate funding. The Gulfport home has been open now for about 9 months, the new one, and we're encouraged to read what's going on down there with regard to care. But we're also concerned about some of the investigations regarding employees.

The Uniformed Services Health System deserves your support and we thank you very much for the opportunity to testify.

[The statement follows:]

PREPARED STATEMENT OF RICK JONES

Chairman Inouye, Vice Chairman 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 2012 Defense Appropriations bill.

My name is 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 fiscal 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 personnel of the active, retired, Reserve and National Guard, disabled veterans, veterans community and their families. We love our country and our flag, 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 defense 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 rec-

ognize 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.

We simply must have a strong investment in the size and capability of our air, land and naval forces. And we must invest in fielding new weapons systems today to meet the challenges of tomorrow.

We cannot depend on aging fleets of aircraft, ships and vehicles across the services. We must continue to drive toward modernization and make available the resources we will need to meet and defeat the next threats to our security.

Our Nation is protected by the finest military the world has ever seen. The message our members want you to hear is simple and direct: Any one who goes into harm's way under the flag of the United States needs to be deployed with the best our Nation can provide. We need to give our brave men and women everything they need to succeed. And we must never cut off or unnecessarily delay critical funding for our troops in the field.

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 also carries concerns about a number of related matters. Among these is the provision of a proper healthcare 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 healthcare 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 increases in TRICARE fees. Mullen said, "It's a given as far as I'm concerned."

Our Association does not believe those who have given so much to their country in service and sacrifice should again be placed at the head of the line for budget reductions. We have testified before the authorizing committee to "hold the line" on fee increases. However, with comments like these from those in military leadership positions, there is little wonder that retirees and active duty personnel are concerned.

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, even in a down economy.

Fraud and Criminal Activity Costs Medicare and TRICARE Billions of Dollars

Reports continue from the Government Accountability Office (GAO), the investigative arm of the United States Congress, and related government agencies that show us that multi-billions of Medicare money is being ripped off every year. While those in government responsible for the management of Medicare and TRICARE tell us that their investigations into these matters are working, the clear sign suggests otherwise. Our Medicare and TRICARE programs are desperately in need of improved management to stop the loss of 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 $1 mil-

lion. 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.

We need action to corral fraud and bring it to an end. What we've seen, however, is delay and second-hand attention with insufficient resources dedicated to TRICARE fraud conviction and recovery of money paid wrongly to medical care thieves.

Last year, we cited the lack of information on TRICARE fraud activities. We suggested that one need only view the TRICARE Program Integrity Office web site to see a reflection of this inactivity. At that time the most recent Fraud Report was dated 2008 there were only two items listed under "News" for 2010 and no items for 2009.

This year, it's good, though hardly adequate, to see the TRICARE Program Integrity Office update its information on its activities. The report for 2010 indicates that a TRICARE Anti-Fraud Conference took place last April. While these is no related "News" on this conference as there was in 2007, the report notes, "the education, information sharing and networking that takes place during and after each conference creates a surge in fraud case identification and referrals from attendees." Yet there is nothing in the "News" that supports such a surge of beneficial activity took place. It seems more gloss than fact.

Our members tire of hearing they should pay more for the healthcare earned in honorable service to country when they hear stories about or see little evidence of our government doing anything but sitting on its hands, often taking little to no action for years on this type of criminal activity, with the exception of an annual conference.

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, we all know who will be left holding the bag and paying higher fees to cover fraud losses—the law-abiding retiree and family.

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. Use your spending power to move TRICARE to root out the corruption, fraud and waste. And help confirm America's solemn, moral obligation 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 2012, the Administration recommends a 1.6 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 commends Congress and the Administration for its attention to troops pay. A good job has been done over the recently past years 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 below 3 percent with the January 2011 pay increase.

The National Association for Uniformed Services applauds you, Mr. Chairman, for the strides you have made, and we encourage you to continue your efforts to ensure DOD manpower policy maintains a compensation package that is attractive and competitive to our fighting men and women.

We also encourage your review of providing bonus incentives to entice individuals with certain needed skills into special jobs that help supply our manpower for critical assets. These packages can also attract "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: 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 September 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 that Reserve Component Forces 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 sustain 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, tornado, 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, Maryland, and the closing of the existing Walter Reed by September 15, 2011.

Our members are concerned about recent reports that the newly expanded medical center in Bethesda, Maryland, and the new community hospital at Fort Belvoir in Fairfax County, Virginia, are unready for the move. According to these reports, a number of operating rooms and patient services are not in conditions to allow transferring patients and staff from Walter Reed.

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 required for uninterrupted care of our catastrophically wounded soldiers and Marines as they move through needed treatment in 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 both Bethesda and Fort Belvoir are in place, fully functional and ready to give appropriate care and treatment to the men and women wounded in armed service. A 9-month delay would make a world of difference for our retirees and for the wounded warriors and their families.

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.

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 systems in use 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 healthcare and other benefits earned in military service.

To improve the DOD/VA exchange, the transfer 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 effective 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 September 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 heathcare 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 these funds, 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 is pleased to note the Subcommittee's continued interest in providing funds for the Armed Forces Retirement Home (AFRH). We urge the Subcommittee to meet the challenge in providing adequate funding for the facilities in Washington, DC, and Gulfport, Mississippi.

And we thank the Subcommittee for the provision of funding that has led to the successful reopening of the Armed Forces Retirement Home in Gulfport, destroyed in 2005 as a result of Hurricane Katrina. The Gulfport facility has the capacity to provide independent living, assisted living and long-term care to more than 500 residents.

Regarding Gulfport, members of our association are seriously concerned about a recent investigation into healthcare and related operations at the Mississippi Retirement Home. According to published reports five employees have resigned as a result of the investigation initiated by the AFRH acting chief operating officer. We ask that you ensure that residents' care and health is not put at risk by the reported troubles at Gulfport.

The National Association for Uniformed Services applauds the Subcommittee's clear recognition of the Washington AFRH as a historic national treasure. And we look forward to working with the Subcommittee to continue providing a residence for and quality-of-life enhancements to these deserving veterans. We ask that continued care and attention be given to the mixed-use development to the property's southern end, as approved.

The AFRH homes are historic national treasures, and we thank Congress for its oversight of this gentle program and its work to provide for a world-class care for military retirees.

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 these patients out of military facilities and 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 educational focus on biological threats and incidents for military, civilian, uniformed first responders and healthcare providers across the nation.

Our members would also like to recognize the high quality of the medical education and training provided at the Uniformed Services University of the Health Sciences. The care given Congresswomen Gabrielle Giffords offers a clear example.

USUHS trained three of the key physicians who performed life-saving procedures in the hours following the tragedy in Tucson. Retired Navy Captain Peter Rhee relied on more than 20 years of military medical experience to provide experienced trauma care to the Congresswoman. Interim Chief of Neurology Army Colonel Geoffrey Ling assisted and Dr. Jim Ecklund, another highly regarded neurosurgeon, was also part of the brain injury team. All are graduates of the military university, and by the way, Dr. Ecklund was a classmate of Dr. Rhee's at USUHS.

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 owed to the families of those still missing as well as to those who served and who currently serve.

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 2012.

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 are confident you will give them 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 service and their earned benefits is a continuing cost of war, and it will never cost more nor is it ever likely to equal the value of their service.

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 INOUYE. Mr. Jones, your concerns will be seriously considered, I guarantee you, sir.

Senator COCHRAN. Mr. Chairman, I can't help but compliment the witness for mentioning the retirement home in Gulfport. I'm happy to report the last time I drove by the facility it looked like it was on the road to full recovery. Residents who had lived there before Hurricane Katrina are returning and happy to be back home. So thank you for the support that you've given to that initiative.

Mr. JONES. Great to hear that report. Thank you, Senator.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, I just want to thank the whole panel, and add Mr. Jones's testimony to that. Thank you very much.

Chairman INOUYE. Thank you very much.

May I thank the panel on behalf of the subcommittee.

Our next panel: Ms. Fran Visco, National Breast Cancer Coalition; Ms. Mary Hesdorffer, Mesothelioma Applied Research Foundation; Major General David Bockel, Reserve Officers Association; Captain Mike Smith, National Military and Veterans Alliance.

STATEMENT OF FRAN VISCO, PRESIDENT, NATIONAL BREAST CANCER FOUNDATION

Ms. VISCO. Thank you very much. Thank you, Chairman Inouye, Ranking Member Cochran, and Senator Shelby, for inviting me to testify today. I'm Fran Visco, a 23-year breast cancer survivor and President of the National Breast Cancer Coalition, which is a coalition of hundreds of organizations from across the country.

I also want to thank you so very much for launching and supporting the DOD peer-reviewed breast cancer research program. It's meant so much to women and men across the country, both within the military and without. You know that you created something innovative, something very special, that has saved lives, and it's given hope to very many.

But there are still too many women and men who die of breast cancer. Like you may remember Lieutenant Colonel Karen Moss of the U.S. Air Force, who spoke to the subcommittee many times about the importance of this program. Lieutenant Colonel Yvonne Andejeski of the U.S. Army, who died of breast cancer in her 30s while she was a director of the peer-reviewed program. And just yesterday, at a meeting of the DOD program we took a moment to remember Lieutenant Commander Yowanna Maria Collins Wilson of the U.S. Navy, who died of breast cancer in her 30s while on active duty.

The partnership that has developed over the years between the military, the public, and the scientists who are involved in this program is extremely important and helpful to all of us. I cannot say enough about the dedication and passion the military has brought to this program. The breast cancer research program is the only government program focused solely, funding program focused solely, on ending breast cancer. It is a program that leverages years of this Nation's investment in biomedical research and in breast

cancer and applies the results of that investment to women and men everywhere. It is known and respected worldwide and it expands this Nation's preeminence in scientific research.

Ninety percent of the funds appropriated go to research. The administrative costs of this program are minimal and that is because of the military and how well they operate this program. It is a transparent program. It's accountable to the taxpayers, and it is complementary and not duplicative of other programs.

Because of the way it is structured and because of the fact that it is in the Army, it is able to rapidly respond to scientific discoveries and quickly fill gaps in scientific and patient needs. I recall General Martinez Lopez, who led these efforts a number of years ago, telling us how important this program was to the military, not just because of the morale that it brought, but also because of the relationships that had been created between DOD and a part of the scientific community that is important to their work, but not typically engaged with the military, and also because of the models that the program created that have been replicated elsewhere within the military and actually even in other countries.

This program has been a resounding success, and I'm here to express our appreciation for your leadership in getting this program started and in making certain that it continues.

Thank you very much.

[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 22-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. Since its founding in 1991, NBCC has been guided by three primary goals: 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 healthcare and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates wherever breast cancer decisions are made. Last September, in order to change the conversation about breast cancer and restore the sense of urgency in the fight to end the disease, NBCC launched Breast Cancer Deadline 2020®—a deadline to end breast cancer by January 1, 2020.

Chairman Inouye and Ranking Member Cochran, we appreciate your longstanding support for the Department of Defense peer reviewed Breast Cancer Research Program. As you know, this program was born from a powerful grassroots effort led by NBCC, and has become a unique partnership among consumers, scientists, Members of Congress and the military. 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 ending this disease. 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 healthcare 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. To support this unprecedented progress moving forward, we ask that you support a separate $150 million appropriation, level funding, for fiscal year 2012. In order to continue the success of the Program, you must ensure that it maintain its integrity and separate identity, in addition to level funding. This is important not just for breast cancer, but for all biomedical research that has benefited from this incredible government program.

Vision and Mission

The vision of the Department of Defense peer reviewed Breast Cancer Research Program is to "eradicate breast cancer by funding innovative, high-impact research through a partnership of scientists and consumers." The meaningful and unprecedented partnership of scientists and consumers has been the foundation of this model program from the very beginning. It is important to understand this collaboration: consumers and scientists working side by side, asking the difficult questions, bringing the vision of the program to life, challenging researchers and the public to do what is needed and then overseeing the process every step of the way to make certain it works. This unique collaboration is successful: every year researchers submit proposals that reach the highest level asked of them by the program and every year we make progress for women and men everywhere.

And it owes its success to the dedication of the U.S. Army and their belief and support of this mission. And of course, to you. It is these integrated efforts that make this program unique.

The Department of the Army must be applauded for overseeing the DOD BCRP which has established itself as a model medical research program, respected throughout the cancer and broader medical community for its innovative, transparent and accountable approach. This program is incredibly streamlined. The flexibility of the program has allowed the Army to administer it with unparalleled efficiency and effectiveness. Because there is little bureaucracy, the program is able to respond quickly to what is currently happening in the research community. Its specific focus on breast cancer allows it 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 pioneering research performed through the program and the unique vision it maintains has the potential to benefit not just breast cancer, but all cancers as well as other diseases. Biomedical research is literally being transformed by the DOD BCRP's success.

Consumer Participation

Advocates bring a necessary perspective to the table, ensuring that the science funded by this program is not only meritorious, but that it is also meaningful and will make a difference in people's lives. The consumer advocates bring accountability and transparency to the process. They are trained in science and advocacy and work with scientists willing to challenge the status quo to ensure that the science funded by the program fills important gaps not already being addressed by other funding agencies. Since 1992, more than 600 breast cancer survivors have served on the BCRP review panels.

Two years ago, Carolina Hinestrosa, a breast cancer survivor and trained consumer advocate, chaired the Integration Panel and led the charge in challenging BCRP investigators to think outside the box for revelations about how to eradicate breast cancer. Despite the fact that her own disease was progressing, she remained steadfast in working alongside scientists and consumers to move breast cancer research in new directions. Unwilling to give up, she fought tirelessly until the end of her life for a future free of breast cancer.

Carolina died in June 2009 from soft tissue sarcoma, a late side effect of the radiation that was used to treat her breast cancer. She once eloquently described the unique structure of the DOD BCRP:

"The Breast Cancer Research Program channels powerful synergy from the collaboration of the best and brightest in the scientific world with the primary stakeholder, the consumer, toward bold research efforts aimed at ending breast cancer."

No one was bolder than Carolina, who was fierce and determined in her work on the DOD BCRP and in all aspects of life she led as a dedicated breast cancer advocate, mother to a beautiful daughter, and dear friend to so many. Carolina's legacy reminds us that breast cancer is not just a struggle for scientists; it is a disease of the people. The consumers who sit alongside the scientists at the vision setting, peer review and programmatic review stages of the BCRP are there to ensure that no one forgets the women who have died from this disease, and the daughters they leave behind, and to keep the program focused on its vision.

For many consumers, participation in the program is "life changing" because of their ability to be involved in the process of finding answers to this disease. In the words of one advocate:

"Participating in the peer review and programmatic review has been an incredible experience. Working side by side with the scientists, challenging the status quo and sharing excitement about new research ideas . . . it is a breast cancer survivor's opportunity to make a meaningful difference. I will be forever grateful to the advo-

cates who imagined this novel paradigm for research and continue to develop new approaches to eradicate breast cancer in my granddaughters' lifetime."———Marlene McCarthy, two-time breast cancer "thriver", Rhode Island Breast Cancer Coalition

Scientists who participate in the Program agree that working with the advocates has changed the way they do science. Let me quote Greg Hannon, the fiscal year 2010 DOD BCRP Integration Panel Chair:

"The most important aspect of being a part of the BCRP, for me, has been the interaction with consumer advocates. They have currently affected the way that I think about breast cancer, but they have also impacted the way that I do science more generally. They are a constant reminder that our goal should be to impact people's lives."———Greg Hannon, PhD, Cold Spring Harbor Laboratory

Unique Structure

The DOD BCRP uses a two-tiered review process for proposal evaluation, with both steps including scientists as well as consumers. The first tier is scientific peer review in which proposals are weighed against established criteria for determining scientific merit. The second tier is programmatic review conducted by the Integration Panel (composed of scientists and consumers) that compares submissions across areas and recommends proposals for funding based on scientific merit, portfolio balance and relevance to program goals.

Scientific reviewers and other professionals participating in both the peer review and the programmatic review process are selected for their subject matter expertise. Consumer participants are recommended by an organization and chosen on the basis of their experience, training and recommendations.

The BCRP has the strictest conflict of interest policy of any research funding program or institute. This policy has served it well through the years. Its method for choosing peer and programmatic review panels has produced a model that has been replicated by funding entities around the world.

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 and consumers 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 to that mission of 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.

Distinctive Funding Opportunities

The DOD BCRP research portfolio includes many different types of projects, including support for innovative individuals and ideas, impact on translating research from the bench to the bedside, and training of breast cancer researchers.

Innovation

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. They 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 as well.

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. For example, in fiscal year 2008, Dr. Mauro Ferrari of the University of Texas Health Science Center at Houston was granted an Innovator Award to develop novel vectors for the optimal delivery of individualized breast cancer treatments. This is promising based on the astounding variability in breast cancer tumors and the challenges presented in determining which treatments will be most effective and how to deliver those treatments to each individual patient. In fiscal year 2006, Dr. Gertraud Maskarinec of the University of Hawaii received a synergistic IDEA grant to study effectiveness of the Dual Energy X-Ray Absorptiometry (DXA) as a method to evaluate breast cancer risks in women and young girls.

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. Dr. Shiladitya Sengupta from Brigham and Women's Hospital, Harvard Medical School, received a fiscal year 2006 Era of Hope Scholar Award to explore new strategies in the treatment of breast cancer that target both the tumor and the supporting network surrounding it. In fiscal year 2007, Dr. Gene Bidwell of the University of Mississippi Medical Center received an Era of Hope Postdoctoral Award to study thermally targeted delivery of inhibitor peptides, which is an underdeveloped strategy for cancer therapy.

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. 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 overexpressed 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 targets that are involved in the initiation and progression of cancer.

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

Translational Research

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 process by which the application of well-founded laboratory or other pre-clinical insight result in 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 Multi Team 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 toward the eradication of breast cancer. Many of these Teams are working on questions that will translate into direct clinical applications. These Teams include the expertise of basic, epidemiology and clinical researchers, as well as consumer advocates.

Training

The DOD BCRP is also cognizant of the need to invest in tomorrow's breast cancer researchers. Dr. J. Chuck Harrell, Ph.D. at the University of Colorado, Denver and the University of North Carolina at Chapel Hill, for example, received a Predoctoral Traineeship Award to investigate hormonal regulation of lymph node metastasis, the majority of which retain estrogen receptors (ER) and/or progesterone receptors. Through his research, Dr. Harrell determined that lymph node microenvironment alters ER expression and function in the lymph nodes, effecting tumor growth. These findings led Dr. Harrell to conduct further research in the field of breast metastasis during his postdoctoral work. Jim Hongjun of the Battelle Memorial Institute received a postdoctoral award for the early detection of breast cancer using post-translationally modified biomarkers.

Dr. John Niederhuber, former 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 2012.

Outcomes and Reviews of the DOD BCRP

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.

The success of the DOD peer reviewed Breast Cancer Research Program has been illustrated by several unique assessments of the Program. The Institute of Medicine (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.

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 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 . . ." 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, 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 website http://influence.breastcancerdeadline2020.org/ to learn more about the exciting research reported at the 2008 Era of Hope. The next Era of Hope meeting will occur this August.

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 reaching Breast Cancer Deadline 2020®'s goal of ending the disease by the end of the decade. 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.

Consumer advocates have worked hard over the years to keep this program free of political influence. Often, specific institutions or disgruntled scientists try to change the program though legislation, pushing for funding for their specific research or institution, or try to change the program in other ways, because they did not receive funding through the process, one that is fair, transparent and successful. The DOD BCRP has been successful for so many years because of the experience

and expertise of consumer involvement, and because of the unique peer review and programmatic structure of the program. We urge this Committee to protect the integrity of the important model this program has become.

There are nearly 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 260,000 will be diagnosed. We still do not know how to prevent breast cancer, how to diagnose it in a way to make a real difference 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 approach 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 nearly 3 million women in the United States living with breast cancer and all those who share in the mission to end breast cancer.

Chairman INOUYE. I thank you very much, Ms. Visco. My wife of 57 years died of cancer, so I'm constantly reminded.

Ms. VISCO. Yes.

Chairman INOUYE. Senator Cochran.

Senator COCHRAN. Thank you very much for your presence. We appreciate the information that you've provided to the subcommittee.

Ms. VISCO. You're welcome.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, I appreciate the testimony and her commitment to finding a cure. We all are supporting this on the subcommittee.

Mr. Chairman, I would be interested—and the subcommittee may have done some work in this, because we all support this because this is the right thing to do, connected to our service people, we all benefit. What connection and how does this correlate with, what we're doing in DOD, to what they're doing in NIH? Because I serve on that subcommittee, as all of you do, and that would be interesting, to make sure that we're spending all we can and getting the bang that we can with the taxpayers' money and make sure that there's not a lot of overlap there.

I don't know this, but as an appropriator with all of us—and you're the chair—we're going to have to look at this, because we're all committed to helping you.

Ms. VISCO. Yes. Actually, Senator, the program is structured in a way to make certain that there is no overlap. I know that members of the military have been and are perfectly willing and capable of briefing you on exactly how that works.

Senator SHELBY. Thank you.

Ms. VISCO. Thank you.

Chairman INOUYE. Thank you very much.

Ms. Hesdorffer.

STATEMENT OF MARY HESDORFFER, MS, CRNP, MEDICAL LIAISON, MESOTHELIOMA APPLIED RESEARCH FOUNDATION

Ms. HESDORFFER. Thank you, Chairman Inouye and Ranking Member Cochran and members of the subcommittee. Thank you for the opportunity to discuss mesothelioma and its connection to the military service. Your support is critical to our mission and I look forward to continuing our relationship with the committee.

My name is Mary Hesdorffer. I'm a nurse practitioner with over a decade's experience in mesothelioma treatment and research, and I serve as the medical liaison to the Mesothelioma Applied Research Foundation, as well as being on staff at Johns Hopkins Medical Institution.

The Mesothelioma Applied Research Foundation is a national nonprofit dedicated to eradicating mesothelioma as a life-ending disease by funding research, providing education and support for patients, and leading advocacy for the national commitment to end this tragedy.

Mesothelioma, as many of you know, is an aggressive cancer. It's directly caused by asbestos. It's one of the most painful and fatal of cancers. It invades the chest, destroys vital organs, and crushes the lungs. Long-term survivors of mesothelioma are described as 3-year survivors, so you know the seriousness of what we are facing.

It disproportionately affects our service men and women and their families. As you may know, until its fatal toxicity became fully recognized it was considered a magic mineral. It was used extensively in the Navy right up until the 1970s. It was used in engines, nuclear reactors, conditioners, packing, brakes, clutches, winches. In fact, it was used all over Navy ships, even in living spaces, where pipes were overhead, and in kitchens, where asbestos was used in the ovens. It was used in wiring of appliances. Aside from the Navy ships, it was used on military planes extensively, on military vehicles, insulating materials on quonset huts, and in living quarters.

As a result, millions of Navy—millions of defense personnel, servicemen and shipyard workers, have been exposed to asbestos. A study at a Groton, Connecticut, shipyard found that over 100,000 workers have been exposed to asbestos over the years at just this one shipyard.

Following the time of exposure, the disease can manifest itself any time from 10 to 50 years. So we still have many, many, many patients who were diagnosed or who were exposed to asbestos in the 70s who will still be developing this disease in future years.

As the daughter of a merchant marine and the mother of a veteran of the war in Iraq, it's an issue that's very close to my heart. These are the people who have defended our country and built its fleet. They're heroes like former Chief Naval Officer Admiral Elmo Zumwalt, who led the Navy during Vietnam. He was diagnosed in the year 2000 and just 3 months after his diagnosis he was dead from this disease.

Lewis Deets was another one of our Navy veterans. He was serving on a ship where a fire broke out. He was exposed to asbestos during the burning and then he was also exposed as he replaced the burned asbestos blocks. In 1999 he was diagnosed with mesothelioma and died 4 months later at the age of 55.

Bob Tregget, another retired sailor, was diagnosed in 2008. He was exposed as a sailor.

I can go on and talk to you about all of these military personnel, but I think we all understand the connection between asbestos and this disease.

Since 1992 the Department of Defense has been charged with promoting research on diseases related to military service. Since then it has funded over $5.4 billion for a range of diseases, some only tangentially related to military service, but overlooked mesothelioma research for 16 years, even though asbestos was used all over military installations and vehicles, especially Navy ships. This is an injustice to the estimated one-third of mesothelioma patients who were exposed to asbestos on U.S. Navy ships and shipyards.

Currently there are about 3,500 patients a year diagnosed with mesothelioma and 3,000 patients a year die from the disease. If we look at one-third of the patients having been Navy vets, we're looking at about 1,000 patients a year of former people who were exposed on the Navy ships.

In fiscal year 2009 the DOD took responsibility more seriously and made awards totaling $2.7 million for two mesothelioma projects. In January of this year, we had two people awarded technology development awards. We have many people applying for the awards, but we're giving less than 2.6 percent of these awards out.

We feel that all of these research areas warrant attention, but since mesothelioma is a rapidly fatal, excruciating and painful cancer, we ask the subcommittee to appropriate to DOD for fiscal year 2012 $5 million for a dedicated mesothelioma research program. I'm asking for your help. We can't do this alone.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF MARY HESDORFFER

Chairman Inouye, Ranking Member Cochran, and Members of the Committee, thank you for the opportunity to discuss the Mesothelioma connection to military service. Your support is critical to our mission, and I look forward to continuing our relationship with this committee.

My name is Mary Hesdorffer, I am a nurse practitioner with over a decade's experience in mesothelioma treatment and research, and serve as the Medical Liaison to the Mesothelioma Applied Research Foundation. The Mesothelioma Applied Research Foundation is the national nonprofit dedicated to eradicating mesothelioma as a life-ending disease by funding research, providing education and support for patients, and leading advocacy efforts for a national commitment to end the mesothelioma tragedy.

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. Mesothelioma disproportionally affects our service men and women and their families.

As you may know, until its fatal toxicity became fully recognized, asbestos was regarded as the magic mineral. It has excellent fireproofing, insulating, filling and bonding properties. By the late 1930's and through at least the late 70's the Navy was using it extensively. It was used in engines, nuclear reactors, decking materials, pipe covering, hull insulation, valves, pumps, gaskets, boilers, distillers, evaporators, conditioners, rope packing, and brakes and clutches on winches. In fact it was used all over Navy ships, even in living spaces where pipes were overhead and in kitchens where asbestos was used in ovens and in the wiring of appliances. Aside from Navy ships, asbestos was also used on military planes extensively, on military vehicles, and as insulating material on Quonset huts and living quarters.

As a result, millions of military defense personnel, servicemen and shipyard workers, were heavily exposed. A study at the Groton, Connecticut shipyard found that over 100,000 workers had been exposed to asbestos over the years at just one ship-

yard. The disease takes 10 to 50 years to develop, so many of these veterans and workers are now being diagnosed. As the daughter of a merchant marine and the mother of a veteran of the war in Iraq, this is an issue close to my heart.

These are the people who defended our country and built its fleet. They are heroes like former Chief Naval Officer Admiral Elmo Zumwalt, Jr., who led the Navy during Vietnam and was renowned for his concern for enlisted men. Despite his rank, prestige, power, and leadership in protecting the health of Navy servicemen and veterans, Admiral Zumwalt died at Duke University in 2000, just 3 months after being diagnosed with mesothelioma.

Lewis Deets was another of these heroes. Four days after turning the legal age of 18, Lewis joined the Navy. He was not drafted. He volunteered, willingly putting his life on the line to serve his country in Vietnam. He served in the war for over 4 years, from 1962 to 1967, as a ship boilerman. For his valiance in combat operations against the guerilla forces in Vietnam he received a Letter of Commendation and The Navy Unit Commendation Ribbon for Exceptional Service. In December 1965, while Lewis was serving aboard the USS *Kitty Hawk* in the Gulf of Tonkin, a fierce fire broke out. The boilers, filled with asbestos, were burning. Two sailors were killed and 29 were injured. Lewis was one of the 29 injured; he suffered smoke inhalation while fighting the fire. After the fire, he helped rebuild the boilers, replacing the burned asbestos blocks. In 1999 he was diagnosed with mesothelioma, and died 4 months later at age 55.

Bob Tregget was a 57 year old retired sailor who was diagnosed with mesothelioma in 2008. Bob was exposed to asbestos as a sailor in the U.S. Navy from 1965 to 1972, proud to serve his country aboard a nuclear submarine whose mission was to deter a nuclear attack upon the United States. To treat his disease, Bob had the state of the art treatment. He had 3 months of systemic chemotherapy with a new, and quite toxic, drug combination. Then he had a grueling surgery, to open up his chest, remove his sixth rib, amputate his right lung, remove the diaphragm and parts of the linings around his lungs and his heart. After 2 weeks of postoperative hospitalization to recover and still with substantial postoperative pain, he had radiation, which left him with second degree burns on his back, in his mouth, and in his airways. Less than 1 year later, in 2009, he lost his battle with Mesothelioma.

Admiral Zumwalt's, Boilerman Deets' and Sailor Tregget's stories are not atypical. Many more meso patients were exposed in the Navy, or working in a shipyard. Almost 3,000 Americans die each year of meso, and one study found that one-third of patients were exposed on U.S. Navy ships or shipyards. That's 1,000 U.S. veterans and shipyard workers per year, lost through service to country, just as if they had been on a battlefield.

I am currently working with Mike Clements, who was diagnosed with Mesothelioma in 2005 at the age of 59. Mike served in active duty for 6 years, at which time he worked in 3 different shipyards and spent time on a submarine. While he cannot pinpoint this exposure to asbestos, he is certain there is a correlation between his service and diagnosis. Further, he lost his father to Mesothelioma, who was also a Navy veteran.

Asbestos exposure among naval personnel was widespread from the 1930s through the 1980s, and exposure to asbestos still occurred after the 1980s during ship repair, overhaul, and decommissioning. We have not yet seen the end of exposures to asbestos. Asbestos exposures have been reported among the troops in Iraq and Afghanistan. On July 14, 2004, members of the 877th Engineer Battalion of Alabama's Army National Guard were exposed to asbestos in their camp in Mosul, Iraq. Soldiers in wars that extend into third world countries, where asbestos use is increasing without stringent regulations, may also be at risk for exposure during tours of duty. Even low-dose, incidental exposures cause mesothelioma. 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.

Since 1992, the Department of Defense (DOD) has been charged with promoting research on diseases related to military service. Since then it has funded over $5.4 billion for a range of diseases—some only tangentially related to military service, but overlooked mesothelioma research for 16 years even though asbestos was used all over military installations and vehicles, especially Navy ships. This is an injustice to the estimated one-third of mesothelioma patients were exposed to asbestos on U.S. Navy ships and shipyards.

There are brilliant researchers are dedicated to mesothelioma. The Food and Drug Administration (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 biomarker discovery for early detection and treatment—look particularly promising in mesothelioma. The Meso Foundation has funded $7.1 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.

Your subcommittee has recognized the need and taken the lead. For the past 3 years a budget has been passed (fiscal years 2008, 2009 and 2010), 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.

As a result, in early 2008 the DOD awarded its first mesothelioma research grant ever, a $1.4 million award to Courtney Broaddus, M.D. for exciting work to understand the role of macrophage induced inflammation in mesothelioma.

The mesothelioma community greatly appreciated this important first step. Thirty-eight mesothelioma researchers applied for support in 2008. The single award represents only a 2.6 percent success rate for mesothelioma applications. This does not comply with the Senate's directive that DOD begin to seriously address this critical disease. Thirty-seven other researchers put in the time, effort and expense to gather preliminary data and apply, and then were rejected. Such a low success rate of 2.6 percent will discourage top researchers from interest in mesothelioma; they will direct their effort and expertise into other, better funded cancers. 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.

In fiscal year 2009, the DOD took its responsibility more seriously, and made awards totaling $2,750,549 for two important mesothelioma projects: Harvey Pass, M.D. and Margaret E. Huflejt, Ph.D. to investigate new markers for early detection of mesothelioma and identify new therapeutic targets. Lee Krug, M.D. received an award to lead a multi-site clinical trial of a promising new therapy based on the WT–1 vaccine, which will directly impact patients and offers them new hope. For the 2009 grants, two mesothelioma projects were awarded, out of 56 applications submitted. This is slightly better, but still an awards-to-applications ratio of only 4 percent.

In January of this year, Michel Sadelain, M.D., Ph.D., and Prasad Adusumilli, M.D. were awarded a $2.6 million Technology/Therapeutic Development Award to translate mesothelin-targeted immunotherapy for fiscal year 2010. This is a reduction of $150,000 from fiscal year 2009 funding levels for mesothelioma.

Such low success rates will not encourage top young researchers to move into mesothelioma, or experienced researchers to stay in meso. Rather than mere eligibility, mesothelioma needs to be one of the diseases that is assigned a specific appropriation.

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, Tuberous 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; and
—Peer Reviewed Cancer Research Program—$16 million.

The Peer Reviewed Cancer Research Program funds are 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 nanoparticles.

In 2010, Congress added dedicated funding for the following as new programs:

—Chiropractic Clinical Trial—$8.2 millionl; and
—Defense Medical Research and Development $275 million.

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 2012 $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. We thank you for considering our fiscal year 2012 request for $5 million for Mesothelioma research.

Chairman INOUYE. Thank you very much, Ms. Hesdorffer.

Senator Cochran.

Senator COCHRAN. Thank you very much. I think your testimony has added to our understanding of how devastating some of these physical problems and life and death issues are, particularly for those of us who served in the Navy. As you were reciting that list of names, I couldn't help but remember my service in the Navy aboard a ship out of Boston, Massachusetts—a wonderful opportunity for me, growing up in the Deep South, to get to know about things around the world that I would have never been exposed to. But to find out I was also exposed to some of these life-threatening situations brings to me the realization of how lucky so many of us are who have led healthy lives in spite of the fact that we've been exposed to these dangerous situations.

But I think we have a definite obligation to do everything we can to try to save lives now and improve the quality of life of those who have been more unfortunate than I was.

Ms. HESDORFFER. Thank you.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

I appreciate your testimony here. We know this is a horrible situation. I've known people—I had a former congressional colleague of mine from Alabama who worked one summer, who's dead now, as an asbestos worker, because it was a great insulator, as you point out. They didn't know then or, if they knew, the workers didn't know what danger they were playing with.

I guess my question—we know that a lot of this lies dormant for years and years and years. I guess we've all been exposed, but some to more degree than others, to a lot of this and didn't even know it. We used to—oh, gosh, all over America we used to have asbestos siding on homes, asbestos everywhere, because it was, as you pointed out, the so-called perfect mineral for insulation. It had great qualities, but a big danger.

What is the real danger today of our troops as they are in harm's way, posted everywhere in the world? Is it third world countries using asbestos because it's there and it's available and maybe they don't appreciate the danger to it?

Ms. HESDORFFER. Well, I think part of the problem is life is cheap, it's expendable. Canada is still mining asbestos and still exporting it. So we have India, we have so many patients are dying of mesothelioma, probably before they're diagnosed because it's mistaken often for tuberculosis.

Our troops have been exposed in Afghanistan, Iraq, in many of the third world countries. An epidemic now is occurring in Japan, because Japan probably has used asbestos now for a number of years, where they're just beginning to see diagnosed cases.

Senator SHELBY. Are they still using—a lot of countries in the world, like you mentioned Japan, are they still using asbestos because of the properties of a great insulator?

Ms. HESDORFFER. Yes.

Senator SHELBY. Irrespective of the danger?

Senator SHELBY. Slumdog Millionaire, if you look at that movie and you saw those huts that those children were running over, those were asbestos huts. Those roofs were all made of asbestos. We're using it as a fire retardant in many countries.

Senator SHELBY. My last question: Briefly, tell us what drug, pharmaceutical breakthroughs, other things, methods of treatment, either help alleviate some of the problems, or is that just too far away?

Ms. HESDORFFER. Well, I'd like to just briefly—we had Olympta was approved in 2004. Prior to that, there was no approved agent. Patients who get Olympta now—without treatment, the life expectancy is 9.2 months. With Olympta, the life expectancy is 12.3 months. Surgery where——

Senator SHELBY. It's a killer, period.

Ms. HESDORFFER. It's a uniformly fatal disease. That's how every research article starts out.

Senator SHELBY. Thank you.

Thank you, Mr. Chairman.

Chairman INOUYE. Thank you.

Ms. HESDORFFER. Thank you.

Chairman INOUYE. Major General Bockel.

STATEMENT OF MAJOR GENERAL DAVID BOCKEL, UNITED STATES ARMY (RETIRED), EXECUTIVE DIRECTOR, RESERVE OFFICERS ASSOCIATION

General BOCKEL. Mr. Chairman, Mr. Vice Chairman, Senator Shelby: The Reserve Officers Association thanks you for the invitation to appear and give testimony. I'm Major General David Bockel, Executive Director of the Reserve Officers Association. I'm also authorized to speak in behalf of the Reserve Enlisted Association.

As both the Congress and the Pentagon are looking at reducing defense expenses, ROA finds itself again confronted with protecting one of America's greatest assets, the reserve components. The National Guard and the other Reserve components are proud members of the total force who fully understand their duty and are proudly serving operationally. Not only have they contributed to the war effort, but they have made a difference in maintaining an all-volunteer military force and providing the active force more time at home.

Yet, as discussions occur in both Congress and the Pentagon on how to reduce the budget and the deficit, the peril of lower defense spending is that the Reserve components will become the billpayer. As seen in the past, the risk exists where defense planners may be tempted to put the National Guard and title 10 reserve on the shelf by providing them hand-me-down outmoded equipment and underfunded training.

With over 800,000 Guard and Reserve members having been mobilized, this Nation has a generation of warfighters who have the knowledge and experience that hasn't existed in the Reserve component since the end of the Vietnam war. Almost every officer and

enlisted leader is a combat-tested veteran. To waste this capability is a poor return on the investment of money already spent. Only by establishing parity in training, equipment, pay, and compensation will permit us to keep them available for use as an enduring operational force.

ROA and REA's written testimony includes a list of unfunded requirements that we hope this subcommittee will fund, but we also urge the subcommittee to specifically identify funding for both the National Guard and other Reserve components exclusively to train and equip the Reserve components by providing funds for the National Guard and Reserve equipment appropriation. Dedicating funds to Guard and Reserve equipment provides Reserve chiefs and National Guard directors with the flexibility of prioritizing their funding.

But some in the active component would cut National Guard and Reserve pay for the active duty, undermining the concept of the total force. Some would have you believe that the National Guard and Reserve are more expensive to maintain than the active duty forces. However, when citizen warriors are recalled for an extended period the cost is about the same as for an active duty member. It's the lower overhead in the years when the National Guard and Reserve member is not on active duty that provides the economy. The citizen warrior cost over a life cycle is far less than the cost of an active component warfighter.

Additional cost savings are found when civilian knowledge and proficiencies can be called upon at no cost to the military for training. DOD officials have admitted that many Reserve component members are working in state-of-the-art industries as civilian employees, an asset that the Pentagon can't match.

Another concern ROA and REA share is legal support for veterans and Guard and Reserve members returning from deployment to face ever-increasing challenges of reemployment. On June 1, 2009, ROA established the Servicemembers Law Center. This is a service to provide active, Guard, and Reserve, as well as separated veterans. The center is averaging over 5,000 inquiries a year, with the majority of them about employment and reemployment rights.

This is a no-fee service and it does not provide legal representation. But such a service does cost money. Currently, through ROA's financial support it allows this center to be a one-man shop. Our vision is to grow this, to increase the staff and services provided to our veteran and Reserve component community, which will take additional funding.

ROA would love to meet with your staff to discuss how this subcommittee can provide monetary support, and it appears that the language may be included in the Senate NDAA that would provide an authorizing source for such funding.

Another concern that I personally have been working for is on the treatment for the victims of traumatic brain injury. Anecdotal evidence of hyperbaric oxygen therapy as well as other alternative treatments have shown significant success and needs to be better funded.

Thank you again for your consideration of our testimony. I'm available to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL DAVID BOCKEL

The Reserve Officers Association of the United States (ROA) is a professional association of commissioned and warrant officers of our Nation's seven uniformed services, and their spouses. ROA was founded in 1922 during the drawdown years following the end of World War I. It was formed as a permanent institution dedicated to National Defense, with a goal to teach America about the dangers of unpreparedness. When chartered by Congress in 1950, the act established the objective of ROA to: ". . . support and promote the development and execution of a military policy for the United States that will provide adequate National Security."

The Association's 65,000 members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on Active Duty to meet critical needs of the uniformed services and their families. ROA's membership also includes officers from the U.S. Public Health Service and the National Oceanic and Atmospheric Administration who often are first responders during national disasters and help prepare for homeland security.

The Reserve Enlisted Association is an advocate for the enlisted men and women of the United States Military Reserve Components in support of National Security and Homeland Defense, with emphasis on the readiness, training, and quality of life issues affecting their welfare and that of their families and survivors. REA is the only Joint Reserve association representing enlisted reservists—all ranks from all five branches of the military.

PRIORITIES

CY 2011 Legislative Priorities are:

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

Issues to help fund, equip, and train

Advocate for adequate funding to maintain National Defense during times of war and peace.

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

Improve and implement adequate tracking processes on Guard and Reserve appropriations and borrowed Reserve Component equipment needing to be returned or replaced.

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 and Maintenance funding separate.

Issues to assist recruiting and retention

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

Pay and Compensation

Simplify the Reserve duty order system without compromising drill compensation.

Offer Professional pay for Reserve Component medical professionals, consistent with the Active Component's pay.

Eliminate the one-thirtieth rule for Aviation Career Incentive Pay, Career Enlisted Flyers Incentive Pay, Diving Special Duty Pay, and Hazardous Duty Incentive Pay.

Education

Continue funding the GI Bill for the 21st Century.

Health Care

Provide Medical and Dental Readiness through subsidized preventive healthcare.

Extend military coverage for restorative dental care for up to 90 days following deployment.

Spouse Support

Repeal the Survivor Benefits Plan—Dependency Indemnity Clause (DIC) offset.

NATIONAL GUARD AND RESERVE EQUIPMENT ACCOUNTS

It is important to maintain separate equipment and personnel accounts to allow Reserve Component Chiefs the ability to direct dollars to vital 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.
—Modernize by 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 add-ons.
—National Guard and Reserve Appropriations (NGREA).
—Supplemental appropriation, such as OCO funding.

NATIONAL GUARD AND RESERVE EQUIPMENT APPROPRIATION

Once a strategic force, the Reserve Components are now also being employed as an operational asset; stressing an ever greater need for procurement flexibility as provided by the National Guard and Reserve Equipment Appropriations (NGREA). Much-needed items not funded by the respective service budget are frequently purchased through NGREA. In some cases, it is used to procure unit equipment to match a state of modernizations that aligns with the battlefield.

The Reserve and Guard are faced with the ongoing challenges of how to replace worn out equipment, equipment lost due to combat operations, legacy equipment that is becoming irrelevant or obsolete, and, in general, replacing what is lost in combat, or aged through the abnormal wear and tear of deployment. The Reserve Components benefit greatly from a National Military Resource Strategy that includes a National Guard and Reserve Equipment Appropriation.

Congress has provided funding for the NGREA for over 30 years. At times, this funding has made the difference in a unit's abilities to carry out vital missions.

ROA thanks Congress for approving $850 million for NGREA for fiscal year 2011, but more dollars continue to be needed. ROA urges Congress to appropriate into NGREA an amount that is proportional to the missions being performed, which will enable the Reserve Component to meet its readiness requirements.

End Strength

The ROA would like to place a moratorium on any potential 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 the support of:

—Army National Guard of the United States, 358,200.
—Army Reserve, 206,000.
—Navy Reserve, 66,200.
—Marine Corps Reserve, 39,600.
—Air National Guard of the United States, 106,700.
—Air Force Reserve, 71,400.
—Coast Guard Reserve, 10,000.

In a time of war and force rebalancing, 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.

NONFUNDED ARMY RESERVE COMPONENT EQUIPMENT

While General Martin E. Dempsey, U.S. Army Chief of Staff, has said that the Army is not going forward with any unfunded requirements in his letter to Congress, this is not the case for the Army Reserve or the Army National Guard.

Army Reserve (USAR) Unfunded Requirements

While the Army Reserve has 80 percent of its equipment on-hand, only 65 percent of it modernized. Further, the USAR remains short in several areas of critical equip-

ment. Around 35 percent of its required equipment lines are at less than 65 percent on hand. A percentage of the USAR equipment is deployed.

An enduring operational force cannot be fully effective if it is underfunded and has to borrow personnel and equipment from one unit to shore up another to meet mission requirements. Currently in the basic budget, the USAR is funded at strategic levels rather than for its operational contributions.

Top USAR Equipping Challenges of an Operational Reserve:

—Equip USAR formations to optimal operational levels for full spectrum operations.

—Maintain USAR equipment at the Army standard of 90 percent fully mission capable.

—Increase equipment modernization in an era of decreasing resources.

—Increase facility and manpower capabilities to sustain modernized and emerging equipment.

—Modernize the Army Reserve Tactical Wheeled Vehicle (TWV) fleet.

—Increase Resourcing for logistics automation technology required refresh.

—Increase Funding for state-of-the-art maintenance facilities.

—Gain full transparency for equipment procurement through unit level receipt.

[Dollars in millions]

	Amount
Ground Vehicles:	
Heavy Expanded Mobility Tactical Truck (HEMTT–LET), 1086 req'd	$161
Rough Terrain Container Handler, 215 req'd	192
Truck, Forklift, ATLAS, 71 req'd	11.8
Tractor Line Haul M915, 169 req'd	29
HEMTT Common Bridge Transporter, M1977, 69 req'd	15.4
Command Post of the Future (CPOF), 49 req'd	16
Soldier Weapons	15.7
Machine Gun, 7.62 mm, M240B, req'd 1,000.	
Carbine, 5.56 mm, M4, req'd 3,233 $1,329 20,058 23,291.	
Machine Gun, Grenade, 40 mm, MK19 MOD III,.	
Helicopter, Utility, UH–60L, 8 req'd	38.4
Power Plants and Generators:	
100KW Distribution System, 1,062 req'd	15.5
Power Plant, 5kW, TM, AN/MJQ–35, 250 req'd	11.6
Generator Set, 10kW, MEP–803A TQG, 445 req'd	6.4
Generator Set, 10kW, PU–798 TQG, 242	6.2

Simulators.—The use of simulations and simulators minimizes turbulence for USAR Soldiers and their families caused by training demands during the first 2 years of the ARFORGEN process by enabling individuals and units to train at their home station and during exercises in a safe environment without the increased wear and tear on equipment.

Army National Guard (ARNG) Unfunded Equipment Requirements

Even though Congress has provided $37 billion in equipment to the Army National Guard (ARNG) in the past 6 years, the on-hand percentage for all equipment is currently at 92 percent, there is a need for modernization and restoration. The Army National Guard provides more than 40 percent of the Army's rotary wing assets. With the increased optemp there is an increase in need for aircraft modernization. Required land force maintenance results in shortages as the ARN does not have a quantity of selected end-items authorized for use by units as immediate replacements when critical equipment is sent to depots for repair.

Top ARNG Equipping Challenges:

—Improve interoperability with AC forces.

—Equip units for pre-mobilization training and deployment.

—Equip units for their Homeland Missions.

—Modernize ARNG helicopter fleet.

—Modernize ARNG Tactical Wheeled Vehicle (TWV) fleet.

[Dollars in millions]

	Amount
Ground Transportation:	
Light, Med, and Heavy Tactical Trailers, 6,675 req'd	$200
Armored Security Vehicle (ASV), M1117	91

[Dollars in millions]

	Amount
Bradley Fighting Vehicle, Infantry, M2A2, 95 req'd	123
HMMWV Shelter Carrier, Heavy, M1097, 707 req'd	43.6
Aviation:	
Helicopter, Utility, UH–60L, 30 req'd	145.7
Light Utility Helicopter, UH–72A, 44 req'd	171.6
Helicopter, Cargo CH–47F, 3 req'd	90
Medical Field Systems, 2,249 req'd	11

The Assistant Secretary of the Army (Acquisitions, Logistics & Technology) recently directed the Program Executive Office—Aviation to divest the C–23 Sherpa aircraft not later than December 31, 2014 as the Army had decided that it shouldn't be in the fixed wing business. Yet these aircraft are needed in the ARNG because the assets would be utilized in state missions, if not Federal.

AIR FORCE RESERVE COMPONENTS EQUIPMENT PRIORITIES

Air Force Reserve Unfunded Requirements

The Air Force Reserve (AFR) is focused on rebalancing its force, recapitalizing its equipment and infrastructure, and supporting its Reservists. Sustaining operations on five continents, the resulting wear and tear weighs heavily on aging equipment. When Legacy aircraft are called upon to support operational missions, the equipment is stressed at a greater rate. Since the start of combat, the majority of AFR equipment requirements have been aircraft upgrades.

Top AFR Equipping Challenges:

—*Defensive Systems*.—LAIRCM, ADS, and MWS: equip aircraft lacking adequate infrared missile protection for combat operations.

—*Data Link and Secure Communications*.—Data link network supporting image/video, threat updates, and SLOS/BLOS communications for combat missions.

[Dollars in millions]

	Amount
F–16 Systems, CDU, Combined AIFF w/Mode 5/S, Sim Trainer Upgrade	$10
C–130 Systems, New Armor, RWR, TAWS, VECTS, LED posit Lights	92.8
LAIR Countermeasures KC–135 (15)	118.4
Infra-Red Counter Measures C–17s	60
Security Forces Weapons & Tactical Equipment	3.2
Guardian Angel Weapon System (GAWS):	
Tactical Communication Headset	5
HC–130 Wireless Intercom	6
CSAR Common Data Link	6

Air National Guard Unfunded Equipment Requirements

Given adequate equipment and training, the Air National Guard (ANG) will continue to fulfill its Total Force obligations. As the Nation's first military responder, the Air Force has increased reliance on its Reserve Components, requiring equipment and training comparable to the active component Air Force. The Air National Guard's support to civil authorities is based upon the concept of "dual use," equipment purchased by the Air Force for the Air National Guard's Federal combat mission, which can be adapted and used domestically when not needed overseas.

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.

ANG Equipping Challenges:

—Modernize aging aircraft and other weapons systems for both dual-mission and combat deployments.

—Equipment to satisfy requirements for domestic operations in each Emergency.

—Support Function (ESF).

—Maintain C–5: Failing major fuselage structures and funding for depot maintenance.

—Define an Air Force validation process for both Federal and state domestic response needs.

—Program aging ANG F–16 aircraft for the Service Life Extension Program (SLEP).

An ANG wing contains not only aircraft but fire trucks, forklifts, portable light carts, emergency medical equipment including ambulances, air traffic control equipment, explosives ordinance equipment, etc., as well as well trained experts—valuable in response to civil emergencies.

[Dollars in millions]

	Amount
C–27J Airlift, 4 req'd	$124
C–40C Airlift, 1 req'd	98
C–38 Replacement Aircraft, 4 req'd	254
C–5 Structural Repair	310
C–17 Next Generation Threat Detection System	59
MC–130 Integrated BLOS/LOS/Data Link/VDL, 167, req'd	66.8
F–16 Advanced Targeting Pod Upgrades	260

NAVY RESERVE UNFUNDED PRIORITIES

Active Reserve Integration (ARI) aligns Active and Reserve component units to achieve unity of command. Operationally, the Navy Reserve is fully engaged across the spectrum of Navy, Marine Corps, and joint operations, from peace to war. It has been the primary provider of Individual Augmentees for the overseas contingency operations filling Army, and Air Force assignments.

Top U.S. Navy Reserve Equipping Challenges:

—Aircraft procurement (C–40A, P–8, KC–130J, C–37B and F/A–18E).

—Expeditionary equipment procurement (MESF, EOD, NCF, NAVELSG, MCAST, EXPCOMBATCAM, and NEIC).

[Dollars in millions]

	Amount
C–40 A Combo cargo/passenger Airlift, 5 req'd	$425
Aircraft recapitalization is necessary due to the C–9B's increasing operating and depot costs, decreasing availability and inability to meet future avionics/engine mandates required to operate worldwide. The C–40A has twice the range, payload, days of availability of the C–9B, and also has the unique capability of carrying hazardous cargo and passengers simultaneously with no restrictions. C–40 replaces an aging fleet of C–9, C–12 and C–20.	
Maritime Expeditionary Security Force	20
Navy Expeditionary Combat Command has 17,000 Navy Reservists and requires $3.1 billion in Reserve Component Table of Allowance equipment. Force Utility Boat MPF–UB, 3 req'd $3 million.	
KC–130J Super Hercules Aircraft tankers, 2 req'd	168
Aircraft needed to fill the shortfall in Navy Unique Fleet Essential Airlift. Procurement price close to upgrading existing C–130Ts with the benefit of a longer life span. 24 req'd.	
Helicopter, Combat SAR, HH–60H (Seahawk), 1 req'd	15.5
C–37 B (Gulf Stream) Aircraft (1)	64
The Navy Reserve helps maintain executive transport airlift to support the Depart. of the Navy.	
Civil Engineering Support Equipment—Tactical Vehicles	4.4

MARINE CORPS RESERVE UNFUNDED PRIORITIES

Marine Forces Reserve (MFR) has two primary equipping priorities—outfitting individuals who are preparing to deploy and sufficiently equipping units to conduct home station training. Individuals receive 100 percent of the necessary warfighting equipment. MFR units are equipped to a level identified by the Training Allowance (TA). MFR units are equipped with the same equipment that is utilized by the Active Component, but in quantities tailored to fit Reserve training center needs. It is imperative that MFR units train with the same equipment they will utilize while deployed.

Top MCR Equipping Challenges:

—Providing units the "right amount" of equipment to effectively train in a pre-activation environment.

—Achieving USMCR goal that the Reserve TA contains the same equipment as the active component.

—Resetting and modernizing the MRF to prepare for future challenges.

	Amount
KC–130J Super Hercules Aircraft tankers, 21 remaining	$1.5 billion

	Amount
The ''T'' and ''J'' aircraft are very different airframes, requiring different logistical, maintenance, and aircrew requirements. The longer both airframes are maintained, the longer twice the cost for logistics, maintenance training, and aircrew training will be spent.	
Light Armored Vehicles—LAV–25, procure 27 remaining,	$68 million
Completing modernization of Light Armored Vehicle (LAV) family filling a shortfall in a USMCR light armor reconnaissance company. It provides strategic mobility to reach and engage the threat, tactical mobility for effective use of fire power.	
Logistics Vehicle System Replacement (LVSR) 108 required	$650,000 each
Supports accelerated modernization and rapid fielding.	
Simulators: KC–130J Weapons System Trainer	$25 million
Training transformation remains the cutting-edge arena of simulation and simulators.	
Training Allowance (T/A) Shortfalls	$145 million
Shortfalls consist of over 300 items needed for individual combat clothing and equipment, including protective vests, ponchos, liners, gloves, cold weather clothing, environmental test sets, tool kits, tents, camouflage netting, communications systems, engineering equipment, combat and logistics vehicles and weapon systems.	

SERVICE MEMBERS LAW CENTER

The Reserve Officers Association developed a Service Members Law Center, advising Active and Reserve service members who are subject to legal problems that occur during deployment.

In the last year, the Service Members Law Center has received over 6,000 calls and e-mails with legal questions. Eighty percent of them deal with the issue of employment and reemployment of veterans. Of those who have contacted us, the ROA Service Members Law Center has referred about 5 percent to attorneys.

The American Bar Association supports legislation S. 1106, Justice for the Troops, to support programs on pro bono legal assistance for members of the Armed Forces. The Service Members Law Center has already been educating the law community on just that, and provides over 700 case studies for online use by law offices.

The Law Center refers names of attorneys who work on related legal issues, encouraging law firms to represent service members. The Center also educates and trains lawyers, especially active and reserve judge advocates, on service member protection cases. It is also a resource to Congress. Last year, the Supreme Court gave judgment on its first USERRA case. The Service Members Law Center filed an amicus curiae (friend of the court) brief on this case.

ROA sets aside office spaces and staffs a lawyer to answer questions of serving members and veterans. Legal services, as suggested by S. 1106, could be sought by the Service Members Law Center if it expanded its staff. This would require additional financial support.

Anticipated overall cost for expansion in fiscal year 2012: $150,000.

Military Voting

The Service Members Law Center also answers questions about Military Voting. Its director works with the Federal Voting Assistance Program staff to help communicate information to improve military voter participation in Federal elections. FVAP announced a $16 million grant program to expand those online voting support tools at the State and local level, all of which will be linked to the voter through the FVAP website portal.

ROA and REA fully support additional funding of DOD's Federal Voting Assistance Program for $35.107 million.

CIOR/CIOMR FUNDING REQUEST

The Interallied Confederation of Reserve Officers (CIOR) was founded in 1948, and the Interallied Confederation of Medical Reserve Officers (CIOMR) was founded in 1947. These organizations are nonpolitical, independent confederations of national reserve associations of the signatory countries of the North Atlantic Treaty Organization (NATO). Presently, there are 16 member nation delegations representing over 800,000 reserve officers. CIOR supports several programs to improve professional development and international understanding. The Reserve Officers Association of the United States represents the United States as its official member to CIOR.

Military Competition.—The CIOR Military Competition is a strenuous 3 day contest on warfighting skills among Reserve Officers teams from member countries. The contest emphasizes 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.

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. Presently no service has Executive Agency for CIOR, so these programs aren't being funded.

Military Competition funding needs at $150,000 per fiscal year.

CONCLUSION

The impact of operations in Iraq and Afghanistan is affecting the very nature of the Guard and Reserve, not just the execution of Roles and Missions. 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 subcommittee 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 INOUYE. Thank you very much, General Bockel.

Senator Cochran.

Senator COCHRAN. Thank you, General Bockel. We appreciate your coming here today and giving us your observations and your service, too, to veterans who have served in our military. When you mentioned the hyperbaric chamber, I just recalled the use of that in rehabilitating horses, thoroughbreds for racing. The fellow who really put the biggest bit of attention and his own personal funds into that had a horse that finally won the Kentucky Derby a couple of years ago.

General BOCKEL. There it is.

Senator COCHRAN. It didn't make him run any faster, but it showed the capabilities of treatment for damaged tissues, and it led to the use by men and women who had been in the service. Out at our Bethesda Naval Hospital, I think they have planned for a unit to be installed for trial, and we now will have an opportunity for a higher rate of recovery from a lot of things because of that initiative.

General BOCKEL. In the case of traumatic brain injury, there is no uniform understanding of the condition and the treatment. It is also a continuity of care issue. From DOD healthcare through Veterans Affairs into the private healthcare arena, there is no continuity, no common understanding. The treatment does work. It's been proven anecdotally. There's a doctor at LSU by the name of Paul Harch who's the leader in the treatment, and I personally know of a retired Army Reserve brigadier general who's a judge in Fort Walton Beach, Florida, who spent 2 years in Walter Reed, most of that time suffering from traumatic brain injury, who re-

ceived the hyperbaric therapy at George Washington University Hospital, and he's back on the bench practicing today.

Senator SHELBY. That's remarkable.

Well, thank you very much for being here. Your testimony will be given very careful consideration.

General BOCKEL. Thank you.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, I appreciate the General's testimony and his advocacy here through the paper. He had a distinguished military career before he came to that. We share one thing in common: We both are graduates of the University of Alabama. When he was there he was a distinguished student, but he was also a distinguished graduate of their ROTC program, which served him well in his career.

General BOCKEL. They never thought I would get this far, Senator.

Senator SHELBY. But you have.

Chairman INOUYE. Thank you very much.

Captain Smith.

STATEMENT OF CAPTAIN MIKE SMITH, UNITED STATES NAVY (RETIRED), NATIONAL MILITARY AND VETERANS ALLIANCE

Captain SMITH. Chairman Inouye, Senator Cochran, and Senator Shelby: The National Military and Veterans Alliance, or NMVA, is honored to again testify. The alliance represents military retiree veterans and survivor associations with over 3.5 million members. The NMVA supports a strong national security.

The challenges of the deficit and an adequately funded defense are at the forefront of discussions in Congress and, while the alliance is well aware that the subcommittee faces certain budget constraints, the NMVA continues to urge the President and Congress to increase defense spending to 5 percent of gross domestic product during times of high utilization of the military to cover procurement, prevent unnecessary personnel cuts, and afford needed benefits for serving members and retirees. With the U.S. military taking action in four different countries, no one can deny that it is being decidedly used.

It is crucial that military healthcare is funded. NMVA is concerned that as new programs are initiated they won't receive the funding that they need. Treating PTS and TBI shouldn't be on the cheap and alternative treatments should be explored so that our serving members can return to a normal life.

The alliance is concerned that the President's DOD healthcare budget continues to undercut the military's beneficiaries' needs. We ask that you continue to fully fund military healthcare in fiscal year 2012.

It is also important that we have parity in equipment and training for the new operational Guard and Reserve. Cuts in the strength of the Reserve component seem counterintuitive to prevent any unforeseen strategic event. The willingness of our young people today to serve in future conflicts will relate to their perception of how the veterans of this war are being treated.

The NMVA thanks this subcommittee for funding the phased-in survivor benefit plan dependency and indemnity compensation off-

set. But widows of members who were killed in the line of service are continuing to be penalized. Even under the present offset, the vast majority of our enlisted families receive little benefit from this new program because SBP is almost completely offset by DIC. The NMVA respectfully requests that this subcommittee find excess funding to expand this provision.

The alliance also hopes that this subcommittee will fully fund the $67.7 million authorized by the Senate Armed Services Committee for the two armed forces retirees homes.

As the overseas contingency operations wind down, the challenges faced by our active and Reserve serving members will not go away. The alliance is confident of your ongoing support of national security and that you will keep the budgeting burden off the shoulders of the warriors, the retirees, their families, and survivors.

The NMVA would like to thank the subcommittee for its efforts and, of course, this morning's opportunity to testify. Thank you.

[The statement follows:]

PREPARED STATEMENT OF CAPTAIN MIKE SMITH

MEMBERSHIP

American Logistics Association
American Military Retirees Association
American Military Society
American Retirees Association
American Veterans (AMVETS)
American WWII Orphans Network
Armed Forces Marketing Council
Armed Forces Top Enlisted Association
Army Navy Union
Association of the U.S. Navy
Catholic War Veterans
Gold Star Wives of America
Hispanic War Veterans Association
Japanese American Veterans Association
Korean War Veterans Foundation
Legion of Valor
Military Order of Foreign Wars
Military Order of the Purple Heart
Military Order of the World Wars
National Association for Uniformed Services
National Gulf War Resource Center
Naval Enlisted Reserve Association
Paralyzed Veterans of America
Reserve Enlisted Association
Reserve Officers Associations
Society of Military Widows
TREA Senior Citizen League
The Flag and General Officers' Network
The Retired Enlisted Association
Tragedy Assistance Program for Survivors
Uniformed Services Disabled Retirees
Veterans of Foreign Wars of the U.S.
Veterans of Modern Warfare
Vietnam Veterans of America
Women in Search of Equity

INTRODUCTION

Mister Chairman and distinguished members of the Committee, the National Military and Veterans Alliance (NMVA) is very grateful to submit testimony to 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.

The "Alliance" is made up of 35 organizations, which provide it with a scope of expertise in military, veteran, family, and survivor issues.

While the NMVA highlights the funding of benefits, we do this because it supports National Defense. A often quoted phrase, "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 and shouldn't be discounted.

The NMVA is very concerned over comments made by the leadership at the Pentagon that pay and compensation of serving members should be cut. This is very

short sighted, based on a false premise that recruiting and retention successes will continue. To make such cuts will just hasten a hollowing of the force.

The young men and women who serve do so under enormous pressures. Telltale signs of this strain include growing post traumatic stress, upsetting suicide rates, and increasing divorce rates. The impact goes beyond just the serving member and affects extended families and communities with further unintended consequences and sometimes tragic results.

The National Military and Veterans Alliance, through this testimony, hopes to address funding issues that apply to the current and future veterans who have defended this country.

FUNDING NATIONAL DEFENSE

NMVA is pleased to observe that the Congress continues to discuss how much should be spent on National Defense, but the baseline defense budget is now 3.5 percent of America's Gross Domestic Product (GDP). The Alliance urges the President and Congress to maintain defense spending at 5 percent of GDP 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 1 percent.

If unable to provide a pay raise higher than the President's request, this committee should target pay raises for the mid-grade members, who have increased responsibility in relation to the overall service mission, are also at the highest risk of leaving the service.

NMVA supports applying 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. Guard and Reserve members are performing more specialized hours, but are currently being paid less.

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) into the calculations of Retirement Pay for military healthcare 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. This point cannot be understated. The operation tempo, financial stress and competition with Active Duty recruiting necessitate continuing incentives. The NMVA supports expanding and funding bonuses to the Reserve Components.

Reserve/Guard Funding.—NMVA is concerned about a possible recommendation from the 11th Quadrennial Review of Military Compensation to end "2 days pay for 1 days work," and replace it with a plan to provide one-thirtieth of a month's pay model, which would include both pay and allowances.

Even with allowances, pay would be less than the current system, and the accounting would be far more complex. Allowances differ between individuals and can be affected by commute distances and even zip codes. Certain allowances that are unlikely to be uniformly paid include geographic differences, housing variables, tuition assistance, travel, and adjustments to compensate for missing healthcare.

Additionally there have been DOD suggestions that pay should differ for those in the Guard and Reserve who are in strategic units and operational units. This concept would undermine the Force Generation Plan, which would have the readiness of a Reserve Component unit increase over a 5 year cycle, favored by both the Army and the Marine Reserve. In the early years a unit would be in a strategic status, and for the final 2 years be in an operational mode. Pay should not differ during different stages of FORCGEN.

The NMVA strongly recommends that the reserve pay system continue on a "2 days pay for two drills in a day," be funded and be retained, as is.

EDUCATIONAL ISSUES

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.

Post 9/11 GI Bill

According to a survey conducted by military.com, 36 percent of individuals on active duty want to transfer the benefit to their spouse and 48 percent would transfer it to their children. The Post 9/11 GI Bill provides the much desired transferability option to spouses and children in exchange for an agreement from the serving member that they will continue to serve another 4 years in military service.

The National Military and Veterans Alliance supports future funding to continue the transferability of the Post 9/11 GI Bill, as it is an important retention and recruiting resource.

MGIB–SR Enhancements

The Montgomery G.I. Bill for Selective Reserves (MGIB–SR) will continue to be an important recruiting and retention tool for the Reserve Components. With massive troop rotations, the Reserve forces can expect to have retention shortfalls, unless the government provides enhanced education 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 million/first year, $1.4 billion over 10.

FORCE POLICY AND STRUCTURE

End Strength

The NMVA is concerned about cuts in the end strength boosts of the Active Duty Component of the Army and Marine Corps as have been recommended by Defense Authorizers. The goal for active duty dwell time is 1:3. This has yet to be achieved under current operations tempo, and end strength cuts will only further impact dwell time. Trying to pay the defense bills by premature manpower reductions will 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 rebalancing of the force is understood. The Alliance is pleased to see a recommended increase in the Navy and Air Force Reserves. NMVA urges this subcommittee to at least fund to last year's levels for other Reserve Components.

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, including funding the Special Survivor Indemnity Allowance.

However, there is still an issue remaining to deal with:

Providing funds to end the SBP/DIC offset.

SBP is a purchased annuity, available as an elected earned employee benefit. This 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 benefits created to fulfill different purposes and needs. At this time the SBP annuity the service member has paid for is offset dollar for dollar for the DIC survivor benefits paid through the Department of Veteran Affairs.

SBP/DIC Offset affects several groups. The first is the family of a medically retired member of the uniformed services. If the service member is leaving the service

disabled it is only wise to enroll in the Survivor Benefit Plan (perhaps being uninsurable in the private sector). If a later death is service connected then the survivor loses their SBP annuity to DIC.

A second group affected by this offset is 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.

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 that 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 that this Subcommittee fund the SBP/DIC offset.

CURRENT AND FUTURE ISSUES FACING UNIFORMED SERVICES

Healthcare

The National Military and Veterans Alliance once again thanks this Committee for the great strides that have been made over the last few years to improve the healthcare 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 improved the life and health of Medicare Eligible Military Retirees, their families, and survivors. Yet many serious problems need to be addressed:

Wounded Warrior Programs

The Alliance supports continued funding for the wounded warriors, including monies for research and treatment on Traumatic Brain Injuries (TBI), Post Traumatic Stress Disorder (PTSD), 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 Military 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 healthcare 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 military healthcare. 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 dollar 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 healthcare providers to accept TRICARE Standard patients. Healthcare 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 healthcare 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 healthcare 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. 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 HEALTHCARE

Mobilized Healthcare—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. However, 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 have no 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, have 180 days of transition healthcare following their period of active service, but 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 a subsidy for 180 days after demobilization 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-payments 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 January 28, 2008 are eligible, which is nearly 6 years and four months after Guard and Reserve members first were mobilized to support the active duty force in this conflict. Over 725,000 Reservists, who have served during this period, 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.

MILITARY VOTING

NMVA also feels that significant progress has been made in military voting rights in the past 2 years through passage of the MOVE Act of 2009, and the new programs implemented by the Federal Voting Assistance Program. These new programs include such innovations as online tools to assist voters in filling out registration forms and back-up ballots, as well as the online ballot delivery tools developed by 17 States, with FVAP support, and fielded for the 2010 election. Recently, FVAP announced a $16 million grant program to expand those online voting support tools at the State and local level, all of which will be linked to the voter through the FVAP website portal.

NMVA fully supports additional funding of DOD's Federal Voting Assistance Program for $35.107 million, and the budget PE Numbers are 0901220SE and 0605803SE, Project 4.

REINTEGRATION PROGRAMS

As overseas contingency operations wind down, a temptation will be to reduce funds to yellow ribbon and other reintegration programs, but young men and women will continue to leave active duty, and members serving and the Guard and Reserve will likely continue to be called up to active duty. NMVA supports continued funding to Yellow Ribbon and TAP programs.

These programs must be further examined to enhance the resilience training. Resilience survival training prepares one to better adapt to life's misfortunes and setbacks. While programs are in place to focus on suicide, there are other challenges to be faced such as unemployment and military divorce that need to be addressed, including seminars to better understand the current laws.

ARMED FORCES RETIREMENT HOMES

Dormitories and buildings at the AFRH—Washington, DC campus continue to need refurbishing. While the AFRJ—Gulfport facility has reopened, the Navy/Marine Corps residents continue to need funding for the finishing touches of the site.

NMVA urges this subcommittee to continue funding upgrades at the Washington, DC facility and improvements at 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.

Chairman INOUYE. Thank you very much, Captain Smith.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, thank you.

Let me again reiterate our appreciation for the participation of those of you who have served in the military and through your experience have direct knowledge of a lot of these issues that we are now confronting. The information that you're providing and the suggestions are deeply appreciated. Thank you.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. I thank Captain Smith and the whole panel. I was looking at your membership. You represent the umbrella of all these groups, so you do it well.

So thank you, Mr. Chairman.

Chairman INOUYE. Thank you.

I'd like to thank the panel. Now the next panel: Captain Ike Puzon, U.S. Navy retired, Associations for America's Defense; Dr. Donald Jenkins, National Trauma Institute; Rear Admiral Casey Coane, U.S. Navy retired, Association for the U.S. Navy; Ms. Karen Goraleski, American Society of Tropical Medicine and Hygiene.

May I call on Captain Puzon.

STATEMENT OF CAPTAIN IKE PUZON, UNITED STATES NAVY (RETIRED), ON BEHALF OF THE ASSOCIATIONS FOR AMERICA'S DEFENSE

Captain PUZON. Mr. Chairman, Senator Cochran, Senator Shelby: The Associations for America's Defense is very grateful to testify today. We would like to thank the subcommittee for your stewardship on the defense issues and setting an example through your nonpartisan leadership.

The Associations for America's Defense is concerned that U.S. defense policy is sacrificing security due to budget pressures and readiness. Most concerning is the vigorous pursuit to cut existing programs. Chairman of the Joint Chiefs of Staff Admiral Mike Mullen in his testimony before the Senate Armed Services Committee in February recognized that: "In the back end of previous conflicts, we were able to contract our equipment inventory by shedding our oldest capital assets, reducing the average age of our systems. We cannot do this today because of the high pace and duration of combat operations. We must actually recapitalize our systems to restore our readiness and avoid becoming a hollow force."

A4AD is in agreement, and in addition we are alarmed that the fiscal year 2012 unfunded program list submitted by the military services was not made publicly available and that the Army do not even have such a list this year. Moreover, the past 2 years we saw significant reductions in the unfunded lists submitted, leading to a speculation that military services are no longer permitted to produce their full unfunded needs.

Additionally, the results of such budgetary policy could again lead to a hollow force whose readiness and effectiveness has been subtly degraded and lessened efficiency will not be immediately evident.

We support increasing defense spending to 5 percent of the gross domestic production during times of war to cover procurement and prevent unnecessary personnel end strength cuts. As always, our military will do everything possible to accomplish its missions, but response time is measured by equipment readiness and availability.

Defense Secretary Robert Gates has warned against hollowing out the force from a lack of proper training, lack of proper maintenance and equipment and manpower. Also, U.S. Joint Forces Command General Ray Odierno said recently: "We must avoid the trap of doing more with less, which is a recipe for creating a hollow force." He further qualified this by asking: "What are we going to stop doing?"

Ominously, both the 30-year shipbuilding and aviation plans are at risk of achieving their goals. The Navy's plan to build a 313-ship fleet doesn't match reality, in which funding is highly unlikely to meet this goal. In addition, there are plans to extend the service life of already 40-year-old ships another 28 years. For the aviation plan, the original assumption forecasted a 3 percent average annual growth for aviation programs over the next decade. But now there are predicted a zero-growth aviation budget for 2017.

As these plans are not bearing the fruit that was originally projected, it is imperative that until the new systems are acquired in sufficient quantities to replace legacy fleets, legacy systems must be sustained and kept operational.

As the military continues to become more expeditionary, more airlifts are needed, such as C–17s, C–130Js, and C–40s. They will be required. Yet DOD has decided to shut down production of C–17. Procurement needs to be accelerated, modernized, and mobility requirements need to be acknowledged. We ask this subcommittee to continue to provide appropriations for unfunded National Guard and Reserve equipment requirements.

Of great concern is the potential to revert the Reserve component back to a strategic reserve. Our national security demands both an operational and strategic reserve. We urge the subcommittee to study the comprehensive review of the future role of Reserve components, which calls for reserve equipment.

We genuinely appreciate the support of the subcommittee, particularly at the time when there is growing pressure on the congressional members promoting further cuts. Thank you again. I look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF CAPTAIN IKE PUZON

ASSOCIATIONS FOR AMERICA'S DEFENSE

Founded in January 2002, the Association for America's Defense (A4AD) is an adhoc group of Military and Veteran Associations that have concerns about National Security issues that are not normally addressed by The Military Coalition (TMC) and the National Military Veterans Alliance (NMVA), but participants are members from each. Members have developed expertise in the various branches of the Armed Forces and provide input on force policy and structure. Among the issues that are addressed are equipment, end strength, force structure, and defense policy. A4AD, also, cooperatively works with other associations, who provide input while not including their association name to the membership roster.

PARTICIPATING ASSOCIATIONS

American Military Society
Army and Navy Union
Association of the U.S. Navy
Enlisted Assoc. of the National Guard of the U.S.
Hispanic War Veterans of America
Marine Corps Reserve Association
Military Order of World Wars
National Assoc. for Uniformed Services
Naval Enlisted Reserve Association

Reserve Enlisted Association
Reserve Officers Association
The Flag and General Officers' Network
The Retired Enlisted Association

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 13 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 ongoing stewardship that it has demonstrated on issues of defense. While in a time of war, this subcommittee's pro-defense and non-partisan leadership continues to set an example.

Force Structure: Erosion in Capability

The 2010 Quadrennial Defense Review's (QDR) objectives include: further rebalance the Armed Force's capabilities to prevail in today's wars while building needed capabilities to deal with future threats; and reform Department of Defense's (DOD) institutions and processes to better support warfighters' urgent needs; purchase weapons that are usable, affordable, and needed; and ensure that taxpayer dollars are spent wisely and responsibly. The new QDR calls for DOD to continually evolve and adapt in response to the changing security environment.

Retiring Secretary of Defense Robert Gates said that, "It is vitally important to protect the military modernization accounts," and to, "push ahead with new capabilities, from an air refueling tanker fleet to ballistic missile submarines." Additionally when referring to paying America's budget by defense Gates also stated that, "If you cut the defense budget by 10 percent, which would be catastrophic in terms of force structure, that's $55 billion out of a $1.4 trillion deficit," further saying, "We are not the problem."

The Chairman of the Joint Chiefs of Staff Admiral Mike Mullen well-known for his saying that the "national debt is the greatest threat to national security," in his testimony before the Senate Armed Services Committee in February 2011 also recognized the following regarding equipment:

In the "back end" of previous conflicts, we were able to contract our equipment inventory by shedding our oldest capital assets, reducing the average age of our systems. We cannot do this today, because the high pace and durations of combat operations have consumed the equipment of all our Services much faster than our peacetime programs can recapitalize them. We must actually recapitalize our systems to restore our readiness and avoid becoming a hollow force.

Hollow Force

A4AD strongly disagrees with placing budgetary constraints on defense especially in light of the fact that many have recommended cutting defense in order to pay off debt despite it only being 20 percent of the overall budget. Member associations also question the current administration's spending priorities which place more importance on the immediate future rather than a short and long term approach. The result of such a budgetary policy again lead to a hollow force whose readiness and effectiveness has been subtly degraded and lessened efficiency will not be evident immediately. This process, echoing the past, raises no red flags and sounds no alarms, and the damage can go unnoticed and unremedied until a crisis arises highlighting readiness decay.

Even Secretary Gates has ominously warned against ". . . hollowing out of the force from a lack of proper training, maintenance and equipment—and manpower." But he's not the only one, the commander of U.S. Joint Forces Command General Raymond Odierno also has said recently, "We must avoid the trap of doing more with less, which is a recipe for creating a hollow force," and further qualified this by asking, "what are we going to stop doing?"

Emergent Risks

Members of this group are concerned that U.S. defense policy is sacrificing future security for near term readiness. Our efforts are so focused to provide security and stabilization and then withdrawal in Afghanistan and Iraq. While risk is being ac-

cepted as an element of future force planning, current planning is driven by current overseas contingency operations, and progressively more on budget limitations.

What seems to be overlooked is that the United States is involved in a Cold War in S.E. Asia as well as a Hot War with two theaters in S.W. Asia. Security issues in North Africa, the Middle East, North Korea, China, Iran, and Russia add to the growing areas of risk.

Arab Awakening

The Middle East is in the midst of great turmoil in which multiple countries have and continue to see uprisings, there's a widening gap between Christians and Muslims in Egypt, Syria has seen numerous civilian deaths, Israel is increasingly defensive, Yemen edges closely to civil war, more attacks are surfacing in Iraq, Libya remains in a stalemate, in addition to other problems.

It is concerning that while in the thick of continuing protests and instability numerous western nations are pledging significant funding for alleged "Arab countries in transition to democracy". The United States' best interest is to ensure that there is reliable leadership in Arab states, civil relations toward Israel, and reduced violence against civilians. Also any assistance given must be targeted to support the U.S. National Security Strategy and have detailed goals attached.

Korean Peninsula

North Korea has 1.2 million active and 7.7 million reserve forces while South Korea had 653,000 active and 3.2 million reserve soldiers in 2010, and there are 28,500 U.S. troops stationed to the South. While not an immediate danger to the United States, North Korea is viewed as an increased threat to its neighbors, and is potentially a destabilizing factor in Asia. North Korea may be posturing, but it is still a failed state, where misinterpretation clouded by hubris could start a war.

Recently South Korea has admitted that it has held secret discussions with North Korea in May, yet North Korea utilized the opportunity to embarrass the South. Some analysts actually believe that the two nations may be entering into a new dangerous phase. This is further emphasized by the cool relations of the past year in which North Korea committed attacks against South Korea on Yeonpyeong Island and the sinking of the navy vessel ROKS Cheonan, which resulted in 50 deaths. In fact South Korea intends to increase its defense budget by nearly 5.8 percent in 2011, which is partially in response to these attacks.

China

China has worked very hard to create a façade to the world to conceal its true strengths and weaknesses. According to Chief of Naval Operations Admiral Gary Roughead, at a SAC–D hearing, "The Chinese Navy is the fastest-growing in the world today."

Of great concern is China's defense budget which 'officially' will increase 12.7 percent, 600 billion Yuan or roughly $91 billion, for 2011. Some of the increase will go toward the strategic nuclear force, the strategic missile unit, and the Navy. But this is not the whole budget and in fact it doesn't include the cost for procuring or building new weapons which could almost double the defense budget. What's more experts across the board estimate that China's actually spends far more than is reported, ranging from over $150 billion as DOD reported in 2010 (up to 250 percent higher than figures reported by the Chinese government) to as much as $400 billion as estimated by GlobalSecurity.org based on "a more appropriate purchasing power parity (PPP) basis".

In addition their cost of materials and labor is much lower. China's GDP climbed to 9.6 percent while the United States is at 2.6 percent as of the third quarter for 2010. According to the CIA World Fact Book "because China's exchange rate is determine by fiat, rather than by market forces, the official exchange rate measure of GDP is not an accurate measure of China's output; GDP at the official exchange rate substantially understates the actual level of China's output vis-a-vis the rest of the world; in China's situation, GDP at purchasing power parity provides the best measure for comparing output across countries."

China's build-up of sea and air military power appears aimed at the United States, according to Admiral Michael Mullen. Furthermore China is reluctant to support international efforts in reproaching North Korea. China has stated that it will field its advanced new J–20 stealth fighter in 2017–19.

Furthermore there is also the aggressive behavior. Recently the Philippines deployed two warplanes when a ship searching for oil complained of being harassed by two Chinese patrol boats in the South China Sea, Japan deployed F–15 fighter jets when Chinese surveillance and anti-submarine aircraft flew near the East China Sea disputed islands, and at all times China pursues overtaking Taiwan.

China also associates with adversarial nations, specifically Iran and Venezuela who both openly antagonize the United States.

Iran

While Iran lobs petulant rhetoric toward the United States, the real international tension is between Israel and Iran, and Iran's handiwork in various Middle Eastern uprisings such as Bahrain which is already considered to be an Iranian quasi-satellite state.

Israel views Tehran's atomic work as a threat, and would consider military action against Iran as 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.

Two Iranian warships passed through the Suez Canal upon receiving approval from Egypt, which Israel called a provocation. Iran has also sent a submarine into the Red Sea.

Russia

While the Obama Administration has been working on a "reset" policy toward Russia, including a new START treaty, there are areas of concern. A distressing issue is their ongoing relationship with Iran. Additionally Russia sells arms to countries like Syria and Venezuela.

Prime Minister Vladimir Putin stated recently, "Despite the difficult environment in which we are today, we still found a way to not only maintain but also increase the total amount of state defense order." Russia's defense budget rose by 34 percent in 2009, as reported by the International Institute of Strategic Study, and has plans for incremental defense spending increases starting 2011 with a $19.2 billion, $24.3 billion in 2012, and then $38.8 billion in 2013.

Funding for the Future

Since Secretary Gates initiated the practice of reviewing all the services' unfunded requirements lists prior to testifying before Congress the unfunded lists have shown a dramatic reduction from $33.3 billion for fiscal year 2008 and $31 billion for fiscal year 2009 to $3.8 billion for fiscal year 2010 and $2.6 billion for fiscal year 2011.

Secretary Gates instituted a plan to save $100 billion over 5 years. Two-thirds of the savings are supposed to come from decreasing overhead and one-third from cuts in weapons systems and force structure. For the 2012 budget, the military services and defense agencies have been asked to find $7 billion in savings. In addition President Obama has ordered $400 billion in national security spending cuts over 10 years as the administration identifies ways to reduce the Federal deficit. These impending cuts are in addition to weapon systems cuts from the past couple years amounting to more than $330 billion.

Secretary Gates stated, ". . . sustaining the current force structure and making needed investments in modernization will require annual real growth of 2 (percent) to 3 percent, which is 1 (percent) to 2 percent above current top line budget projections," in a briefing at DOD in Aug. 2010.

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 defense spending at 5 percent of Gross Domestic Product during times of war to cover procurement and prevent unnecessary end strength cuts.

A Changing Manpower Structure

The 2010 QDR reduces the number of active Army brigade combat teams to 45 and Air Force tactical fighter wings to 17, while maintaining the 202,100 Marine Corps active manpower level. The Navy's fiscal year 2011 budget keeps the goal of a 313 ship battle fleet, but its 30 year shipbuilding plan includes 276 ship, thus not reaching the goal. As a result of these planned cuts, the Heritage Foundation projects there will be a 5 percent decrease in manpower over the next 5 years.

A4AD supports a moratorium on further cuts including the National Guard and Title 10 Reserve. We further suggest that a Zero Based Review (ZBR) be performed to evaluate the current manning requirements. Additionally, as the active force is cut, these manpower and equipment assets should be transferred into the Reserve Components.

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, sealift inventory, logistics, and communications 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.

Dependence on Foreign Partnership

Part of the U.S. military strategy is to rely on long-term alliances to augment U.S. forces. 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." The fiscal year 2012 budget request included $500 million for fiscal year 2012, which helps build capabilities of key partners. Yet many allies are cutting their forces.

The risk of basing a national security policy on foreign interests and good world citizenship is increasingly uncertain because their national objectives can differ from our own. Alliances should be viewed as a tool and a force multiplier, but not the foundation of National Security.

Seapower Dominance

The United States, as a maritime Nation, is on the cusp of losing it dominance at sea. The U.S. Navy has been incrementally depreciating through reductions and ever-more aging assets. Now, there are plans to extend the service life of already 40-year old ships another 28 years through 2039. While service life extension programs may cost effective in the short term, continual repairs and downgraded readiness will prove to be more expensive than replacing an asset in the long term.

The cost will not just be defense based, but will impact the national and world economy. The United States has maintained its presence and strength throughout the world, attributing greatly to reducing aggressive behavior such as dealing with piracy, regional disorder, drug trade, human trafficking and much more. According to MacKenzie Eaglen of Heritage Foundation, "The U.S. Navy's global presence has added immeasurably to U.S. economic vitality and to the economies of America's friends and allies, not to mention those of its enemies."

A4AD is particularly concerned that the Navy is no longer as of 2011 required to submit a full plan each year to Congress, but rather ties it to the QDR which is only updated once every 4 years, causing the Navy to be slow to respond to changing threats. Once the U.S. seapower capability is lost, it will be extremely difficult to regain a dominant position in the world seas.

UNFUNDED REQUIREMENTS

The Unfunded Program Lists submitted by the military services to Congress have been reduced significantly since fiscal year 2009 and A4AD has concerns that these requests continue to be driven more by budgetary factors than risk assessment. Of particular concern is the Army who officially has no unfunded requirements, in spite of the fact that its equipment has been the most highly utilized in overseas contingency operations in Iraq and Afghanistan, leading to high wear and tear. A4AD is distressed that by limiting the unfunded lists, Congress is unable to make informed decisions on appropriating for defense.

Aviation Plans

Although the first long-term aviation plan was submitted to Congress in fiscal year 2011 forecasting a 3 percent average annual real growth for aviation programs over the next decade, in the fiscal year 2012 report investment assumptions changed and now predict a zero real growth aviation budget after 2017. Regrettably the aviation plan did not consider rotary wing, tilt-rotor, or trainer aircraft.

Tactical Aircraft

The Air Force has accelerated a plan to retire 250 fighter jets including 112 F–15s and 134 F–16s. Also the Air Force plans to ground 18 F–16s in the USANG due to the fiscal year 2012 presidential budget request that didn't include funding for three F–16s for six States each.

The Air Force-Navy-Marine Corps fighter inventory will decline steadily from 3,264 airframes in fiscal year 2011 to 2,883 in fiscal year 2018, at which point the air fleet is supposed to have a slow increase.

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. Air Force and Naval airframes and air crews are being stressed by these lift missions. As the military continues to be more expeditionary it will require more airlift. Procurement needs to be accelerated and modernized, and mobility requirements need to be reported upon.

While DOD has decided to shut down production of C–17s, existing C–17s are being worn out at a higher rate than anticipated. Congress should independently examine actual airlift needs, and plan for C–17 modernization, a possible follow-on procurement. Furthermore shutting down production of C–17s or any equipment causes great difficulty for reopening such lines and will cause unnecessary delays in the future.

The Navy and Marine Corps need C–40A replacements for the C–9B aircraft; only nine C–40s have been ordered since 1997 to replace 29 C–9Bs. 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.

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 and lists are not in priority order. Amounts are total cost, not individual. If item is preceded by a number in parentheses that is the quantity needed.]

	Amount
Air Force Active:	
F–35 Joint Strike Fighter	Unknown
Aircraft Training Simulators	Unknown
F–16 SLEP	Unknown
Air Force Reserve (USAFR):	
C–130—requirement of LAIRCOM and SLOS/BLOS capability	$73.3 million
A–10/F–16—requirement of Day/Night Helmet Mounted Integrated Targeting (HMIT) (PA, SP)	$9.8 million
ACS—requirement of Grissom R–12 Refuelers	$0.9 million
HC–130—requirement of Integrated EW suite (ALQ–213) with VECTS	$6 million
C–130—requirement of SAFIRE Look Out Capability and MASS Spray System	$19.3 million
Air Force Reserve (USAFR) Submitted MILCON Requirements:	
Airfield Control Tower/Base Ops, March, CA	$16.39 million
RED HORSE Readiness and Training Facility, Charleston, SC	$9.593 million
Unspecified Minor Construction—Reserve, Various Locations	$5.434 million
Planning and Design—Reserve, Various Locations	$2.2 million
Air Force Reserve (USAFR) Significant Major Item Shortages Submitted:	
(21) C–130 Large Aircraft Infrared Countermeasures (LAIRCOM)	$63 million
(55) C–130 SLOS/BLOS Capability	$20.7 million
(148) A–10/F–16 Mounted Cueing System (HMCS)	$4.3 million
(4) Grissom R–12 Refuelers	$0.9 million
(5) HC–130 Integrated EW suite (ALQ–213) with VECTS	$3 million
Air National Guard (USANG):	
F–15 AESA—Continues to be a high priority for adds because it is too expensive to spend NGREA on. Some could be a purchased if NGREA is significantly increased	Unknown
A–10 and F–16 HMIT	Unknown
KC–135 IRCM	Unknown
C–130 IRCM	Unknown
Guardian Angel (GA) Recovery Vehicles. This is also called ''PJ recovery vehicles'', but GA is the weapon system encompassing PJs, Special Tactics Squadrons, and Combat Controllers and they all need recovery vehicles	Unknown

UNFUNDED EQUIPMENT REQUIREMENTS—Continued

[The services and lists are not in priority order. Amounts are total cost, not individual. If item is preceded by a number in parentheses that is the quantity needed.]

	Amount
Air National Guard (USANG) Significant Major Item Shortages Submitted:	
(322) A–10/F–16 Helmet Mounted Integrated Targeting System	$38.64 million
(77) Large Aircraft Infrared Countermeasures (LAIRCOM) (C–140, C–17, C–5)	$431.2 million
(68,272) Security Force Mobility Bag Upgrades, Personal Protective Equipment (PPE), and Weapons	$86.15 million
C–130 Loadmaster Lookout Windows and Crashworthy Loadmaster Seats	$164 million
(30) F–15 Active Electronically Scanned Array (AESA) Radar	$261.6 million
Army Active:	
Ground Combat Vehicle	Unknown
Mobile, Secure Wireless Network—Brigade Combat Team Modernization (BCTM)	Unknown
HMWWV Modernization	Unknown
CH–47 Chinook Helicopter	Unknown
AH–64 Apache Longbow Block III upgrade	Unknown
Army National Guard (USARNG) Significant Major Item Shortages Submitted:	
(30,442) Command Posts—Tactical Operations Center (TOC) & Standardized Integrated Command Post System (SICPS)	$1.166 million
(5,428) Family of Medium Tactical Wheeled Vehicles	$1.519 million
(11) Shadow Tactical Unmanned Aircraft Systems	$297 million
(3,614) General Engineering Equipment—for homeland response missions	$366.7 million
(290) Chemical/Biological protective Shelter	$208.8 million
Army National Guard (USARNG) Top Equipment MOD and Capability Shortfall List:	
Army Battle Command System (ABCS)	Unknown
Air & Missile Defense Systems (Avenger Modernization)	Unknown
ATLAS (All Terrain Lifter-Army System I and II)	Unknown
Aviation Ground Support Equipment	Unknown
Aviation Systems (CH–47F, UH60 A–A–L Mod, UH–60M, AH64 MOD, LUH–72 MEP)	Unknown
Army Reserve (USAR) Significant Major Item Shortages Submitted:	
(34) Command Post System and Integration (SICPS)	$6.8 million
(4,860) Medium Tactical Vehicles	$1.701 billion
(63) HMMWV Ambulance	$25.01 million
(4,541) Light Medium Tactical Truck Cargo	$1.589 billion
(98) Heavy Scraper—for Horizontal Construction mission	$30.58 million
Marine Corps Reserve (USMCR) Significant Major Item Shortages Submitted:	
(5) Light Armored Vehicle (LAV), 25 mm (LAV–25A2)	$16 million
(5) LAV, Maint/Recovery (LAV–R)	$11 million
(15) LAV, Logistics (LAV–L)	$30 million
(3) LAV, Mortar (LAV–M)	$7.5 million
(14) LAV, Anti-tank (LAV–AT)	$44.8 million
Navy and Marine Corps Active [1]:	
F–35 Joint Strike Fighter	Unknown
Attack Submarines	Unknown
LPD–17	Unknown
Navy Reserve (USNR) Significant Major Item Shortages Submitted:	
(5) C–40A	$408.5 million
Naval Construction Force (NCF) Tactical Vehicles and Support Equipment Table of Allowances (TOA)	$38 million
Navy Expeditionary Logistics Support Group (NAVELSG) TOA Equipment	$75 million
Explosive Ordnance Disposal (EOD) TOA Equipment	$58.89 million
Maritime Expeditionary Security Force (MESF) TOA Equipment	$119 million

[1] The Navy's fleet is the smallest it has been in almost 100 years. While the service has made plans to expand in the coming years; to 324 ships by 2021; funding doesn't support this growth. Shipbuilding costs continue on an exponential path and at the same time domestic shipbuilding yards are beginning to close, putting a larger fleet at risk; the ship building budget needs to be increased.

Reserve Components (RCs)

According to the National Guard and Reserve Equipment Report (NGRER) for fiscal year 2012 the aggregate equipment shortage for all of the RCs is about $54.2 billion as compared to $45 billion from last year. Common challenges for the RCs are ensuring that equipment is available for pre-mobilization training, transparency of equipment procurement and distribution, and maintenance.

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 INOUYE. Thank you very much, Captain Puzon.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, I want to join you in welcoming and thanking this panel of witnesses for being here today. We have a copy of the testimony and background information that our staff has provided us. It's a shame that we have such a pressurized situation that we're facing here with many commitments all during the same day and at the same time we're supposed to be here. I was just looking at my schedule to see where I was supposed to be right about now and it was somewhere else.

But that's something that you shouldn't have to suffer from, and that's why I wanted to simply say, because we are not spending 2 or 3 hours, which we probably ought to do, with this one panel because of the pressure of so many other activities and issues, we are forced to make decisions that are troublesome to us.

So, having said that, I'm going to yield to my good friend from Alabama for specific questions that he may have of this witness. But thank you very much for taking time to provide us with your testimony.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

Thank you for your testimony and also your complete written testimony. I think one of your strong statements is in the record. You say members of this group—that's your group—"are concerned that the U.S. defense policy is sacrificing future security for near-term readiness." That is a concern of all of us. We've got to balance that, because if we have near-term readiness where are we going to be in 10 years, 5 years, because we've been on the cutting edge a long time, and it's served us well and we cannot give this up.

The other point that you make in your written testimony, the Chinese navy is the fastest growing navy in the world today. I think we realize this on this Defense Appropriation Committee, and we've got to consider today, but we've also got to consider tomorrow, because if we're not prepared for tomorrow, as you pointed out, we've not served our country well, have we?

Captain PUZON. That's correct, sir. Thank you.

Senator SHELBY. Thank you, Mr. Chairman.

Chairman INOUYE. Thank you.

Dr. Jenkins.

STATEMENT OF DONALD H. JENKINS, M.D., VICE CHAIRMAN, NATIONAL TRAUMA INSTITUTE

Dr. JENKINS. Mr. Chairman, Vice Chairman Cochran, Senator Shelby: Thank you for the opportunity to testify today on behalf of the National Trauma Institute, or NTI, to urge the subcommittee to invest a greater amount of Department of Defense medical research funds in the primary conditions which kill our soldiers.

According to military medical officials, non-compressible hemorrhage is the leading cause of death among combatants whose deaths are considered potentially survivable. NTI believes an accelerated program of research into non-compressible hemorrhage will result in the first truly novel advances in treating this difficult problem, will save the lives of soldiers wounded in combat, and will have a tremendous impact on civilian casualties and costs as well.

I'm currently the Chief of Trauma for the Mayo Clinic and serve on the Defense Health Board. Prior to retiring from the United States Air Force, I was Chairman of General Surgery and Chief of Trauma at Wilford Hall Air Force Medical Center, the Air Force flagship medical facility. I'm here today in my capacity as Vice Chairman of the nonprofit National Trauma Institute, which was formed in 2006 by leaders of America's trauma organizations in response to frustration over lack of trauma research funding.

NTI advocates for trauma research and is a national coordinating center for trauma research and funding. Military officials estimate that 19 percent of combat deaths are potentially survivable. To put that in context of our current war operations, 1,100 warriors wounded in the current wars might have survived, but didn't because treatment strategies were lacking.

Over 84 percent of those deaths were due to hemorrhage and about 600 potentially survivable deaths resulted from hemorrhage in regions of the body, such as the neck, chest, abdomen, groin, and back, that couldn't be treated by tourniquets or compression. New tourniquets and hemostatic bandages have had major impact on the decline in trauma combat deaths due to extremity hemorrhage, but compression is rarely effective for penetrating wounds to the torso, where major vessels can be damaged, resulting in massive hemorrhage. At present such wounds are normally only treatable through surgery and typically such patients do not survive to reach the operating table.

Current combat casualty care guidelines for medics do not include strategies to stop bleeding from non-compressible hemorrhage, because there are none. There is not even a method to detect whether a soldier is bleeding internally or how much blood has been lost. It should be a priority to develop simple, rapid, and field-expedient techniques which can be used by medics on the battlefield or first responders in the civilian setting to detect and treat non-compressible hemorrhage.

Turning to that civilian context, trauma is responsible for over 60 percent of deaths of Americans under the age of 44. That's more than all other causes of death combined in that age group. It's responsible for the deaths of nearly 180,000 Americans and nearly 30 million injuries every year. And it's the second most expensive public health problem facing the United States. Hemorrhage is responsible for nearly 40 percent of deaths following traumatic injury in the civilian setting.

Advances in research can be applied to both military and civilian casualties. It has been proven repeatedly that medical research saves lives. In 1950 a diagnosis of leukemia was a death sentence. Research led to chemotherapy and treatments such as bone marrow transplant, such that today 90 percent of those patients survive. Imagine even a 5 percent decrease in trauma-related death,

injury, and economic burden. That would save the United States $35 billion a year, prevent 1.5 million injuries, and save nearly 9,000 American lives every year.

NTI recommends the subcommittee fund research into the major cause of preventable death of our military and set aside at least $15 million for peer-reviewed research into non-compressible hemorrhage for the fiscal year 2012 DOD appropriations bill.

Mr. Chairman, Senator Cochran, Senator Shelby, thank you for the opportunity to present the views of the National Trauma Institute.

[The statement follows:]

PREPARED STATEMENT OF DR. DONALD H. JENKINS

Mr. Chairman, Vice Chairman Cochran and Members of the Subcommittee: Thank you for the opportunity to testify today to urge the subcommittee to invest a greater amount of DOD medical research funds in the primary conditions which kill our soldiers. According to military medical officials, non-compressible hemorrhage is the leading cause of death among combatants whose deaths are considered "potentially survivable." The National Trauma Institute (NTI) believes an accelerated program of research into non-compressible hemorrhage will result in the first truly novel advances in treating this difficult problem, will save the lives of soldiers wounded in combat, and will have tremendous impact on civilian casualties and costs.

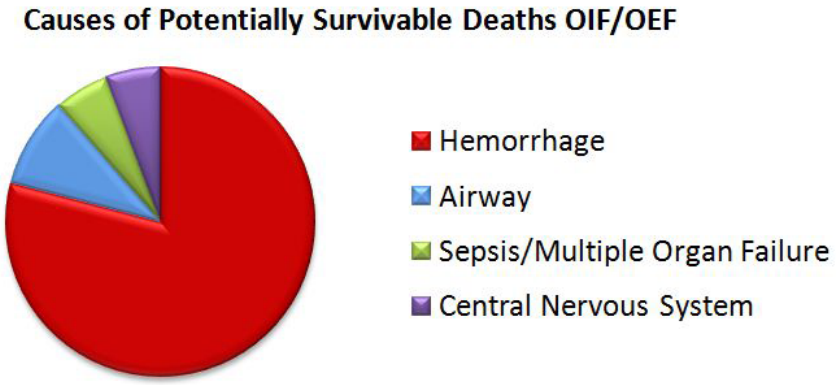
I am currently the Chief of Trauma for the Mayo Clinic and serve on the Defense Health Board. Prior to retiring from the Air Force in 2008, I was Director of the Joint Theater Trauma System, Chair of General Surgery and Chief of Trauma Services at Wilford Hall Medical Center, the Air Force's flagship medical facility. During my Air Force career, I also served as principal advisor to the Air Force Surgeon General on all surgery and trauma-related issues for first-strike deployable teams.

I am here today in my capacity as vice chairman of the nonprofit National Trauma Institute which was formed in 2006 by leaders of America's trauma organizations in response to frustration over lack of funding of trauma research. With the support and participation of the national trauma community, NTI advocates and manages funding for trauma research and is a national coordinating center for trauma research funding. Since September 2009, NTI has issued two national calls for proposals and has received a total of 177 pre-proposals from 32 States and the District of Columbia. After rigorous peer-review, the organization awarded $3.9 million to 16 proposals—seven single-center studies and nine multi-center studies involving an additional 32 centers. Studies are ongoing, and NTI expects the first research outcomes within 6 months. However, $3.9 million is a drop in the bucket, and these studies will barely begin to build the body of knowledge necessary for improved treatments and outcomes in the field of trauma in the United States.

NON COMPRESSIBLE HEMORRHAGE

According to military documents and officials, the major cause of death from combat wounds is hemorrhage. Nineteen percent of combat deaths are judged to be potentially survivable [1]. In other words, 1,100 warriors wounded in Iraq or Afghanistan might have survived to come home to their loved ones, but didn't because treatment strategies were lacking. Over 900 (84 percent) deaths were due to hemorrhage, and 66 percent of these, about 600 potentially survivable deaths, resulted from hemorrhage in regions of the body such as the neck, chest, abdomen, groin, and back that couldn't be treated by a tourniquet or compression [1].

[1] Kelly, J.F., Ritenour, A.E., McLaughlin, D.F., Bagg, K.A., Apodaca, A.N., Mallak, C.T., Pearse, L., Lawnick, M.M., Champion, H.R., Wade, C.E., and Holcomb, J.B. (2008) Injury severity and causes of death from Operation Iraqi Freedom and Operation Enduring Freedom: 2003–2004 versus 2006. J Trauma 64, S21–26.



Extremity wounds are amenable to compression to stop bleeding, and new tourniquets and hemostatic bandages have had a major impact on the decline in combat deaths due to extremity hemorrhage. But compression is rarely effective for penetrating wounds to the torso and major vessels can be damaged resulting in massive hemorrhage. At present, such wounds are normally only treatable through surgical intervention and typically such patients do not survive to reach the operating room.

Currently, there is no active intervention for noncompressible hemorrhage available to military medics, who along with civilian responders have only the tools their predecessors had in the early 20th century. There is not even a method to detect whether the wounded warrior is bleeding internally, and if so, how much blood has been lost. The current Tactical Combat Casualty Care guidelines for medics and corpsmen do not include strategies to stem bleeding from non-compressible hemorrhage because no solutions are available[2]. NTI hopes to decrease the mortality of severely injured patients suffering from torso hemorrhage. This can only be accomplished through research into the development of simple, rapid and field-expedient techniques which can be used by medics on the battlefield or first responders in a civilian context to detect and treat non-compressible hemorrhage. Examples of current NTI research in non-compressible hemorrhage include:

—The use of ultrasonography to measure the diameter of the vena cava to determine whether this will give an accurate indication of low blood volume.

—An observational study to determine the incidence and prevalence of clotting abnormalities in severely injured patients and to study the complex biology of proteins to better understand, predict, diagnose and treat bleeding after trauma.

—Supplementation of hemorrhagic shock patients with vasopressin, a hormone needed to support high blood pressure. Vasopressin at high doses has been shown to improve blood pressure, decrease blood loss and improve survival in animal models with lethal blood loss. This study will investigate the use of vasopressin in trauma patients.

Another challenge in hemorrhage is resuscitation—the restoration of blood volume and pressure. Traditional resuscitation includes large volumes of intravenous fluids followed by blood and finally plasma. However, now this large intravenous fluid load is thought to worsen the trauma patient's coagulopathy (blood clotting problems), increasing bleeding. There is strong retrospective evidence that for patients requiring massive transfusion, a higher proportion of plasma and platelets, when compared to red cells, results in improved survival. Based on a 2004 research study[3], the current Joint Theater Trauma Clinical Practice Guideline for Forward Surgical Teams and Combat Support Hospitals advocates a plasma, platelet, and red cell resuscitation regime in lieu of the standard intravenous fluids. Currently, there is no blood substitute available for in-theater use. The Army Medical Department/USA Institute of Surgical Research is working on a freeze dried plasma solution; however

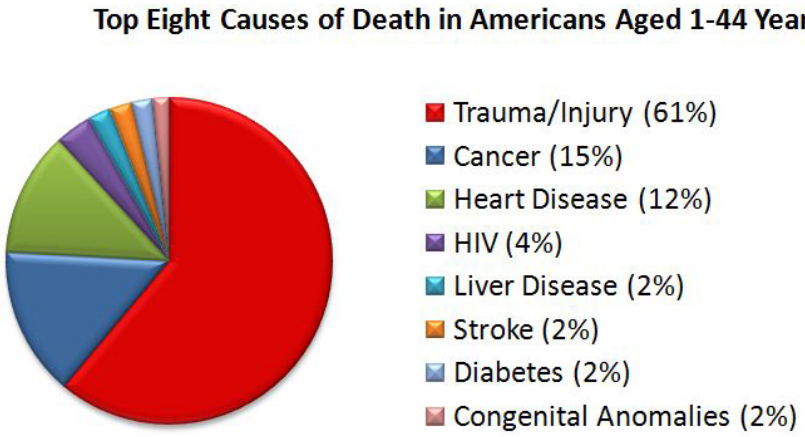
[2](2009) Tactical Combat Casualty Care Guidelines. http://www.usaisr.amedd.army.mil/tccc/TCCC%20Guidelines%20091104.pdf. Accessed June 2, 2011.

[3]Holcomb, J.B., Jenkins, D., Rhee, P., Johannigman, J., Mahoney, P., Mehta, S., Cox, E.D., Gehrke, M.J., Beilman, G.J., Schreiber, M., Flaherty, S.F., Grathwohl, K.W., Spinella, P.C., Perkins, J.G., Beekley, A.C., McMullin, N.R., Park, M.S., Gonzalez, E.A., Wade, C.E., Dubick, M.A., Schwab, C.W., Moore, F.A., Champion, H.R., Hoyt, D.B., and Hess, J.R. (2007) Damage Control Resuscitation: Directly Addressing the Early Coagulopathy of Trauma. The Journal of Trauma 62, 307–310.

this product has not yet received FDA approval. Remarkably, current treatments used by military medics for restoration of blood volume are very similar to those originally used in 1831 when saline was first given as an intravenous fluid to cholera patients [4].

IMPACT OF TRAUMA ON UNITED STATES CIVILIANS

Traumatic injury is the cause of death of nearly every soldier in combat. On the civilian front, trauma/injury is responsible for over 61 percent of the deaths of Americans between the ages of 1 and 44 each year [5]. That's more than all forms of cancer, heart disease, HIV, liver disease, stroke and diabetes combined. An American dies every 3 minutes due to trauma. That's 179,000 deaths in addition to 29.6 million injuries every year [5].



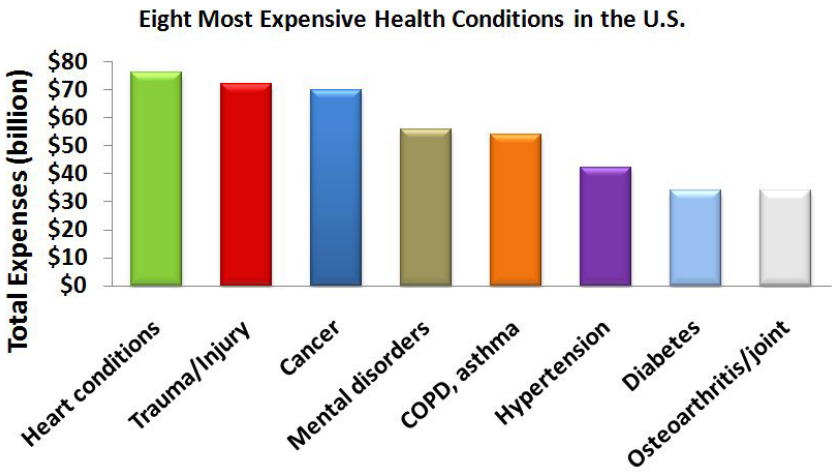
Trauma is the second most expensive public health problem facing the United States. Data from the Agency for Healthcare Research and Quality (AHRQ) on the 10 most expensive health conditions puts the annual medical costs from trauma at $72 billion, second only to heart conditions at $76 billion, and ahead of cancer and all other diseases [6]. The National Safety Council estimates the true economic burden to be more than $690 billion per year, since trauma has an ongoing cost to society due to disability, and is the leading cause of years of productive life lost [7].

[4] Blackborne, L.H.C. (2011) 1831. The Army Department Medical Journal April–June 2011, 6–10.

[5] CDC (2006) Centers for Disease Control/WISQARS. http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html. Accessed March 16, 2011.

[6] AHRQ (2008) Big Money: Cost of 10 Most Expensive Health Conditions Near $500 Billion. Agency for Healthcare Research and Quality http://www.ahrq.gov/news/nn/nn012308.htm. Accessed June 2, 2011.

[7] NSC (2011) Summary from Injury Facts, 2011 Edition. National Safety Council http://www.nsc.org/news_resources/injury_and_death_statistics/Documents/Summary%202011.pdf. Accessed March 16, 2011.



Advances in research can be applied to both military and civilian casualties. Many of the problems associated with hemorrhage of all kinds are potentially solvable and are transferable between military and civilian trauma care. The funding recommended by NTI could have a dramatic impact on civilian mortality in the U.S. Hemorrhage is responsible for 30 percent to 40 percent of deaths following a traumatic injury to civilians [8].

WHY TRAUMA RESEARCH IS SO CHALLENGING

Trauma research is challenging for many reasons. Injury can be severe, and diagnosis of extent and location of injury can be difficult. Sometimes the patient is unconscious or unable to communicate, unable to give consent. Patients are often unaccompanied by next-of-kin to assist in decisionmaking. Enrolling patients in trauma studies sometimes requires community consent and involvement because treatments may need to be started en route to the hospital or military treatment facility. Placebos are not usually an option, because real treatment must be given to injured patients.

In trauma, there is no time to try different treatments, consider alternatives or have multiple appointments to discuss care. We must arm medical personnel with the tools they need to make the right decisions quickly. Lives can be saved. Focused clinical research will provide knowledge, tools and answers.

Often a single Level 1 Trauma Center can't recruit enough patients with specific enrollment criteria to conduct a statistically significant study that provides enough evidence to reach a conclusion that would alter clinical practice. Therefore large, multi-center studies are required, and these necessitate substantial funding. Due to limited funding, studies have often been narrow in size, sporadic, and/or conducted on the basis of a physician's personal interest, rather than a cohesive approach borne from a national trauma research agenda.

The majority of the funding added by Congress in fiscal year 2011 did not go to trauma-related research [9]. The Congressionally Directed Medical Research Program did fund some research into areas that cause a high degree of disability in wounded warriors returning home, such as orthopaedic, eye, ear, craniofacial, and traumatic brain injury. NTI urges the subcommittee to equally fund the major cause of preventable death of our soldiers, sailors, airmen and marines.

For fiscal year 2011, Congress added over $700 million to the President's budget request for DOD medical research funding. Recognizing the need to reduce overall Federal spending, this sum is significantly less than Congress provided in fiscal year 2009 and fiscal year 2010 when over $1 billion was added each year.

The National Trauma Institute believes that whatever additional sum Congress determines can be allocated to DOD medical research for fiscal year 2012 should be

[8] Holcomb, J.B. (2010) Optimal Use of Blood Products in Severely Injured Trauma Patients. Hematology, 465–469.
[9] (2011) H.R.1473.

directed more specifically to research of the traumatic medical conditions which most severely affect our soldiers.

RESEARCH WORKS

It has been proven repeatedly that medical research saves lives. For instance, in 1950 a diagnosis of leukemia was tantamount to a death sentence. Research led to chemotherapy treatments in the 1950s and bone marrow transplantations in the 1970s. A substantial investment in research has led to safer and more effective treatments, and today there is a 90 percent survival rate for leukemia [10]. Another example is breast cancer. Thirty years ago only 74 percent of women who were diagnosed lived for another 5 years. Due to research into early detection, chemotherapy and pharmaceuticals, the 10-year survival rate for breast cancer is now 98 percent [11].

Fifty years of dedicated research into proper diagnosis and treatment of leukemia has led to an 80 percent reduction in the death rate. Imagine even a 5 percent reduction in trauma deaths, injuries and economic burden—this would save the United States $35 billion, prevent 1.5 million injuries, and save almost 9,000 lives every year.

Recommendation.—Hence NTI recommends that Congress set aside a major portion of DOD medical research funding—at least $15 million—in the Defense Health Program account for a peer-reviewed research program to spur better technology to treat non-compressible hemorrhage.

Chairman INOUYE. I thank you very much, Dr. Jenkins.

Senator COCHRAN. I may have missed it, but what specifically would you recommend that we do in terms of procedure or education requirements that would help address the problem that you've described in your testimony?

Dr. JENKINS. Yes, sir. Hemorrhage from the extremities has been treated with a number of devices that have been developed, invented specifically for use in combat, that have now been translated over into the civilian setting, so that EMS agencies carry tourniquets and hemostatic bandages. There is no such device if your liver or spleen is damaged in a traumatic event. The soldiers on the battlefield when injured, cared for by medics, the medic has no tools to treat that non-compressible hemorrhage except to get him to surgery as soon as possible. These soldiers have died awaiting the opportunity to get to surgery.

We need treatments that we can render to those soldiers on the battlefield, to those citizens in the field, by EMS agencies, so that we can stop that hemorrhage and stop that death.

Senator COCHRAN. Thank you very much.

Chairman INOUYE. Thank you.

Senator Shelby.

Senator SHELBY. Mr. Chairman, just a quick observation and question. We've learned a lot and we've also, with helicopters and medical treatment, which have changed a lot. We've learned a lot since Vietnam, certainly since Korea, since the Second World War, and so forth. What is the basic survival rate in combat, heavy combat, now compared to, say, Vietnam, Korea? Do you have some statistics on that, because I know from what I have observed at Walter Reed and Bethesda and talking to a lot of veterans they probably wouldn't have survived, a lot of them, even in Vietnam, in the Second World War, Korea, and so forth.

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[10] (2011) Research Successes. Leukemia and Lymphoma Society http://www.lls.org/#/aboutlls/researchsuccesses/. Accessed June 2, 2011.

[11] (2011) Our Work. Susan G. Komen For the Cure http://ww5.komen.org/AboutUs/OurWork.html. Accessed June 2, 2011.

You're doing a lot better that way, but also they're facing great challenges. The sooner you get to them and the sooner they get medical help and sometimes get to the hospital, the better.

Have you got any comments on that? Am I right, on the right track here?

Dr. JENKINS. You are on the right track, sir. The Joint Trauma Registry keeps very specific data on this and keeps a rolling number that they look at. We look specifically at what one would call the case fatality rate, if injured the risk of dying.

Senator SHELBY. Can you furnish this to the subcommittee? You may have, but as I said earlier, I serve on another committee, subcommittee, dealing with the NIH and everything, and we're all interested in all of it. Right now we're focused on the military. But trauma is everywhere and what goes on in the military translates to others too, does it not?

Dr. JENKINS. Yes, sir. Survival is better because of advances in combat medicine, because of better body armor. We're at the point now where we have—we're looking specifically at casualties who should have survived had we only better tools and techniques to be able to get them to live through it.

Senator SHELBY. Thank you, Mr. Chairman.

Chairman INOUYE. Thank you, Dr. Jenkins.

Rear Admiral Coane.

STATEMENT OF REAR ADMIRAL CASEY COANE, UNITED STATES NAVY (RETIRED), EXECUTIVE DIRECTOR, ASSOCIATION FOR THE UNITED STATES NAVY

Admiral COANE. Mr. Chairman, Senator Cochran, Senator Shelby: The Association for the United States Navy is once again very pleased to have this opportunity to testify. Our association focuses its legislative activity on both personnel issues and the equipment necessary for the Navy and Navy Reserve to accomplish its missions. It is only through the attention of Congress and SUBcommittees such as yours that we can be sure that their needs are met.

We are grateful for this annual opportunity and, in a departure from many of my colleagues earlier this morning, I'm going to speak about equipping the Navy. The ships and aircraft of which I am speaking are vital to this war effort and directly support the thousands of Navy and other services' men and women serving on the ground in Iraq, Afghanistan, or other places ashore in operations worldwide, 53,000 sailors deployed today, including 5,300 mobilized reservists.

I have a few general statements and then I will address specific programs. We are pleased with the increased emphasis that the House and Senate have shown toward Navy shipbuilding in order to fulfil the Nation's maritime strategy. To meet those requirements, the Navy needs your support for the current shipbuilding plans. The Navy is behind on the 313-ship plan due to funding shortages and the only means to achieve a realistic plan is through this subcommittee's efforts.

As the current efforts in Iraq and Afghanistan wind down, the need for our Navy to protect our sea lines of communication, through which 90 percent of our commerce flows, will, as always, remain an issue of national security.

Regarding the Navy Reserve, the irreversible transition from a strategic reserve to an operational reserve with predictable and periodic mobilization increases the need for these Reserve components to be properly resourced for equipment. The recent comprehensive review on Reserve component report stresses the need to ensure that these components have both the equipment necessary to do the job and also the equipment necessary to train for the mission.

The Navy's 30-year aircraft program, the Naval Aviation Plan 2030, is well laid out and moving forward, but it still has significant challenges ahead in the areas of tactical fighters and logistics for out-CONUS operations. Aircraft programs of great concern are the C–40 replacement for the C–9s and the KC–130J tactical airlifters to replace the C–130s. Both of these aircraft are extensively used for intra-theater operations for Iraq, Afghanistan, and support Navy fleet movements worldwide, including disaster relief operations.

The issue is not just newer aircraft. The C–40As are Navy-unique fleet essential airlift, not VIP transport. The issue is that the current C–9 aircraft and C–20Gs have turned the maintenance expense curve to the extent that prudent business practices dictate replacement now. These aircraft in Hawaii, Fort Worth, and Maryland are scheduled to be decommissioned in fiscal year 2012 to 2014.

The Navy needs five to six more C–40s to finish the program and it needs some of them this year. Anything that this subcommittee could do to fund and accelerate that program, perhaps by utilization of the National Guard and Reserve equipment accounts, would be most beneficial to the Navy and the Navy Reserve.

The 30-year plan has the requirement for the replacement of the C–130Ts with the KC–130J aircraft. Currently this essential tactical intra-theater airlift is operating five aircraft short of requirement. Each year that the new aircraft is delayed will force the Navy to spend more money to upgrade worn-out aircraft to meet the new worldwide aviation equipment standards. We urge the committee to bring the KC–130J forward in the FYDP or by adding to the NGRE account.

The P–8 aircraft is an on-time, on-budget program to replace the P–3 aircraft, the backbone of the Navy's reconnaissance effort in theater, as well as the Navy's current anti-submarine and anti-shipping combat aircraft, as demonstrated recently in Libyan operations. Unfortunately, P–8 procurement was planned so far to the right that many, many P–3s are already grounded with broken wings. Anything that this subcommittee could do to accelerate that program, perhaps again by use of the NGRE accounts, would be most beneficial.

Again, the Association of the United States Navy thanks the subcommittee for their tireless efforts on behalf of the Navy and for providing this opportunity to be heard today.

[The statement follows:]

PREPARED STATEMENT OF REAR ADMIRAL CASEY COANE

THE ASSOCIATION OF THE UNITED STATES NAVY

The Association of the United States Navy (AUSN) recently changed its name as of May 19, 2009. The association, formerly known as the Naval Reserve Association, traces its roots back to 1919 and is devoted solely to service to the Nation, Navy, the Navy Reserve and Navy Reserve officers and enlisted. It is the premier national education and professional organization for Active Duty Navy, Navy Reserve personnel, Veterans of the Navy, families of the Navy, and the Association Voice of the Navy and Navy Reserve.

Full membership is offered to all members of the U.S. Navy and Naval Reserve. Association members come from all ranks and components.

The Association has active duty, reserve, and veterans from all 50 States, U.S. Territories, Europe, and Asia. Forty-five percent of AUSN membership is active reservists, active duty, while the remaining 55 percent are made up of retirees, veterans, and involved DOD civilians. The National Headquarters is located at 1619 King Street Alexandria, Virginia. 703–548–5800.

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 transitioned VSO–MSO association works diligently to educate Congress, our members, and the public on Navy equipment, force structure, policy issues, personnel and family issues and Navy veterans.

I thank this Committee for the ongoing stewardship on the important issues of national defense and, especially, the reconstitution and support of the Navy during wartime. At a time of war, non-partisan leadership sets the example.

Your unwavering support for our deployed Service Members in Iraq and Afghanistan (of which over 14,000 Sailors are deployed at Sea in the AOR and over 10,000 are on the ground—Active and Reserve) and for the world-wide fight against terrorism is of crucial importance. Today's Sailors watch Congressional actions closely. AUSN would like to highlight some areas of emphasis.

As a Nation, we need to supply our service members with the critical equipment and support needed for individual training, unit training and combat as well as humanitarian and peacekeeping operations. Additionally, we must never forget the Navy families, reserve members and the employers of these unselfish volunteers—Active and Reserve.

In recent years, the Maritime Strategy has been highlighted, debated and disputed. We feel this is a time where the Total Navy force needs to be stabilized, strengthened, and be reconstituted—because of the consistent, constant, and increasing National Security crisis in a dangerous world—

—Piracy is on the rise in many areas of the world, and especially in the 5th Fleet AOR;

—The flow of commerce still remains a top priority for our economy;

—Naval engagement and support on the ground, in the air, and on the seas for OIF and OEF has not decreased;

—Ever increasing Middle East instability;

—Ballistic missile threats (N Korea-Iran) and the Navy requirement to be the front line of defense for missile defense threat;

—U.S. Navy response to natural disasters; tsunami, Haiti, Chile, and possible man made disasters (oil spill support);

—Humanitarian assistance in the Philippines, Indonesia, and American Samoa; and

—Ever increasing and changing Arctic issues.

In addition to equipment to accomplish assigned missions, the AUSN believes that the administration and Congress must make it a high priority to maintain, if not increase, but at least stabilize the end strengths of already overworked, and perhaps overstretched, military forces. This includes the Active Navy and the Navy Reserve.

—Reductions in manpower are generally resource driven within the Service, not because people are not needed, and the reductions of their benefits are resource driven.

Our current maritime history and strategy—requires that our Nation must achieve the 313+ Navy Ships, not decrease them, and there should be a balance between personnel end-strengths and equipment.

As proven in recent events (Libya, Piracy, Osama Bin Laden, OCO operations) Naval Special Operations, U.S. Carriers, submarines, and Naval Aviation are more relevant than ever—as proven by constant actions in Iraq and Afghanistan and ongoing operations in OIF–OEF and throughout Southwest Asia. Additionally—Navy weapon systems and personnel play a critical role in Natural disasters around the

world! Therefore, it is not a time—to cut back. Our adversaries are only waiting for the time for us to cut back or to stall. China is developing a peer Chinese Navy.

We must fund the Navy for proper shipbuilding and aviation programs which the House this year authorized funds to accomplish.

As you know, neither the Navy nor the Navy Reserve has ever been a garrisoned force—but, a deployed force. Nothing has changed in recent contingency operations or wars, except that the Navy's forces needs equipment as much as anyone. We have worn out current equipment and we need the manpower and infrastructure to ensure that current and future equipment stays ready.

We recognize that there are many issues and priorities that need to be addressed by this Committee and this Congress. The Association of the United States Navy supports the Navy's fiscal year 2012 budget submission and the past years Unfunded Programs List provided by the Chief of Naval Operations that addressed an increased shipbuilding and increase aircraft procurement to relieve the documented shortages and maintenance requirements.

Overwhelmingly, we have heard Service Chiefs, Reserve Chiefs and Senior Enlisted Advisors discuss the need and requirement for more equipment and unit equipment for training in order to be ready as well as combat equipment in the field. Navy needs to have equipment and unit cohesion to keep personnel trained. This means—Navy equipment and Navy Reserve equipment with units.

Equipment Ownership

Issue: Sharing of equipment has been done in the past. However, nothing could be more of a personnel readiness issue and is ill advised. This issue needs to be addressed if the current National Security Strategy is to succeed.

Position: The overwhelming majority of Navy and Navy Reserve members join to have hands-on experience on equipment. The training and personnel readiness of members depends on constant hands-on equipment exposure. History shows, this can only be accomplished through appropriate equipment, since the training cycles are rarely if ever—synchronized with the training or exercise times or deployment times. Additionally, historical records show that units with unit hardware maintain equipment at higher than average material and often have better training readiness. This is especially true with Navy Reserve units. Current and future warfighting requirements will need these highly qualified units when the Combatant Commanders require fully ready units.

Navy has proven its readiness. The personnel readiness, retention, and training of all members will depend on them having equipment that they can utilize, maintain, train on, and deploy with when called upon. AUSN recommends the Committee strengthen the Navy equipment appropriation as the House has done in the fiscal year 2012 NDAA in order to maintain optimally qualified and trained Navy and Navy Reserve forces.

Equipment Needs and Request

AUSN respects the tremendous pressure on the U.S. budget. However, the Navy and the Navy Reserve where a deployed force prior to September 11, 2001 and the Navy and the Navy Reserve will remain a deployed force for foreseeable future. Therefore we request that you give strong consideration to: Funding one C–40A in the fiscal year 2012 appropriations bill for replacement of aged aircraft in Maryland and Hawaii; fund two C–130J aircraft for Navy and Navy Reserve in the fiscal year 2012 appropriations bill; and ensure the proper lead funding is available to maintain TACAIR aircraft for 11 Carrier Air Wings.

Manpower issues—Pay, and End-strength

Pay needs to be competitive. If pay is too low, or expenses too high, a service member knows that time may be better invested elsewhere.

The current discussions about changes in retirement and increases in healthcare is woefully inappropriate when the Nation considers what service members, Navy members, are doing in defense of this Nation, and in support of natural disasters. The risks and sacrifices of every service member, to defend this great Nation, make it illogical to formulate a policy change in retirement pay for military when they sacrifice so much. It just does not make common sense.

End-strength is the core of any service accomplishing the mission. Navy and Navy Reserve has taken a fair share of budget driven end-strength cuts in the previous 10 years. It is time to stop the cuts and ensure that we have the right number of people to conduct operations.

Care must be taken that the current tremendous reservoir of operational capability be maintained and not lost due to resource shortages. Officers, Chief Petty Officers, and Petty Officers need to exercise leadership and professional competence to maintain their capabilities. In the current environment of Navy Individual

Augmentee in support of ground forces, there is a risk that Navy mid-grade leadership will not be able to flourish due to the extended ground war of OIF and OEF. Having the right equipment is critical to our Maritime Strategy.

In summary, we believe the Committee needs to address the following issues for Navy and Navy Reserve in the best interest of our National Security:

—Fund one C–40A for the Navy, per the past years documented request;
  —Navy must replace the C–9s and replace the C–20Gs in Hawaii and Maryland.
—Fund the FA–18 E/F and FA–18 E/F Growlers per the House fiscal year 2011 NDAA and include unit assets for Navy Reserve units currently in EA–6B aircraft.
—Fund the Navy Ships provided for in the House fiscal year 2012 NDAA.
—Just as other services are having difficulties with intra theater C–130 assets, the Navy needs to replace their C–130 aircraft with C–130J for the Navy and Navy Reserve.
  —Request you fund 2 C–130J Aircraft for Navy Reserve for combat support for Navy and Navy Reserve assets in theater operations for OCO.
—Increase funding for Naval Reserve equipment in NGREA
  —Increase Navy Reserve NGREA by $100 million
  —Naval Expeditionary Combat Equipment
—Ensure proper lead funding for TACAIR Navy Aircraft.

For the foreseeable future, we must be realistic about what the unintended consequences are from a high rate of usage. History shows that an Active force and Reserve force are needed for any country to adequately meet its defense requirements, and to enable success in offensive operations. Our Active Duty Navy and the current operational Reserve members are pleased to be making a significant contribution to the Nation's defense as operational forces; however, the reality is that the added stress on Active Navy and the Reserve could pose long term consequences for our country in recruiting, retention, family and employer support. In a time of budget cut discussions, this is not the time to cut end-strengths on an already stressed force. We have already been down this road previously. This issue deserves your attention in pay, maintaining end-strengths, proper equipment, Family Support Programs, Transition Assistance Programs and for the Employer Support for the Guard and Reserve programs.

Thank you for your ongoing support of the Nation, the Armed Services, the United States Navy, the United States Navy Reserve, their families, and Navy veterans, and the fine men and women who defend our country.

Chairman INOUYE. Thank you very much, Rear Admiral Coane.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, I was wondering about our other witness at the table here. We're to ask you questions now?

Let me ask you. If the funding is added as you request, is this going to be additional funding that we'll have to come up with over and above the allocation of the subcommittee, or do you recommend any offsets in funding that would have to be undertaken?

Admiral COANE. No, sir. I'm concerned—we have—in this year's budget there's one C–40, but in the 2012, 2013, and 2014 budgets those have been zeroed out. The Navy's program is to buy 17 of them. There are still five more they've got to have. As I mentioned, the C–20Gs are falling off the table, literally.

So this is additional National Guard and Reserve equipment funding that we're suggesting. The unfunded list, as has been mentioned before, for the Navy is virtually nonexistent. That's not because they don't need things. That's because of DOD policy. So we need to look further into supporting these aircraft.

The C–20Gs in Hawaii and the ones here at Andrews have flown thousands of hours beyond what Gulfstream ever intended those airplanes to fly, because they were built as corporate jets. The Navy operates them with cargo doors, but they're used up and they're going to just simply go away. We've got to replace that asset.

Senator SHELBY. Do we run the risk of having accidents and failures if we don't replace those with other assets?

Admiral COANE. Senator, I'm careful. I had a 34-year career in the airline world as well as an aviator, so I'm very careful to talk about—are we running the risk? Well, flying aircraft is always a risk-reward or risk-benefit business. Any time we get airborne, as you know, there's risk involved. Does the risk go up on the aircraft? I would say that our military people manage the aging of the aircraft. What goes up is the expense of operating the aircraft. In the case of broken-wing P–3s, they're simply worn out and you can't do anything about it.

So I wouldn't suggest to you that—I wouldn't ring the safety bell and say that our military won't continue to be safe, because they're good at that. But the financial obligation—when an aircraft turns the maintenance curve, the dollars go significantly higher very, very quickly. Our C–9s and our C–20s and the C–130Ts are at that point.

Senator COCHRAN. Thank you very much for your perspective. I think that's very helpful to our subcommittee.

Admiral COANE. Yes, sir.

Senator COCHRAN. Thank you.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, I'll try to be brief here. The Admiral here has gotten my attention on some things, and I'm sure the subcommittee.

The survivability rate—well, the death rate of hemorrhage—hemorrhage is a big cause of death, right, battlefield, hemorrhaging?

Admiral COANE. Senator, are you referring to my colleague here to my right?

Senator SHELBY. Yes, hemorrhaging; is that right, on the battlefield?

Dr. JENKINS. Yes, sir.

Senator SHELBY. So what they're trying to do, you're trying to get into research whether you can deal with wounds to the torso, the neck, the blood vessels, all of this, because if you can do that you'll save lives, right?

Dr. JENKINS. Yes, sir, precisely correct.

Senator SHELBY. But a lot of that is—you're using, a lot of it's the same treatment we've used for years. We haven't had a superbreakthrough there, have we?

Dr. JENKINS. And that's directly related to the lack of research funding and why NTI exists, sir, yes, sir.

Senator SHELBY. Thank you.

Chairman INOUYE. Thank you very much.

Ms. Goraleski.

STATEMENT OF KAREN A, GORALESKI, EXECUTIVE DIRECTOR, AMERICAN SOCIETY OF TROPICAL MEDICINE AND HYGIENE

Ms. GORALESKI. Chairman Inouye, Ranking Member Cochran, Senator Shelby, and subcommittee staff: My name is Karen Goraleski and I am the Executive Director of the American Society of Tropical Medicine and Hygiene. Thank you for the privilege of testifying before you today. We are the principal professional mem-

bership organization of scientists, physicians, clinicians, epidemiologists, and program professionals dedicated to the prevention and control of tropical diseases.

We are here today to request that the subcommittee expand funding for the DOD's efforts to develop new preventions, treatments, vaccines, and diagnostics that will prevent—that will protect our service members and other Americans from tropical diseases and at the same time will reduce premature deaths and disability in the developing world.

The central public policy priority of the Society is to reduce the burden of infectious disease in the developing world, areas of the world where many of our military serve. Many of our top health concerns align with the superbly executed and longstanding DOD research on tropical diseases and on what are also called the neglected tropical diseases. Mission success and readiness will be hampered without sustained efforts to reduce these no longer so-called "exotic" health threats.

Infectious disease is the ever-present enemy. The drugs and preventive measures used in earlier conflicts in tropical regions no longer are as reliable as they once were. Therefore, our task list for new and effective tools must not only focus on today, but on tomorrow.

There are three particular DOD facilities working to strengthen mission readiness and success: The Army Medical Research Institute for Infectious Diseases, the Walter Reed Army Institute for Research, and the U.S. Naval Medical Research Center.

First, USAMRID. Its mission is to protect our military from biological threats. Through its biosafety levels 3 and 4 labs and its world-class highly trained personnel, they are in the business of generating countermeasures to biological threats to our country. Like each of these facilities, their work delivers a return on investment that extends beyond our military to citizens.

Next is WRAIR. A large part of the DOD investment in infectious disease research and development is facilitated through WRAIR. In addition to DOD funding, WRAIR has advanced infectious disease research and provided cost-effective solutions, in part by working smart through domestic and international public-private partnerships. Their portfolio includes work on a malaria vaccine and efforts to control its transmission, as well as that of other vector-borne diseases, drug developments for leishmaniasis, enteric disease research, and HIV/AIDS research.

Through its collaborative efforts, WRAIR has developed several exciting vaccine candidates, including one that recently began the ever-large phase 3 trial for a malaria vaccine, RTSS. Is this encouraging? Yes. Do we need to find out more? Yes.

Last, NMRC. The premier research facility includes a focus on malaria, enteric diseases, causes of traveler's diarrhea, dengue fever, now seen in southern Florida, and scrub typhus. In addition to its work accomplished in the United States, the Navy's three overseas medical research laboratories located in Peru, Egypt, and Indonesia offer outstanding scientific collaborations and equally productive relationships with their governments that in turn help the United States.

In closing, all three facilities offer state-of-the-art technologies to protect our troops and can save millions of lives of people around the world. Closer to home, they also provide good-paying, quality jobs to American scientists, lab personnel, and ancillary businesses. ASTMH is confident that increased support for efforts to reduce these global and in some instances U.S. health threats is the smart thing to do for America and the right thing to do for the world.

Thank you for this opportunity. The Society stands ready to serve as an expert resource to you. We are all in this together.

[The statement follows:]

PREPARED STATEMENT OF KAREN A. GORALESKI

EXECUTIVE SUMMARY

The American Society of Tropical Medicine and Hygiene (ASTMH)—the principal professional membership organization representing, educating, and supporting scientists, physicians, clinicians, researchers, epidemiologists, and other health professionals dedicated to the prevention and control of tropical diseases—appreciates the opportunity to submit written testimony to Senate Defense Appropriations Subcommittee.

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 research, prevention, and control of infectious diseases that are leading causes of death and disability in the developing world, and which pose threats to U.S. citizens. Many of our current priorities overlap with the excellent and long-standing tropical medicine and neglected disease research work being done within the Department of Defense, including malaria and other vector-borne diseases; tropical diseases such as dengue fever and leishmaniasis; and enteric diseases.

Because U.S. servicemen and women are often deployed to tropical regions endemic to tropical diseases, reducing the risk that these diseases present to servicemen and women is often critical to mission success. Our military has long taken a primary role in the development of treatments for tropical diseases, such as antimalarial drugs. As a result of this investment and the innovation employed by these military scientists, they have developed many of the most effective and widely used treatments for these diseases.

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 service members from malaria and tropical diseases. Specifically, ASTMH requests that increased funding be allocated to the Army Medical Research Institute for Infectious Diseases (USAMRIID), the Walter Reed Army Institute of Research (WRAIR), and the U.S. Naval Medical Research Center (UNMC), who work closely together to maximize and ensure the most efficient research portfolios.

UNITED STATES ARMY MEDICAL RESEARCH INSTITUTE FOR INFECTIOUS DISEASES

USAMRIID's mission includes advancing research to develop medical solutions—vaccines, drugs, diagnostics, and information—to protect our military service members from biological threats. USAMRIID has Biosafety Level 3 and Level 4 laboratories and world-class expertise in the generation of countermeasures for biological threats playing a critical role in the status of our country's preparedness for biological terrorism and biological warfare. While their primary mission is to protect the service members, like each of the research facilities, their important work benefits civilians as well.

WALTER REED ARMY INSTITUTE OF RESEARCH

A large part of DOD investments in infectious disease research and development are facilitated through WRAIR, which since fiscal year 2007 has performed more that $250 million in DOD research. Through critical public private partnerships with companies such as GSK and Sanofi, as well as nonprofits such as the Gates Foundation and Medicines for Malaria Venture, WRAIR invests in malaria vaccine and drug development, drug development for leishmaniasis, enteric disease research, vector control for malaria and other vector-born infections, and HIV/AIDS research and treatment. While each of these investments is crucial to the protection

of U.S. troops abroad, WRAIR is also a partner to the global health community in saving the lives of some of the world's poorest people suffering from some of the most neglected diseases.

WRAIR has research laboratories around the globe, including a public health reference laboratory in The Republic of Georgia; dengue fever clinical trials in the Philippines; malaria clinical studies and Global Emerging Infectious Surveillance in Kenya; military entomology network field sites in Thailand, the Philippines, Nepal, Cambodia, Korea, Kenya, Ethiopia, Egypt, Libya, Ghana, Liberia and Peru; as well as several other coordination efforts with national health ministries and defense units. This diversity in research capacity puts WRAIR in the unique position to be a leader in research and development for tropical diseases—research that will aid our military men and women as well as people living in these disease-endemic countries.

UNITED STATES NAVAL MEDICAL RESEARCH CENTER

NMRC is a premier medical and health research organization whose focus includes tropical medicine and infectious disease. The Infectious Disease Directorate (IDD) of NMRC focuses on malaria, enteric diseases, and viral rickettsial diseases. IDD has an annual budget exceeding $10 million and conducts research on infectious diseases that are considered to be a significant threat to our deployed sailors, marines, soldiers and airmen. Their current research efforts are focused on malaria, bacterial causes of traveler's diarrhea, dengue fever, and scrub typhus with particular emphasis on vaccine discovery and testing. The research is enhanced by IDD's close working relationship with the Navy's three overseas medical research laboratories located in Peru, Egypt, and Indonesia. These laboratories also afford diplomatic advancement through the close working relationships they have developed with governments and citizens of those countries.

TROPICAL MEDICINE AND TROPICAL DISEASES

The term "tropical medicine" refers to the wide-ranging clinical, research, and educational efforts of physicians, scientists, and public health officials with a focus on the diagnosis, mitigation, prevention, and treatment of vector borne diseases prevalent in the areas of the world with a tropical climate. Most tropical diseases are located in either sub-Saharan Africa, parts of Asia (including the Indian subcontinent), or Central and South America. Many of the world's developing nations are located in these areas; thus tropical medicine tends to focus on diseases that impact the world's most impoverished individuals.

U.S. troops are currently deployed or likely to be deployed in many of these same tropical areas. U.S. citizens, working, traveling and vacationing overseas are similarly impacted by these same tropical diseases, many of which have been ignored and neglected for decades. Furthermore, some of the agents responsible for these diseases could be introduced and become established in the United States (as was the case with West Nile virus), or might even be weaponized.

The United States has a long history of leading the fight against tropical diseases which cause human suffering and pose a great financial burden that can negatively impact a country's economic and political stability. The benefits of U.S. investment in tropical diseases extend beyond economics and humanitarianism and into diplomacy as well.

MALARIA—A FORMIDABLE FOE FOR U.S. MILITARY OPERATIONS

Service members deployed by the U.S. military comprise a majority of the healthy adults traveling each year to malarial regions on behalf of the U.S. Government. Malaria has long been a threat to U.S. military deployment success. In fact, more person-days were lost among U.S. military personnel due to malaria than to bullets during every military campaign fought in malaria-endemic regions during the 20th century. 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.

In recent years the broader international community has increased its efforts to reduce the impact of malaria in the developing world, particularly by reducing childhood malaria mortality, and the U.S. military plays an important role in this broad partnership. However, military malaria researchers at NMRC and WRAIR 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. NMRC and WRAIR are working on the development of a malaria vaccine and on malaria diagnostics and other drugs to treat malaria—an especially essential investment as current malaria drugs face their first signs of drug resistance.

The malaria parasite demonstrates a notorious and consistent ability to quickly develop resistance to new drugs. The latest generation of medicines is increasingly facing drug-resistance. Malaria parasites in Southeast Asia have already shown resistance to mefloquine; resistant strains of the parasite have also been identified in West Africa and South America. 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. Further, the most deadly variant of malaria—Plasmodium falciparum—is believed by the World Health Organization to have become resistant to "nearly all anti-malarials in current use."

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. However, the sheer speed with which the parasite is developing resistance to mefloquine and artemisinin—drugs developed in the 1970s—bodes of a crisis of such significance that military malaria researchers cannot afford to rest on their laurels.

WRAIR, in concert with multiple organizations including the CDC and vaccine manufacturers, has developed several exciting vaccine candidates, including one that recently began the first ever large-scale Phase 3 trial for a malaria vaccine, (RTS,S). In earlier trials, the vaccine has been shown to decrease clinical episodes of malaria by over 50 percent in children in Africa. Despite these advances, the vaccine might be unsuitable for deploying personnel and travelers, because of its efficacy level. As a result, there is still a significant need for continued funding for ongoing research.

Developing new antimalarials as quickly as the parasite becomes resistant to existing ones is an extraordinary challenge, and one that requires significant resources, especially as U.S. military operations in malaria-endemic countries increase. Without new anti-malarials to replace existing drugs as they become obsolete, military operations could be halted in their tracks by malaria. The recent malaria outbreak affecting 80 of 220 Marines in Liberia in 2003 serves as an ominous reminder of the impact of malaria on military operations. Humanitarian missions also place Americans at risk of malaria as evidenced by several Americans contracting malaria while supporting Haitian earthquake relief efforts.

TROPICAL DISEASE IMPACT ON MILITARY OPERATIONS

Few other U.S. Government agencies devote as much time, funding, manpower, and direct research to tackling these devastating diseases as the DOD. The work ultimately goes beyond protecting soldiers and benefits the people living in the countries where these diseases cause the most harm. The recent success of the RTS, S malaria vaccine and its advancement to Phase 3 trials is just one success story from this program. DOD also does great research for other tropical diseases including leishmaniasis and dengue fever, two potentially deadly diseases of great risk to our troops and even greater risk to the citizens of these disease endemic regions.

Leishmaniasis is a vector borne disease that is caused by the parasite leishmania. It is transmitted through the bite of the female phlebotomine sandfly. Leishmaniasis comes in several forms, the most serious of which is visceral leishmaniasis, which affects internal organs and can be deadly if left untreated.

According to the WHO, over 350 million people are at risk of leishmaniasis in 88 countries around the world. It is estimated that 12 million people are currently infected with leishmaniasis and 2 million new infections occur annually. Coinfection of leishmaniasis and HIV is becoming increasingly common, and WHO notes that because of a weakened immune system leishmaniasis can lead to an accelerated onset of AIDS in HIV-positive patients.

Because of leishmaniasis' prevalence in Iraq, the DOD has spent significant time and resources on the development of drugs and new tools for the treatment of leishmaniasis. As more troops return from Iraq and Afghanistan, it is likely DOD will see an increase in leishmaniasis cases in our soldiers. WRAIR discovered and developed Sitamaquine, a drug that once completed, will be an oral treatment for leishmaniasis. While essential for the safety of our servicemen and women abroad, these types of innovations will also be extremely beneficial to the at risk populations world wide that are living in leishmaniasis endemic countries.

Dengue fever, according to the WHO is the most common of all mosquito-borne viral infections. About 2.5 billion people live in places where dengue infection is pos-

sible and last year we saw a few cases pop up in the United States. There are four different viruses that can cause dengue infections. While infection from one of the four viruses will leave a person immune to that strain of the virus, it does not prevent them from contracting the other three, and subsequent infections can often be more serious.

The DOD has seen about 28 cases of dengue in soldiers per year. While none of these cases resulted in the death of a soldier, hospitalization time is lengthy. Currently, there are several research and development efforts underway within the department of defense both for treatments and vaccines for dengue.

U.S. GOVERNMENT ACTION IS NEEDED FOR MISSION READINESS

The role of infectious disease in the success or failure of military operations is often overlooked. Even a cursory review of U.S. and world military history, however, underscores that the need to keep 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 and tropical diseases 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 tools. Additional funds and a greater commitment from the Federal Government are necessary to make progress in malaria and tropical disease prevention, treatment, and control.

ASTMH feels strongly 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. We appreciate the opportunity to share our views in our testimony, and please be assured that ASTMH stands ready to serve as a resource on this and any other tropical disease policy matters.

Thank you for your attention to this matter.

Chairman INOUYE. I thank you very much, Ms. Goraleski.

Senator Cochran.

Senator COCHRAN. Ms. Goraleski, how close do you think we are to developing a new vaccine or a more effective vaccine against malaria? It seems to be a big threat.

Ms. GORALESKI. We are at a very positive place in terms of a malaria vaccine. We're just starting that phase 3 clinical trial. We're very hopeful.

Chairman INOUYE. Thank you very much.

Senator Shelby.

Senator SHELBY. Besides malaria, what are, say, one or two of the most challenging tropical diseases? I know there are many out there.

Ms. GORALESKI. The parasitic diseases are very, very challenging. Sandflies transmit leishmaniasis. We also have other parasites that are equally debilitating and often hard to diagnose at first and then can last for decades.

Senator SHELBY. Thank you.

Chairman INOUYE. I thank the panel very much.

Now may I call upon: Major General Gus Hargett, National Guard Association of the United States; Mr. Dale Lumme, Navy League of the United States; Mr. John R. Davis, Fleet Reserve Association; Ms. Susan Leighton, Ovarian Cancer National Alliance.

May I call upon Major General Hargett.

STATEMENT OF MAJOR GENERAL GUS HARGETT, UNITED STATES ARMY (RETIRED), PRESIDENT, NATIONAL GUARD ASSOCIATION OF THE UNITED STATES

General HARGETT. Mr. Chairman, thank you for the opportunity to testify on behalf of the 470,000 national guardsmen across the country, our citizen soldiers and airmen.

As our Nation struggles with how to get its financial house in order, I propose we give a hard look at how we could leverage the cost efficiencies inherent in the National Guard to reduce defense costs without reducing capabilities. Every day soldiers and airmen of the National Guard are serving across the Nation and around the world in more places than any component of the armed forces, and they do it for a fraction of the cost. To best meet its Federal and State missions, the National Guard must be resourced adequately and proportionately, increasing National Guard personnel end strength and ensuring the force has the equipment and resources needed to provide more capabilities at a lower cost to the taxpayer.

Our National Guard has been an integral part of the war fight. Hundreds of thousands of Army national guardsmen have deployed overseas since September the 11th, many serving multiple deployments. We have a battle-proven operational force and it would be a disservice for our National Guard to revert back to pre-9–11 levels of equipment, readiness, and training.

It has been estimated that the annual requirement for the Army Guard to maintain its current operational level is $400 million. While DOD has asked more and more of our National Guard, the funding requests for the Guard have not kept pace. Thankfully, Congress has helped bridge the gap. Since 1982 Congress has provided valuable funding through the National Guard and Reserve equipment account, enabling both the Army and Air Guard to procure more needed equipment and provide essential modernization upgrades. With this funding, the Army Guard has been able to significantly close the gap on many of its unfunded requirements. It has enabled units across the Nation to go from 40 percent of its required dual use equipment on hand just a few years ago to nearly 75 percent today. While the Army Guard has made significant progress in recent years, the need for equipment, additional equipment, remains.

The Air Guard also continues to use NGREA funding for vital modernization efforts and domestic operation requirements. Along with NGREA, Congress has been instrumental in other modernization efforts for the Air Guard. This subcommittee has led the way in funding the active electronic scanned array radar, or AESAR, for the Air Guard F–15s. However, even with the progress made to date, there remains a shortfall in funding of $52.8 million to complete this program.

Without adequate funding from NGREA and other sources, the Air Guard will be unable to modernize fighter and mobility legacy platforms. The Air Guard must remain an equal and effective partner in all fielding modernization, to include the C–130Js, C–27s, F–35s, the KC–45.

While equipment funding is vital, the true strength of the National Guard is its people. An unrivaled blend of civilian and military skills ensures that our National Guard members are effective when conducting missions abroad and at home. The National Guard State Partnership Program, the Agricultural Development Teams, and the Southwest Border Missions are shining examples of the unique skill set of our National Guard men and women. However, the current budget request creates a shortfall of $12 mil-

lion for the State Partnership Program and $75 million for the counterdrug program.

In conclusion, as America's first military organization, the National Guard has proven for 375 years that it is right for America. Drawing on the experience of the last 10 years of the war fight, we are convinced that the National Guard will emerge as a more cost effective and more mission-capable force into the future.

Thank you for the opportunity to testify today on behalf of our Guard men and women.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL GUS HARGETT

The National Guard Association of the United States is a nonpartisan organization representing nearly 45,000 current and former Army and Air National Guard officers. Formed in 1878, NGAUS is focused on procuring better equipment, standardized training and a more combat-ready force by petitioning Congress for resources. Well over a century later, NGAUS has the same mission.

Our goal is to maintain the freedom and security of this Nation by guaranteeing a strong national defense through the provision of a vital, dynamic National Guard as a part of the Total Force.

THE NATIONAL GUARD—"RIGHT FOR AMERICA"

"A National Guard in balance is one that adds value to America. It is structured and resourced with adaptive and innovative citizen Soldiers and Airmen, ready to provide global security and assistance. A National Guard in balance works as a critical interagency partner at the local, State and Federal levels . . . anytime, anywhere."———General Craig R. McKinley, Chief, National Guard Bureau

Following the Vietnam war, General Creighton Abrams was determined to establish a clear linkage between the employment of the Army and the engagement of public support for military operations. General Abrams reasoned that by creating a force structure that integrated Reserve and Active Components so closely as to make them inextricable would ensure Presidents would never again send the Army to war without the Reserves and the commitment of the American people.

Today, with locations in more than 3,300 communities across the Nation, the National Guard provides an indispensable link between the military and the citizens of our great Nation.

The key to National Guard efficiency is the predominantly part-time (traditional) force that can mobilize quickly for combat operations, or respond when needed for disaster response or homeland defense.

Unless activated for combat service, fully trained traditional National Guard members cost approximately 25 percent of their Active counterparts. National Guard efficiencies compared to regular military components include: fewer "pay days" per year, lower medical costs, significantly lower training costs beyond initial qualification training, virtually no costs for relocating families and household goods to new duty assignments every 3 or 4 years, fewer entitlements such as basic allowance for housing, lower base support costs in terms of services and facilities including commissaries, base housing, base exchanges, and child care facilities.

On average, 17 United States Governors call out their National Guard each day to protect life or property, and the Guard responds immediately, effectively, appropriately, and in-force.

The Air National Guard (ANG) has 106,700 personnel and provides 33 percent of the Total Air Force capabilities for less than 7 percent of the Total Force Defense Budget including: 100 percent of the Air Force's air defense interceptor force, 33 percent of the general purpose fighter force, 45 percent of the tactical airlift and 6 percent of the special operations capability, 43 percent of the air refueling KC–135 tankers, 28 percent of the rescue and recovery capability, 23 percent of tactical air support forces, 10 percent of the bomber force and 8 percent of the strategic airlift forces. Additionally, Air Guard members provide a wide variety of support missions to include: security, medical support, civil engineering, air refueling, strike, airlift, and Intelligence, Surveillance, and Reconnaissance (ISR).

The Army National Guard has 358,200 personnel and provides 32 percent of the Total Army end-strength for only 11 percent of the Total Army Defense Budget. By the end of fiscal year 2010, the Army National Guard force structure will include 8 Division Headquarters, seven Brigade Combat Teams (BCT), and 44 multi-func-

tional Support Brigades. Additionally, the Army National Guard will have continued the conversion of 21 BCTs, completing transformation of the second set of seven BCTs in fiscal year 2010. Since 9/11/2001, more than 340,000 Army National Guard men and women have been activated in support of ongoing combat operations. On any given day, more than 50,000 Guard soldiers are "on point" for the Nation.

As the Department of Defense implements policies to reform the way the Pentagon does business by directing the Service chiefs to find more than $100 billion in savings over the next 5 years, the National Guard is ready and able to play an important role in achieving these necessary goals.

The National Guard provides vast capabilities to our country in its dual-use, domestic support missions and overseas defense, missions while continuing to maintain cost-effectiveness. Increasing National Guard end strength and resourcing and recapitalizing its force will offer more capability and value at a lower cost to America.

Maintaining a Ready, Relevant, and Accessible National Guard

For the National Guard to best meet it's Federal and State missions it must be resourced adequately and proportionately. Since fiscal year 1982 Congress has funded the National Guard and Reserve Equipment Account (NGREA) enabling both the Army and Air National Guard to procure much needed equipment and provide essential modernization upgrades. Since its start in fiscal year 1982, the Army National Guard has received more $9.29 billion and the Air National Guard has received $6 billion in NGREA funding.

Since fiscal year 2006 Congress has provided the ARNG with 50 percent of its total NGREA funding. With this funding, the ARNG has been able to significantly close the gap on many of its emerging requirements and new equipment program procurements. This has enabled our units across the country to go from 40 percent of required equipment on-hand a few years ago, to nearly 75 percent today. This dramatic turnaround is the direct result of congressional support and action.

For example, using NGREA funds, the ARNG has been able to purchase an additional 1,500 Family of Medium Tactical Vehicles (FMTVs), with plans to purchase another 1,100. The ARNG has been able to invest millions in critical updates to systems such as Tactical Operation Combat System (TOCS), Standard Integration Command Post System (SICPS), and War fighter Information Network-Tactical (WIN–T).

While the ARNG has made significant progress, the need for additional equipment funding remains. The National Guard and Reserve Equipment Report for Fiscal Year 2012 (Fiscal Year 2012 NGRER), completed in accordance with Section 10541, Title 10, United States Code, identifies several challenges for the ARNG. The fiscal year 2012 NGRER identifies a $40 billion total shortfall for the ARNG (Page 1–4). Additionally, the ARNG estimates it needs "$3.5 to $4.5 billion in annual programmed funding (versus a $2.3 billion per year average in the current Future Years Defense Program) to continue to modernize and maintain current EOH levels and interoperability" (Fiscal Year 2012 NGRER, Page 2–9).

The Fiscal Year 2012 NGRER also identifies the following challenges regarding equipment:

—Achieving full component-level transparency for equipment procurement and distribution;

—Equipping ARNG units for pre-mobilization training and deployment; and

—Equipping ARNG units for their homeland missions (pages 1–8, 1–9).

NGAUS has worked with Congress over the years to increase the transparency of equipment procurement and better equip the force for training requirements and homeland missions.

The ARNG helicopter fleet remains an area of concern. The Army National Guard Black Hawk fleet will soon grow to 849 helicopters. Five hundred of these are older UH–60A models, with an average age exceeding 25 years. Many UH–60As are in need of immediate replacement/conversion. The "A" model is more expensive to operate, cannot operate at higher altitudes, and has a 1,000 lbs lower payload capability than the newer "L" and "M" models.

The ARNG currently has a documented requirement for 210 UH–72A Lakota helicopters to support domestic missions in "permissive" environments. With over 150 aircraft now delivered to the Army on-cost and within schedule, the UH–72A has proven to be a robust and efficient multirole platform. Leveraging the success of this program for additional missions could lead to even greater efficiencies in meeting operational needs.

The Army National Guard Chinook helicopter fleet total requirement is 161 aircraft. Currently, the shortage is 17 aircraft, and all aircraft in this fleet are CH–47D models except 3 new CH–47Fs that were delivered in May. The average age

of the CH–47D aircraft are 25 years, with many that are older. The need for replacement is immediate because the helicopters are not only being utilized at home to support many missions, but also in deployments abroad especially in Afghanistan. This is compounded with the CH–47D's deterioration from age, recent operational tempo, and losses in theater. The new CH–47F provides better survivability, upgraded avionics (CAAS cockpit), a new airframe, and improved operational capability. The new features save lives and allow missions to be completed that wouldn't have been attempted with the CH–47D models.

Finally, modernizing the ARNG Tactical Wheeled Vehicle fleet is an issue. While the ARNG has reached 100 percent of the requirement for High-Mobility Multipurpose Wheeled Vehicles (HMMWV), 72 percent of the fleet has already reached its Economic Useful Life of 20 years and over 60 percent of the ARNG's HMMWV inventory are legacy vehicles, and are between 20 to 25 years old. Additionally, the ARNG remains short of its requirement for Family of Medium Tactical Vehicles.

The ANG continues to use NGREA funding for vital modernization efforts and specialized domestic operations requirements. They have procured essential equipment such as satellite communications kits for our Tactical Air Control Party (TACP), medical equipment for pararescue, body armor for security forces, helmet mounted cuing systems for fighter aircraft, defensive systems for mobility aircraft, firefighting vehicles, and more. With the need to fully fund ongoing operations and continued pressure on defense budgets, obtaining adequate funding for procuring equipment and modernization efforts will continue to be a challenge. Without adequate funding from NGREA or other sources, the ANG will be unable to modernize legacy platforms and equipment and will no longer remain an equal and effective partner in the Total Force.

In the last year the National Guard Bureau has implemented process changes in order to better obligate these funds and field the procured equipment and upgrades to our Soldiers and Airmen at a more rapid rate.

Along with NGREA, Congress has been instrumental in other modernization efforts for the Air National Guard. It was Congress that funded the LITENING Targeting pods for the Air National Guard F–16 which killed the insurgent leader Abu Musab al-Zarqawi in Iraq. And it is Congress that has continued to fund the Active Electronic Scanned Array (AESA) radar for Air National Guard F–15Cs. Since fiscal year 2006, Congress has provided $313 million for the AESA radar program for ANG F–15s. The AESA radar is being fielded to our fighter wings which currently perform the air sovereignty alert mission in the skies over our Nation. This new radar provides our pilots with the combat capability necessary to perform the homeland defense mission by providing the ability to detect asymmetric threats like cruise missiles or low observable aircraft threatening our Nation's security. However, there remains a shortfall in funding to complete this program. The fiscal year 2012 President's budget request again did not provide the necessary funding to continue this essential program. For fiscal year 2012, the ANG has recognized an unfunded requirement of $52.8 million for F–15C AESA radars in its Weapons System Modernization Book.

The Fiscal Year 2012 NGRER identifies a $7 billion shortfall for modernization programs and shortfalls (page 5–11) in the ANG documented in the Weapons System Modernization Book. NGAUS has identified unfunded modernization priorities to include (in addition to the already identified AESA radar):

—$13.85 million for the Helmet Mounted Integrated Targeting (HMIT) for A–10's (Aircraft Procurement);
—$8.3 million for the HMIT for F–16's (Aircraft Procurement);
—$12.12 million for the Center Display Unit for F–16's (Aircraft Procurement);
—$32.8 million for the Center Display Unit for F–16's (RDTE);
—$9 million for the Center Display Unit for F–15's (RDTE);
—$20.5 million for LC–130 Eight Bladed Propeller Upgrade (Aircraft Procurement);
—$10.74 million for Advanced Infrared Countermeasures (IRCM) Self Protection Suite for C–130's (Aircraft Procurement);
—$70.3 million for Infrared Counter Measures (IRCM) Defensive Systems for KC–135's (Aircraft Procurement);
—$6 million for Infrared Counter Measures (IRCM) Defensive Systems for KC–135's (RDTE);
—$2.4 million for Improved Watercraft and Ground Recovery Vehicles (Other Than Aircraft Procurement); and
—$46 million for two D–RAPCON Systems (Other than Aircraft Procurement).

In the near future the ANG will be fully submerged into the recapitalization crisis that the entire Air Force has become victim too. When the F–22 buy was cut off at 187 aircraft (from the 750 originally planned to be purchased) the ANG lost most

hope of being assigned those aircraft, with the exception of the classic associate relationship at Langley (Richmond, Virginia ANG) and Hawaii.

Although the USAF is planning to acquire 1763 F–35's, the only ANG facility identified to receive the F–35 to date has been Burlington, Vermont. Beyond that, the USAF has been very slow to make any other final decisions as to which, if any other, ANG locations will receive these aircraft beyond the first six Active units, leaving ANG leaders wondering if the Guard will make the cut if the F–35 buy is cut short.

The USAF has announced that it will perform a Service Life Extension Program (SLEP) to approximately 300 F–16s, most of which will be Active Component (AC) Block 50 and 40's. The question remains, how will the USAF ensure the longevity of older ANG F–16s, or will they eventually "cascade" the modernized Block 40/50's F–16's to the ANG as the AC receives new F–35's? And, what happens if the AC does not receive F–35's as anticipated? The Air Force has lacked transparency with the Air National Guard leadership. We believe it is time to end this and use the ANG as a model of how to field and execute the fighter mission in the future.

When discussing the crisis as related to the airlift and transport fleet one should remember how the ANG received the aircraft they now have. During the 1980's and early 1990's, the Air National Guard acquired a significant number of C–130 Hercules via congressional ad's, even though the effort was opposed by the Pentagon. Today, however, the Pentagon is either looking to transfer some of the newer models to AC locations, or claiming there is an excess of up to 40 of these aircraft, which, they indicate are offsetting an equal amount of C–27Js.

The USAF is modernizing its C–5B/C fleet with both the Avionics Modernization Program (AMP) and Reliability Enhancement and Re-engining Program (RERP), to the C–5M configuration. However, even though the Air Force has programmed the C–5A's (only operated in the Reserve Component) for AMP, these aircraft are not programmed to receive the RERP upgrade. Today, the USAF has begun to retire some of these aircraft. Despite not having the same upgraded range and fuel efficiency, unmodified C–5A's would not be inter-flyable by Active/Reserve Component crews. This lack of commitment to the ANG C–5 fleet has left units that operate these aircraft wondering what lies ahead in their future, thereby negatively impacting their ability to recruit the future generation of militia airmen.

After several years of the Army and Air Force coordinating to determine how many C–27J's would be required to provide direct "last tactical mile" airlift support for the Army, and homeland response capabilities for the ANG, the Joint Requirements Oversight Council (JROC) validated that 78 aircraft were necessary to fill this requirement. However, subsequently, the Secretary of Defense (SECDEF) seemed to "arbitrarily" change that number to 38, assigned the mission to the ANG, and justified the cut in C–27's to the Mobility Capabilities Requirements Study 16 (MCRS) that had identified an excess of 40 older C–130's. Unfortunately, the MCRS had not included the C–27 direct support mission in this study. When the total number of C–27's were reduced from 78 to 38, this caused the Air Force to also reduce the number of aircraft based in any one location from the standard 8 Primary Assigned Aircraft (PAA) per unit to 4, which hampers effective training and operations. Additionally, since the Army has declared that "fixed wing aviation is not a core competency," the Pentagon is also divesting the ARNG of its aging C–23 fleet before the ANG will be in a position to provide comparable airlift support stateside, since it will be focused on fulfilling its combat mission in the Middle East.

Although the USAF has finally selected a new tanker aircraft, to date, it is unclear where these aircraft will be stationed.

Finally, even though the Army does not consider fixed-wing aviation to be a core competency, logic tells us that some level of fixed-wing capability makes economic and functional sense as a niche mission, which has always been acknowledged and authorized under Joint Doctrine. And, even though the ANG may fully commit to providing direct support (primarily during combat operations), there will always be "pop up" missions, both stateside and deployed, that would justify a small fleet of fixed-wing support aircraft for the ARNG. Thus, a program to replace the aging C–12 and C–26 aircraft with a fleet of new light aircraft to take on this requirement should be pursued.

The Added Value of Citizen Soldiers and Airmen

The true strength of the National Guard is in its people. It's our citizen soldiers and airmen who juggle two jobs and a family life are invaluable to our Nation's defense. An unrivaled blend of civilian and military skills ensures that our members are effective when conducting missions abroad and at home.

The National Guard supports programs unmatched to other Active and Reserve Components. Members of the National Guard actively work on global engagement

programs, domestic support programs and youth programs to improve our communities.

The State Partnership Program (SPP) was created in 1993 with only a handful of partner nations. Today, these mutually beneficial relationships are established with more than 60 foreign nations. They work together to improve regional security, stability and prosperity. The fiscal year 2012 President's budget request creates a shortfall of $12 million for the SPP.

The Agribusiness Development Teams (ADT) is another great example of the National Guard's fusion of military capability and civilian skills. The ADTs are working with the Afghan Ministry of Agriculture, Irrigation and Livestock to educate and train Afghan farmers in modern agriculture methods and techniques. These efforts will undoubtedly increase the quality of life and economic stability for the region while leading to improved opportunities for the Afghanistan agriculture community.

The domestic support realm ranges depending on the immediate needs of the regions and the longer term outcomes that they will produce. The National Guard has successfully supported the Southwest border security mission during Operation Jump Start from 2006–2008 and has continued to assist the U.S. Customs and Border Protection, Department of Homeland Security and the Immigrations and Customs Enforcement. Along with border security, National Guard members are assisting these entities by engaging in counter-narcotic missions on the Southwest border.

The National Guard's Counter Drug Programs help local law enforcement agencies with analysis and ground support resulting in tens of billions of dollars worth of drugs, property, weapons and cash each year. The National Guard's Training Centers in Mississippi, Florida, Iowa, Pennsylvania, and Washington train over 100,000 military personnel, law enforcement officers, and interagency members each year. The fiscal year 2012 funding shortfall for the Counterdrug Program is $75 million.

When a crisis occurs, whether man-made or natural, the National Guard is ready to respond. National Guard members have responded to an unprecedented number of devastating tornadoes across the Nation in from Alabama to Massachusetts, including the town of Joplin, Missouri; they are currently performing flood relief missions in Arkansas, Louisiana, Mississippi, Montana, North and South Dakota, Nebraska, Vermont and Wyoming; and just a few months ago they were fighting wildfires over West Texas with their C–130Js from the California ANG.

The National Guard has designed structured response packages which are scalable to provide tiered response to local, State, regional or national level chemical, biological, radiological, nuclear, or explosives (CBRNE) incidents. In addition, the National Guard is working with the Department of Defense to stand up 10 Homeland Response Forces (HRFs). These HRFs will consist of 566 personnel and provide life saving capabilities during emergencies, bridging the gap between the initial National Guard response and Title 10 capabilities.

Our citizen soldiers and airmen are dedicated to improving their communities and our Nation's future. This is why the National Guard Youth ChalleNGe Program exists. The NGYCP is an award winning, community based program which mentors high school dropouts and leads them to become successful and productive citizens and lead successful and fulfilling lives. Since 1993, the NGYCP has graduated over 95,500 students and saved over $175 million annually in juvenile correction costs.

Conclusion

In today's fiscally challenged environment, it is imperative that our Nation looks to our cost effective and mission proven National Guard as a solution to maintain our high level of national security at an affordable cost. As America's first military organization, the National Guard has proven for 375 years that it is "Right for America." With the continued support of Congress, the National Guard will emerge as an even more cost-effective and mission capable force in the future.

Chairman INOUYE. Thank you very much, General Hargett.

Senator Cochran.

Senator COCHRAN. You may have mentioned this in your statement and I didn't notice the specifics, but is the National Guard being called on for deployments at this time in any conflict going on anywhere outside the United States?

General HARGETT. Yes, sir. There are still guardsmen in Iraq, Afghanistan, and Kuwait, and probably Kosovo and other places around the world.

Senator COCHRAN. Do you have any estimation or any indication—you can't predict when the war's going to be over and we can come home and declare victory, but what do you hear from people you trust about the future for the Guard's deployment? At some point you're going to have to say, hey, wait a minute, we don't have anybody to send.

General HARGETT. I predict that we will be deploying guardsmen long into the future. I think we're an integral part of the force and I think to continue to even do the peacekeeping operations we will continue to deploy some guardsmen.

Senator COCHRAN. It seems to me that, with the continued pressures and strains on family relationships and unpredictability of deployment schedules, how you can maintain a job at home, in the traditional sense of the Guard and Reserve being mobilized for emergencies only, things that aren't anticipated or couldn't be handled by regular forces—do you see any breakdown in the system?

General HARGETT. You know, as the former Adjutant General of the Tennessee Guard, I can speak for Tennessee. But I will tell you that the one thing that's unrecognized in what we have done for the last 10 years are the families and employers who have—I will tell you that I think the guardsmen are willing to do this forever. I think the strain will be families and employers as we go forward, and I think we've got to have programs that take care of families, programs that take care of employers, and look toward the future.

But I think continued use of the Guard and Reserve can easily be accomplished with the proper programs with employers and families involved in those programs.

Senator COCHRAN. Well, I know just from my personal experience, my son was a National Guard officer in the Mississippi Army National Guard and he loved it and was ready to go any minute, anywhere. I think that's an indication of the way most people felt in our State. I just wonder how long they can sustain that, though, and manage family, homes, careers, which is what they do.

But thank you very much. It's a real compliment, I think, to those who are involved in the Guard and continue to make it an important force for our national security.

General HARGETT. Thank you.

Senator COCHRAN. Thank you for your service.

Chairman INOUYE. Thank you.

Senator Shelby.

Senator SHELBY. I just appreciate his appearance here and his testimony. All of you, I think this has been a good hearing. I know you've had limited time, but we're going to absorb a lot of this.

Thank you, Mr. Chairman.

Chairman INOUYE. Thank you.

Mr. Lumme.

STATEMENT OF DALE LUMME, NATIONAL EXECUTIVE DIRECTOR, NAVY LEAGUE OF THE UNITED STATES

Mr. LUMME. Chairman Inouye, Ranking Member Cochran, distinguished members of the subcommittee: Thank you for the opportunity to appear before you today to discuss the most urgent needs of our sea services and maritime industry. As a retired Navy captain and naval aviator, and on behalf of the thousands of world-

wide members of the Navy League, I would like to thank this subcommittee for its diligent stewardship and oversight of the sea services. I think, as witnessed by Chairman Inouye receiving the highest Navy League award 3 years ago for his maritime stewardship and then the reigning Navy League Award winner Senator Cochran, thank you for your service to the Navy, Marine, Coast Guard, and flag merchant marine.

The Navy League is a nonprofit civilian organization whose mission it is to educate the American people about the enduring importance of sea power to a maritime Nation and to support the men and women of the United States sea services. Since the Navy League's founding in 1902 with the support of President Teddy Roosevelt, the organization has vigorously promoted America's maritime interests through our strong advocacy of our sea services, the U.S. flag merchant marine, Coast Guard, Marine Corps, and Navy.

President Roosevelt asserted that a Navy could justify its existence only by the protection of maritime shipping. He stated that "True national greatness has in all ages and in all countries throughout the world been based upon waterborne commerce."

Just this past weekend, in response to the President's weekend address, North Dakota Senator John Hoeven stated: "Over 100 years ago, President Roosevelt launched a Navy mission known as the Great White Fleet on a voyage around the world. President Roosevelt's leadership put the world on notice that the United States was a global maritime Nation open for business."

The Navy League strongly believes that a vibrant U.S. maritime industry is a critical part of our national security and now a vital part of our economic recovery. Navy veteran President John F. Kennedy in June 1963 aboard the USS *Kitty Hawk* stated: "Recent events have indicated that control of the sea means security, control of the seas can mean peace, and the United States must control the seas to protect its own national security."

Over the last 20 years, a disturbing trend has emerged. We continue to ask our sea services to do more and more for our country, yet the size of our naval fleet continues to shrink. The Congress has heard recent testimony that our Navy is at its lowest level since 1916.

It is not the job of the Navy League to advise the U.S. Congress how to tackle our national debt crisis, but it is the job to pass appropriations bills and not continuing resolutions. The Navy and Marine Corps and Coast Guard is still recovering from the continuing resolution from fiscal year 2011 and we implore upon you for fiscal year 2012 not to pass another continuing resolution to harm our combat readiness.

It may appear an easy way to cut spending is to cut defense and big procurement items like ships and aircraft, and that may be considered some of the easiest targets. The national security of the United States depends on a Navy with sufficient number of ships to maintain a forward global presence critical to the U.S. economy and the protection of our democratic freedoms that we take for granted.

The number one problem facing the United States Navy today is the lack of a fully funded, achievable shipbuilding program that

produces the right ships with the right capabilities for the right cost, in the most cost-efficient, economic quantities. The Navy League of the United States fully supports rebuilding the fleet to a goal, as recently stated by the Secretary of the Navy, of 325 ships to properly execute the maritime strategy.

The Navy League also supports pursuit of multi-year procurement strategies for the MH–60 helicopter, continued acquisition of the F–35 to replace the AV–8, the acquisition of an affordable combat vehicle to replace the aging and costly amphibious assault vehicle, and, importantly, supports the sustainment of a significant deterrent capability of our ballistic missile submarine forces, including the replacement of the Ohio class submarines, and strongly believes this should be funded on a national imperative outside of the Navy's FCN. The Navy is buying what they can afford, not what our Nation's security needs.

The CNO recently commented at a current strategy forum: "It is our persistent forward presence that allows for speed and flexibility of response for our Nation that has been called upon repeatedly over the last 2 decades, and most recently in ongoing ops in Libya and Japan."

The Secretary of the Navy recently commented that: "Sometimes the U.S. Navy-Marine Corps team follows the storm to the shore and sometimes it must bring the storm." The United States is a maritime Nation with global responsibilities. With a forward-engaged naval tradition as a foundation of our existence, the Navy-Marine Corps team is inseparable.

The future success of shipbuilding and many of our Navy programs is contingent upon our Nation's support of science, technology, engineering, and math education programs. The Navy League strongly supports additional funding levels for STEM and is working to support efforts to expand this program through our Navy Sea Cadets and Worldwide Councils.

In conclusion, America is a maritime Nation and must maintain its status of maritime superiority if there is to be peace and prosperity and economic prosperity throughout the world.

Thank you for your continued support of America's sea services.

[The statement follows:]

PREPARED STATEMENT OF DALE LUMME

Chairman Inouye, Ranking Member Cochran, distinguished members of the Subcommittee, thank you for the opportunity to appear before you today to discuss the most urgent needs of our sea services and maritime industry.

On behalf of the 50,000 members of the Navy League worldwide, I would like to thank this committee for its diligent work to ensure our sea services are provided with the very best our country can give them.

The Navy League is a nonprofit civilian organization whose mission is to educate the American people and their leaders about the enduring importance of sea power to a maritime nation, and to support the men and women of the U.S. sea services.

Since the Navy League's founding, in 1902, with the support of President Theodore Roosevelt, the organization has vigorously promoted America's maritime interests through our strong advocacy of all the sea services—to include the U.S.-Flag Merchant Marine, the U.S. Coast Guard, the U.S. Marine Corps and the U.S. Navy—and the industries that support them.

The founding direction of the Navy League—adopted 109 years ago—is still appropriate today. The Navy League mission strongly supports the long-standing U.S. policy that a viable U.S. maritime industry is a critical part of our national security and now a vital part of our economic recovery.

President Roosevelt asserted that a navy could justify its existence only by the protection of maritime shipping. He described the sea as a network of trade routes, and stated that true national greatness has, in all ages and in all countries throughout the world, been based upon waterborne commerce.

It is the Navy League's firm belief that providing for maritime security is—and must always be—the first and most important cornerstone of national security.

However, over the last 20 years, a disturbing trend has emerged. We continue to ask our sea services to do more and more for our country, yet the size of our naval fleet continues to shrink and plans to fund and rebuild naval platforms continue to be plagued by unchecked cost growth and significant construction delays. The security and prosperity of our Nation lies in our ability to protect and defend our people, our shores and our economic interests at home and abroad. Until we change the tone of the conversation on the industrial base and future readiness from "like to have" to "urgent priority," we may be putting the security and prosperity of the American people in jeopardy.

With respect to the Navy League's support of the United States Navy

The number one problem facing the Navy today is the lack of a fully funded, achievable shipbuilding program that produces the right ships, with the right capabilities, for the right costs, in the most cost effective economic quantities.

The goal of a 325-ship Navy is a long way from reality, but as we have seen in recent operations this Nation's fleet is in high demand on a daily basis.

Our fleet already is stretched to the breaking point and it will become more difficult to react rapidly to humanitarian and disaster situations and stand ready to defeat aggression. The United States will not be able to meet all of our global commitments as the number of ships continues to decline.

In order to provide our Nation with the maritime security capability needed to meet our global commitments, our Shipbuilding and Conversion, Navy (SCN) account should be funded at $25 billion per year (or more) to achieve a force level of 325 ships.

A 325-ship Navy is not just a number. It means hulls with the capability to maintain presence, project power and influence events. They must be capable of prevailing in conflict, whether alone or as part of a task force.

The fleet must have sufficient aircraft of the right mix, and key to that requirement is getting the next-generation fighter/attack aircraft—the carrier variant and the short take-off and vertical-landing (STOVL) variant of the F–35 Lightning II, also known as the Joint Strike Fighter (JSF)—operational in numbers. The timely delivery of the JSF, along with the recently extended multiyear buy of F/A–18E/F Super Hornet multirole fighters and EA–18G Growler airborne electronic attack aircraft, will help close the projected strike fighter gap in the latter part of this decade.

Finally, it is vitally important that the Navy maintain a credible cyber force and develop leap-ahead, interoperable and resilient capabilities in cyberspace to successfully counter and defeat a determined, asymmetric threat.

Chief of Naval Operations Admiral Gary Roughead recently commented at the Current Strategy Forum in June 2011 that:

The Navy's forward presence and flexible range of capabilities gives our Nation options to remain globally engaged with partners, and ensure our access wherever our Nation's interests might dwell.

While our ships are able to surge on short notice, it is our persistent forward presence that allows for the speed and flexibility of response the Nation has called upon repeatedly over the last two decades, and most recently in ongoing operations in Libya and Japan.

Specifically, the CNO stated:

"Off Libya, deployed ships and submarines broke off their patrol and maritime ballistic missile defense missions to deliver tomahawk missiles against radar and command and control sites, creating in short order the conditions under which a no-fly zone could be imposed.

"Off Japan, the deployed Ronald Reagan Strike Group responded immediately to the natural disaster there, with helicopter flights to deliver humanitarian aid and medical capabilities, with nuclear expertise and heavy lift to participate in the relief effort."

The Navy League of the United States:

—Fully supports rebuilding the fleet to a level of 325 ships to properly execute the Maritime Strategy and, inclusive in this ship count, should be not less than: 11 aircraft carriers; 38 amphibious ships, four more if the Global Fleet Station concept is adopted; 48 attack submarines; and 55 Littoral Combat Ships (LCSs).

—Supports the sustainment of a minimum of 10 carrier air wings, including the continued multi-year procurement of the F/A–18E/F Super Hornet, the pursuit of multi-year procurement strategies for the MH–60 helicopter and the E–2C/D Hawkeye airborne early warning (AEW) aircraft, and full development and follow-on procurement of the F–35 Lightning II.
—Supports the continuing development, procurement and deployment of the Navy portion of the Ballistic Missile Defense System, including long-range surveillance and tracking capability to queue ground-based intercept systems and, ultimately, the ability to detect, track and engage medium and long-range ballistic missiles well distant from the United States.
—Supports the sustainment of the significant deterrent capability that our ballistic-missile submarine, or SSBN, force offers, including the replacement of the Ohio-class SSBNs at the rate of one per year, which should be funded as a national imperative outside of the Navy's SCN plan.
—Strongly supports the acquisition of two new Virginia-class submarines per year.
—Supports maintaining two U.S.-owned sources for building Navy submarines, and maintaining a teaming agreement for constructing Virginia-class submarines wherein one shipyard serves as the prime contractor and the other serves as its major subcontractor.
—Supports the Navy's LCS acquisition strategy to select 10 units of each hull form, based on sea trials and operating experience of the initial hulls, to attain the unique attributes of each for the LCS class.
—Supports the P–8A Multi-mission Maritime Aircraft and Broad Area Maritime Surveillance System, which will contribute surveillance data to Maritime Operations Centers and Regional Operations Centers. These centers will fuse information for dissemination to Navy, Coast Guard and Joint Force Maritime Component Commanders and our allies for military and counterdrug operations.
—Supports the continuing integration of unmanned aircraft systems (UASs) into the fleet, including the expansion of the deployment of the MQ–8B Fire Scout vertical takeoff unmanned aerial vehicle, and deploying an unmanned aircraft squadron on an aircraft carrier at the earliest opportunity.
—Believes that increased emphasis and funding is required to allow Navy and Coast Guard operations in the polar regions to protect our access to natural resources as well as preclude these regions from becoming sanctuaries for potential adversaries. Communications, logistics, ship and aircraft modifications are essential for such operations.
—Supports continued funding for Combat Logistics Force assets, including oiler/ammunition carriers and dry cargo/ammunition carriers; large, medium-speed roll-on/roll-off ships; and new classes of special mission vessels, all of which will be employed in the Maritime Preposition Force (Future) squadrons.
—Urges that naval C^4ISR systems have increased levels of information flow, resource assignments and adaptability, and that procurement processes be modified to ensure the rapid insertion of new technology.
—Supports Navy emphasis on cyber warfare to ensure the viability of our C^2 systems even in the face of increased cyber attacks.
—Supports rapid passage of the United Nations Convention on the Law of the Sea, or Law of the Sea Treaty, which seeks to establish a comprehensive set of rules governing the oceans.

With respect to the Navy League's support of the United States Marine Corps

The United States is a maritime nation with global responsibilities. With a forward engaged naval tradition as the foundation of our existence, the Navy-Marine Corps Team is inseparable. The forward presence allows for the Navy-Marine Corps Team to build relationships around the globe. But, we must remember, countries, like mothers-in-law, are happy to see you come, but you are just as happy to see you go.

The Navy-Marine Corps Team's persistent forward presence and multimission capability present an unparalleled ability to rapidly project U.S. power across the global commons—land, sea, air, space and cyber.

Amphibious forces with robust and organic logistical sustainment bring significant advantages, including the ability to overcome the tyranny of distance and to project power where there is no basing or infrastructure—a strong deterrent capability for our Nation. To Marines, "expeditionary" is a state of mind that drives the way they organize, train, develop and procure equipment.

By definition, the role of the Navy-Marine Corps Team as America's crisis response force necessitates a high state of unit readiness and an ability to sustain ourselves logistically.

The Corps must regain its expertise in amphibious operations and maintain that capability in force structure. The service also must be provided the resources to reset the force; restore or acquire anew the equipment capabilities consumed in the ongoing wars; and field the F–35B STOVL variant, develop a new, affordable Amphibious Combat Vehicle and field sufficient amphibious lift, starting with an additional LPD 17.

The new Marine Armor System, the up-armored High Mobility Multipurpose Wheeled Vehicle (or Humvee), the Marine Personnel Carrier and the Joint Light Tactical Vehicle will be instrumental in achieving these goals. To enhance the forcible-entry ability, the Corps must develop the expeditionary fighting vehicle replacement vehicle, the Amphibious Combat Vehicle.

Significant support is needed for weapon improvements for the MAGTF, particularly in the 155 mm Howitzer, the High Mobility Artillery Rocket System (HIMARS) and Naval Surface Fire Support.

Within Marine Aviation, the F–35B STOVL variant of the Lightning II, the MV–22 Osprey tiltrotor, the CH–53K heavy-lift helicopter, the UH–1 and AH–1 helicopters will provide the MAGTF commander with unsurpassed warfighting capability.

The combatant commanders (COCOMs) multiple missions require more than the planned number of amphibious ships to meet their demand for forward presence and crisis response. At a minimum, 38 amphibious ships are needed to provide an adequate number of Expeditionary Strike Groups (ESGs) and Marine Expeditionary Units, deploy naval forces in single ships as Global Fleet Stations and provide adequate time for training and maintenance.

The COCOMs know that in a natural disaster or humanitarian crisis, a large-deck amphibious ship is the most utilitarian platform in the naval fleet. The Amphibious Force brings helicopter lift, mobile communications, medical and engineering, all the capabilities most needed in a humanitarian assistance or disaster relief scenario.

The Nation requires a fleet of amphibious ships to support the forcible entry amphibious force of two brigades. In light of fiscal constraints, the Department of the Navy stated that it will sustain a minimum of 33 amphibious ships in the assault echelon. Amphibious capability demands sea basing and the Maritime Prepositioning Force. Protecting U.S. interests around the globe and forcible entry are directly tied to these amphibious capabilities.

The Navy League of the United States supports:

—The full funding of costs associated with resetting the force to meet current and future requirements.

—The acquisition of an affordable amphibious combat vehicle to ensure we have the ability to maneuver against adversaries that are becoming increasingly capable, and to replace the aging and costly Amphibious Assault Vehicle force.

—The continued acquisition of the F–35B to replace the AV–8 Harrier and F/A–18 Hornet aircraft, and the acquisition of unmanned air and ground systems to further enhance the flexibility, mobility and versatility of Marine Corps forces.

—Adequate Navy shipping and sealift platforms to provide the expeditionary lift to support present and future COCOM requirements.

—Continued full-rate production of the MV–22 Osprey. Recent successful deployments to Afghanistan of the MV–22 reinforce the immediate need for this capability for both the Marine Corps and U.S. Special Operations Command.

—The recapitalization of the workhorses of Marine Corps aviation—the KC–130J aircraft, equipped with an improved aerial refueling system, and the CH–53K, and the acquisition of UH–1Y Huey and AH–1Z Super Cobra helicopters.

—The acquisition of modern air, ground and logistics C^2 systems such as Combat Operations Centers, the Joint Tactical Radio System, the Common Air C^2 System, Joint Tactical Common Operational Picture Workstation and the Global Combat Support System to support joint and coalition operations.

—The successful and continuous armor upgrades of vehicles as well as anti-sniper technology and anti-improvised explosive device technologies.

—The continued acquisition of MAGTF fires improvements, particularly in the 155 mm Howitzer and HIMARS, and sufficient naval surface fire for joint forcible-entry operations.

—The ongoing reconstitution and modernization efforts in the wake of the extremely demanding rotation cycle of personnel and equipment in Afghanistan.

—The transition to network-centric expeditionary forces able to execute the war on terrorism with ready, relevant and capable forces, supported by ISR assets that strengthen joint and combined capabilities, ensure presence and provide surge.

With respect to the Navy League's support of the United States Coast Guard

The U.S. Coast Guard, the 5th Armed Force, is the lead agency for maritime homeland security. The USCG is in the process of determining operational requirements for the Offshore Patrol Cutter, and then will build the ships as soon as feasible to replace outdated and unreliable Medium Endurance Cutters. The total requirement is for 25 vessels delivered at two per/year.

Global climate change is opening up polar sea lanes, highlighting competing territorial claims. Therefore, it is essential that responsibility for ensuring our national sovereignty and interests in the Polar Regions is assigned appropriately to the U.S. Coast Guard.

The NLUS Supports the transfer of icebreaker maintenance funds from the National Science Foundation to the Coast Guard. The need for a robust presence in the polar regions is supported by the Joint Chiefs of Staff to accommodate security and sovereignty concerns. The first step is to put the management of the Nation's icebreaking capability where it belongs—with the Coast Guard.

With respect to the Navy League's support of the United States Flag Merchant Marine

A strong commercial U.S. Flag Merchant Marine is more critical than ever.

95 percent of the equipment and supplies required to deploy U.S. forces is delivered by U.S. flagged and government owned vessels, manned by U.S. citizen mariners.

The Navy League of the United States supports the Jones Act and the Passenger Vessels Services Act which requires U.S. built ships and U.S. citizen crews—because they protect critical national infrastructure and provide added sealift capacity, are important to economic and national security.

The recapitalization of the ready reserve force (RRF) is vitally important to our maritime industry. The RRF should not be cut back until sufficient replacement capacity and capability are available.

A strong strategic sealift merchant reserve component is needed in the U.S. Navy to ensure that critical mariner skills and experience are retained to support Navy and strategic sealift transportation.

The Navy League of the United States supports combined government and industry efforts to counter piracy by introducing new technologies, and if requested by the shipping companies, placing armed guards aboard ships to prevent boardings.

SHIPBUILDING

The Navy continues to struggle to meet its operational demand for deployable warships. The Navy deploys as many ships today as it did in the early 1990s, but with only two-thirds the number of ships in the fleet. The Navy is hard pressed to match and outpace threats from ballistic missiles, cruise missiles, aircraft and submarines.

All three of the U.S. Navy's fleets—the fleet in planning, the fleet in construction and the fleet in being—are stressed with budget limitations.

Good news lies with the success of aircraft carrier construction and the midlife refueling overhauls of the existing Nimitz class. The Virginia-class submarine construction continues with two boats a year authorized and funded beginning in 2011.

The Ohio SSBN replacement is under design, with efforts to restrain costs and still meet the expected operational demands. This development and construction program, if allowed to remain in the Navy's SCN funding accounts, will create havoc with other vital construction programs. These costs should be funded independently as a national strategic investment.

Major shipyards along the gulf coast have suffered from modest amounts of facility modernization and significant storm damage repair over the past decade. These shipyards must be able to plan on a sustainable and predictable workload, which will provide the revenue to support a trained work force, and facilities needed to construct our fleet.

Along with constructing and supporting the Navy fleet, these yards, with the Naval Sea Systems Command, must support and cooperate closely with the U.S. Coast Guard, Military Sealift Command and MARAD. The plans, best practices, procedures, and research and development all must be shared with the industrial base. There also must be development in the domestic oil and gas industry's emergency response capability, sufficient to handle large and small oil spill response, such as the Deepwater Horizon oil spill.

The shipbuilding industry needs increased investment in maritime research and development that includes dual-use vessels for America's Marine Highway System,

with military-useful capabilities that can be called upon for DOD strategic sealift capability.

The Navy must continue to strengthen and improve research and reassess its design, procurement and integration processes to produce affordable, combat-credible and survivable surface ships and submarines. Research is vital to the future fleet and its capabilities.

The Navy League of the United States supports:

—An increase of shipbuilding funds to the level of at least $25 billion per year, with the associated research and development dollars to fund the requirements and design work that precedes contracting for ship and submarine construction.

—Ensuring that the funds for the SSBN(X), the Ohio-class submarine replacement, are provided as needed outside of the Navy's SCN budgets to preclude the disruption and delay of other vital shipbuilding programs.

—Adequate funding to recover and continue to build and sustain a vital organic Navy Shipbuilding Technical Authority, including a robust design and research capability and capacity, which has dwindled and remains at a reduced and inadequate size.

INDUSTRIAL BASE

The industrial base that services this Nation's Sea Services is, at best, stagnant and most likely declining. This is cause for great concern because it inhibits efficient ship construction, ship repair (battle damage) and ship modernization in a time of increased tension or crisis. It also inhibits price and technical competition, which results in paying more for goods and services and acquiring less advanced equipment and systems for warships and aircraft.

The Navy and Coast Guard are only purchasing what they can afford—not what they require to meet fleet needs. Our stocks of spare parts are reduced in number and our critical battle spares (shafts, propellers, reduction gears) are nearly nonexistent. The same limited availability of combat system components, such as weapon launchers, guns and sensors, would preclude our performing meaningful battle damage repairs and restoration, which with a small fleet is an important capability.

The only practical source of this equipment today is found in the new-construction shipyards. The manufacturing lead time is extensive, therefore we need spares. The defense supply system stocks little if any of the critical steel, aluminum, piping and electric cable needed for major repairs.

The labor pool possessing the critical skills necessary to produce our equipment and systems and construct our warships is aging, with key personnel leaving and not being replaced in kind. Ship construction and related industries are not viewed by today's younger generation as a viable career path.

The key element to achieving on-time and on-price production for our technically advanced systems and ships is a trained and dedicated workforce. These shortages result in the all-too-common poor performance experienced in shipyards and manufacturing plants. The only solution is additional training and education at all levels. We are especially stressed with the low number of experienced ship design personnel and senior managers within the Navy and in industry.

The future success of shipbuilding and many other Navy programs is contingent on our Nation's support of Science, Technology, Engineering, and Mathematics (STEM) education programs. According to the Office of Naval Research, more than 30 percent of current DOD Science and Technology professionals are expected to retire within the next 9 years.

STEM education equips our next-generation Sailors, Marines, scientists, architects, and engineers with the tools they need to develop new technologies and platforms that will defend America in the future.

The National Science Foundation notes that roughly half of all U.S. economic growth over the last 50 years was the product of scientific innovation. It is vital to our economic and national security that we encourage and support math and science education programs at all levels. A host of programs have been designed and funded in STEM disciplines in order to reach kids in middle school and high school and inspire them to explore the opportunities and rewards that exist with a technical major.

From its beginnings, the U.S. Navy has been a leader in leveraging technology and developing science-based solutions to defend U.S. interests. Today's investments in science and technology research will help the Navy maintain its edge as the high-tech service of the future. The Navy League supports additional funding levels for STEM and is working to support efforts to expand this program.

Global trade is still robust, yet our own foreign commerce is carried in mostly foreign-built and foreign-crewed ships. A modest increase, beyond Jones Act construc-

tion, in commercial shipbuilding would give a substantial boost to our shipyards and marine vendors.

Facilities at the larger shipyards in the United States are capable of constructing merchant ships as well as warships, but cannot match the costs, schedules and efficiencies of shipyards in Europe and Asia. On the other hand, U.S. yards construct and equip the best warships, aircraft carriers and submarines in the world. They are unmatched in capability, but are struggling to maintain that lead.

No nation can support and sustain a capable and sizeable Navy without a strong and sustaining industrial base manned with adequate numbers of skilled personnel. It is essential that this Nation have a policy at the highest levels of government to support and sustain an adequate industrial base capable of providing and supporting a strong Navy and maritime commerce.

The Navy League of the United States urges:

—The U.S. Government to develop and institute an effective industrial base policy that addresses critical issues such as the development of improved ships, ship systems and weapons with the capacity to annually produce multiple ships of a class and the capability to increase capacity rapidly in time of national need or emergency.

—An increased and stable level of predictable funding for the ships, submarines, aircraft and combat systems that are the essential elements of our fleet. The cost of these programs continues to rise beyond normal inflation rates, which is linked to low production rates and unstable funding. Improved staffing, additional research and stable programs with a reasonable annual production rate will help contain rising costs. Costs are related to schedule and, at present, our production times are excessive and should be reduced. A strong industrial base will assist in achieving affordable pricing for the Navy's programs.

—Capital investments in our existing infrastructure to allow us to stay abreast of the latest technological advances, attract the best young engineers and skilled workers, and ensure that we have the capability and capacity to surge repair, produce and construct the nation's fleet in time of crisis.

—Expanded use of advanced acquisition strategies, including block buys, multiyear-priced options with innovative funding approaches, such as time-phased and advanced appropriations that stabilize accounts and avoid disruptive funding spikes and voids.

—Support of the provision included in the fiscal year 2012 National Defense Authorization Act that allows the Secretary of the Navy the authority of advance purchase of major components during construction of the next two Ford-class aircraft carriers and to achieve cost savings by entering into multiyear advance procurement agreements.

—Adopting incentives to cut costs and schedules and reward firms that achieve significant savings in both money and time, while maintaining quality. This will create an environment in which high-performing companies can achieve returns on capital comparable to those commercial enterprises of similar risk and capitalization. Contracts should be structured so that earning higher fees for higher performance is achievable.

RESETTING OUR FORCES

The national imperative to reset our Maritime Forces requires, not only the replacement of equipment, but also demands the continued effort to attract, train and retain intelligent and capable men and women.

The resetting of our Maritime Forces requires the will of the American people, the President and Congress to commit the necessary resources to be prepared for our Nation's next battle. We can no longer demand more from an already stressed manpower pool to respond to worldwide disasters while redeploying to war zones and maintaining a high operational tempo.

Combat operations have been continuous and equipment has been subjected to intense use in harsh environments. Aside from the requirement to buy new equipment for the increased end strength, the entire force needs extensive rehabilitation, repair and replacement as weapons and equipment are rotated out of combat.

Likewise, prepositioned stocks and training base stocks must be replenished. The current reset cost estimate exceeds $15.6 billion, of which only about $10.9 billion has been funded. As the fight continues, the reset costs for equipment and training will increase apace, and Congress needs to understand and support this requirement.

As the Marine Corps modernizes its combat forces, funding must be continued for individual survivability programs, to include personal protective equipment, lighter-weight gear and modern force-protection systems. Ground mobility must be im-

proved to provide the Marine Corps the capability to effectively operate across the mission spectrum yet remain tailored in size to be deployable and employable.

Navy League Community Service

Every year, the Navy League participates in countless activities that support service members and their families. Highlights of some of the accomplishments of the Navy League this past year include:

—$1,395,712 was given by Navy League of the United States to support the members of the sea services and their families.
—Navy League supported 1,545 Welcome Home Receptions, Holiday Parties, Child Care, R&R Programs, Ship Dinners and Luncheons and BBQ's totaling $603,046.
—Navy League adopted or supported 401 Navy, Coast Guard and Merchant Marine ships and Marine Corps units in 2010.
—Navy League organized or provided substantial support for 16 Navy and Coast Guard ship commissioning ceremonies.
—1,925 Sea Service Awards were given in 2010 totaling $185,720.
—$41,970 was given in support of 546 transitioning sea service members and their families.
—$230,227 was provided to 146 Sea Cadets.
—$103,158 was provided to 415 JROTC units.
—$112,981 in scholarships were given to 71 sea service youths.
—Over $20,000 worth of care packages were sent to the USO and troops overseas.
—Over 1 million paperback books have been sent to Operation Paperback for overseas military personnel.

Additionally, the Navy League of the United States is the sponsor of the Naval Sea Cadet Corps (NSCC). The Sea Cadets were founded by the Navy League in 1958 at the request of then-CNO Admiral Arleigh Burke. The goal was to establish a youth organization that would "create a favorable image of the Navy on the part of American youth." The Naval Sea Cadet Corps was subsequently chartered by Congress in 1962 as a nonprofit, civilian development and training organization for youth ages 13 through 17, sponsored by the Navy League and supported by both the U.S. Navy and U.S. Coast Guard.

The Sea Cadets recently signed a Memorandum of Understanding with the Coast Guard Auxiliary for training and support, and have also discussed Sea Cadet participation in the activities of NOAA. Included under the NSCC umbrella is the Navy League Cadet Corps, a junior program for children ages 11 through 13. The NSCC program has grown nationally to 10,487 participants in 387 units in all 50 States, Guam and Puerto Rico. The program is run by volunteers with the objective of developing within youth an interest and skill in seamanship and seagoing subjects; developing an appreciation for our navy's history, customs, traditions and its significant role in national defense; developing positive qualities of patriotism, courage, self-reliance, confidence, and pride in our Nation and other attributes which contribute to development of strong moral character, good citizenship traits and a drug-free, gang-free lifestyle; and to present the advantages and prestige of a military career.

Many cadets enlist in the services, estimated at about 2,000 per year from an eligibility pool of about 20,000. Admiral Roughead recently indicated that every ex-Sea Cadet that enlists in the Navy represents a $14,000 saving in recruiting costs to the Navy. We are very proud that over 12 percent of the current brigade of Naval Academy Midshipmen are former Naval Sea Cadets.

CONCLUSION

Forward deployed forces provide a forward presence creating global engagements that are critical to the U.S. economy, world trade and the protection of democratic freedoms that so many take for granted. The guarantors of these vital elements are hulls in the water, boots on the ground and aircraft overhead.

Since "presence with the capability to engage" is the primary strength of the Sea Services, it is imperative that we fund an aggressive shipbuilding and modernization program. Sustained maritime superiority is paramount to supporting the American economy.

America is a maritime nation and must maintain its status of maritime superiority if there is to be peace and economic prosperity around the world. Secretary of the Navy Mabus recently commented that: "Sometimes the U.S. Navy-Marine Corps Team follows the storm to the shore—sometimes we must bring the storm".

In 2020, 40 percent of the U.S. Gross Domestic Product will be dependent on ocean shipping and maritime trade. Maritime superiority is essential to our economy.

The Navy League is committed to educating and informing, the senior leadership in the Executive and Legislative branches of the U.S. Government, as well as the media and the American people, of the continuing need for U.S. sea power, both naval and commercial, to protect U.S. interests throughout the world and ensure the Nation's economic well-being.

The most important "reform" that can be made in the field of national defense is to provide adequate funding for America's Sea Services, which are the greatest force for peace in the world.

Chairman INOUYE. Thank you very much, Mr. Lumme.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, thank you.

Thank you very much, Mr. Lumme, for your comments and observations. I know the Navy League is a voluntary organization of mostly former officers or enlisted active duty persons who have served in the U.S. Navy; is that right?

Mr. LUMME. Actually, it's not, sir. We only have 28 percent that are former military, so we have over 70 percent that are volunteers that had no military service at all.

Senator COCHRAN. How do you sell people on the fact that they ought to pay dues to the Navy League? What is the purpose of the organization?

Mr. LUMME. Our advocacy of the sea service is not only for the combat readiness and support of maritime—because we do flag merchant marine and Coast Guard also. We also support the families. We have individual augmentee programs, we have adopt a sailor programs, adopt a ship programs. Most of the ship commissionings that go on around the United States, Coast Guard and Navy, are done by the Navy League as a sponsor.

So we sell that because of patriotic support by the members who didn't join the military, but maybe want to help in other ways.

Senator COCHRAN. Well, I think that's admirable and I commend you for the work you do. I enjoyed serving in the Navy. We were lucky we weren't at war at the time. I might not have enjoyed it so much if somebody had been shooting at us or trying to sink our ship.

But the Navy has really done a great job in projecting power and a presence and influence throughout the world, I guess for the last—how many years? When did the Navy League start?

Mr. LUMME. The Navy League started in 1902.

Senator SHELBY. 1902. Quite a record of service and accomplishment.

Thank you.

Chairman INOUYE. Thank you.

Senator Shelby.

Senator SHELBY. Mr. Chairman, I just want to tell Mr. Davis I appreciate his testimony and appearing here today.

Chairman INOUYE. Our next witness is Mr. John Davis of the Fleet Reserve Association.

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

Mr. DAVIS. Chairman Inouye, Vice Chairman Cochran, and Senator Shelby: My name is John Davis and I want to thank you for the opportunity to express the views of the Fleet Reserve Association.

Ensuring adequate funding for the military health system is a top legislative priority for the association and very important to every segment of our membership. This is reflected in responses to the association's 2011 online survey, which revealed that over 90 percent of all active duty, reserve, retired, and veteran respondents cited healthcare access as a critically important quality of life benefit associated with their military service.

FRA opposes drastic TRICARE enrollment fee increases and opposed the 2006 proposed increase, which was up to $2,000 increase every year for TRICARE Prime and an estimated index which would cause an increase every year of about 7.5 percent.

The association opposes the current administration's proposal. Although it provides a modest increase in 2012, it does mandate further increases past 2012 based on an index that measures healthcare inflation and assumes a 6.2 percent increase every year.

The FRA prefers the TRICARE provisions in the House and Senate defense authorization bills. That, like the administration's proposals, provides a modest adjustment, $2.50 per month for individuals and $5 per month for families that are getting TRICARE Prime, and—and I can't overestimate this enough—in the out-years it provides a cap for any future increases that is no more greater than the percentage increase for the cost of living adjustment for retirees. This ensures that the military retirees' compensation will not be eroded by their healthcare costs in future years.

We are also thankful that there are no increases for TRICARE Standard, for their survivors, for TRICARE for Life, and of course for active duty military.

The House version also eliminates copays for mail order generic drug prescriptions. That is something that FRA has long supported.

FRA welcomes the administration's focus on creating an electronic health record for service members that can follow them to the Department of Veterans Affairs and for the rest of their life.

Notwithstanding the oversight limitations, adequate funding for an effective delivery system between DOD and VA to guarantee a seamless transition and quality of service for wounded personnel is very important to our membership.

The association notes that the administration has not proposed authorizing chapter 61 retirees to receive full military retired pay and veterans disability compensation, as it has done the last 2 years. FRA continues to seek authorization and funding of full concurrent receipt from all disabled retirees.

Family support is also important and should include funding for compensation, training, and certification for respite care for family members functioning as full-time caregivers for wounded warriors. These provisions were enacted in the fiscal year 2011 defense authorization and are similar to the Caregivers and Veterans Omnibus Health Care Service Act, S. 1963, that was enacted for the VA. Both acts improve compensation, training, and assistance for caregivers of severely disabled active duty service members.

FRA also supports the funding for a 1.6 percent active duty pay increase, which at least keeps pace with salaries in the private sector. If authorized, FRA supports funding retroactive eligibility for

early retirement benefit, to include reservists who have supported contingency operations since September 11, 2001.

Again, I want to thank you for allowing me to submit my views, the FRA's views, to this subcommittee.

[The statement follows:]

PREPARED STATEMENT OF JOHN R. DAVIS

THE FRA

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

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

FRA's mission is to act as the premier "watch dog" organization in maintaining and improving the quality of life for Sea Service personnel and their families. FRA is a leading advocate on Capitol Hill for enlisted active duty, Reserve, retired and veterans of the Sea Services. The Association also sponsors a National Americanism Essay Program and other recognition and relief programs. In addition, the newly established FRA Education Foundation oversees the Association's scholarship program that presents awards totaling nearly $120,000 to deserving students each year.

The Association is also a founding member of The Military Coalition (TMC), a consortium of more than 30 military and veteran's organizations. FRA hosts most TMC meetings and members of its staff serve in a number of TMC leadership roles.

FRA celebrated 86 years of service in November 2010. For nearly nine decades, dedication to its members has resulted in legislation enhancing quality of life programs for Sea Services personnel, other members of the uniformed services plus their families and survivors, while protecting their rights and privileges. CHAMPUS, now TRICARE, was an initiative of FRA, as was the Uniformed Services Survivor Benefit Plan (USSBP). More recently, FRA led the way in reforming the REDUX Retirement Plan, obtaining targeted pay increases for mid-level enlisted personnel, and sea pay for junior enlisted sailors. FRA also played a leading role in advocating recently enacted predatory lending protections and absentee voting reform for service members and their dependents.

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

OVERVIEW

Mr. Chairman, the Fleet Reserve Association salutes you, members of the Subcommittee, and your staff for the strong and unwavering support for essential programs important to active duty, Reserve Component, and retired members of the uniformed services, their families, and survivors. The Subcommittee's work in funding these programs has greatly enhanced care and support for our wounded warriors, improved military pay, eliminated out-of-pocket housing expenses, improved healthcare, and enhanced other personnel, retirement and survivor programs. This funding is critical in maintaining readiness and is invaluable to our Armed Forces engaged in a long and protracted two front war, sustaining other operational commitments and fulfilling commitments to those who've served in the past. But more still needs to be done.

A continuing high priority for FRA is full funding of the Military Health System (MHS) to ensure quality care for active duty, retirees, Reservists, and their families. FRA's other 2011 priorities include annual active duty pay increases that are at least equal to the Employment Cost Index (ECI), to help keep pace with private sector pay, retirement credit for reservists that have been mobilized since September 1, 2001, enhanced family readiness via improved communications and awareness initiatives related to benefits and quality of life programs, retention of full final month's retired pay for surviving spouse, and introduction and enactment of legislation to eliminate inequities in the Uniformed Service Former Spouses Protection Act (USFSPA).

The Association also supports additional concurrent receipt improvements to expand the number of disabled military retirees receiving both their full military retired pay and VA disability compensation as proposed in the administration's budget request from last year.

The fiscal year 2012 budget calls for a 1.6-percent active duty pay increase that equals the Employment Cost Index (ECI) and FRA supports that increase. The Association also supports efforts to reduce the so-called "Military Widows tax" imposed on beneficiaries whose Survivor Benefit Plan (SBP) annuity is offset by the amount they receive in Dependency and Indemnity Compensation (DIC), and if authorized, funding to support this change.

HEALTHCARE

Healthcare is especially significant to all FRA Shipmates regardless of their status and protecting and/or enhancing this benefit as noted above is the Association's top legislative priority. Responses to a recent FRA survey indicate that nearly 90 percent of active duty, Reserve, retired, and veteran respondents cited healthcare access as a critically important quality-of-life benefit.

The administration is proposing an increase to the TRICARE Prime annual enrollment fee from $230 to $260 for individuals and from $460 to $520 per retired family. Starting in 2013 the annual enrollment fee would be increased to keep pace with a medical inflation index. The proposal also eliminates pharmacy co-pays for mail-order generic drugs and increases the current retail formulary pharmacy $9 co-pay by $2 to $3. There are no proposed increases for TRICARE Standard, survivors, TRICARE-for-Life beneficiaries, and those who are medically retired. There are also no out-of-pocket costs for active duty service members. This proposed fee increase would represent a 13 percent increase in the TRICARE Prime annual enrollment fee in the first year and would apparently be indexed to Medicare Part B coverage cost increases in the out-years. FRA is opposed to using Medicare costs for disabled and 65 and older beneficiaries as a basis for adjusting premiums for military retirees age 38–64 that undoubtedly have lower healthcare costs than individuals under Medicare.

If approved, FRA believes future premium adjustments for TRICARE Prime beneficiaries under age 65 should be based on the Consumer Price Index (CPI) since military retired pay cost-of-living-adjustments (COLAs) are based on that measure. Any index in excess of the CPI would grind down the value of their retired pay and would counter the purpose of the COLA which to maintain the purchasing power of the beneficiary. The House Defense Authorization bill (H.R. 1540) authorizes the 2012 fees increase per the administration's budget, but limits further increases to no more than the annual COLA, and provides the requested changes to pharmacy co-pays.

The House Defense Appropriations Subcommittee bill provides $32.3 billion for the Military Health System (MHS) in 2012 which is $935 million more than the last fiscal year and $119 million more than requested by the administration. In conjunction with this, FRA strongly supports funding to fully implement bidirectional electronic health records that will follow service members as they transition from DOD to the VA.

FRA also notes recommendations in recent Government Accountability Office (GAO) testimony before the House Committee on Oversight and Government Reform which identified Federal programs, agencies, offices and initiatives that have duplicative goals or activities. Number two on a list of 81 areas for consideration is realigning DOD's military medical command structures and consolidating common functions to increase efficiency which would result in projected savings of from "$281 million to $460 million" annually. In addition, GAO cites opportunities for DOD and the Department of Veterans' Affairs (VA) to jointly modernize their respective electronic health record systems, and also control drug costs by increasing joint contracting.

DOD must continue to investigate and implement other TRICARE cost-saving options. The Association notes the elimination of 780 contract positions in conjunction with streamlining TRICARE Management Activity functions along with increasing inter-service cooperation and co-locating medical headquarters operations.

FRA also notes progress in expanding use of the mail order pharmacy program, Federal pricing for prescription drugs, 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 healthcare spending in the coming years.

WOUNDED WARRIOR CARE

Last year Congress authorized a monthly stipend under the DOD family caregiver program for catastrophically injured or ill wounded warriors that is equal to the caregiver stipend provided by the Department of Veterans' Affairs (VA). The new program will help many caregivers, however, the enactment and implementation of the legislation is only the first step and effective oversight and sustained funding are also critical to ensuring future support for these caregivers. A recent Navy Times survey on wounded warrior care (November 29, 2010) indicates that 77 percent of caregivers have no life of their own; 72 percent feel isolated; and 63 percent suffer from depression.

DES

In response to the Dole/Shalala Commission Report a pilot program was created (NDAA—fiscal year 2008—Public Law 110–181) known as the Disability Evaluation System (DES). The pilot provides a single disability exam conducted to VA standards that will be used by both VA and DOD and a single disability rating by VA that is binding upon both Departments. This pilot program has expanded and become the Integrated Disability Evaluation System (IDES) and is viewed as a common-sense approach that FRA believes will reduce bureaucratic redtape and help streamline the process and warrants expansion to the entire disability rating system. Despite jurisdictional concerns, the Association urges the Subcommittee to provide oversight and adequate funding as the IDES is implemented.

CONCURRENT RECEIPT

The Association notes that the administration has not proposed authorizing Chapter 61 retirees to receive their full military retired pay and veteran's disability compensation as it has the last two fiscal years. FRA continues to seek timely and comprehensive implementation of legislation that authorizes and funds the full concurrent receipt for all disabled retirees and supports "The Retired Pay Restoration Act" (S. 344) sponsored by Majority Leader Senator Harry Reid (Nevada) which is comprehensive legislation that authorizes concurrent receipt for all disabled retirees, including those with less than 20 years of service who have been medically retired (Chapter 61s).

FULL FINAL MONTH'S PAY

Current regulations require survivors of deceased armed forces retirees to return any retirement payment received in the month the retiree passes away or any subsequent moth thereafter. Upon the demise of a retired service member in receipt of military retired pay the surviving spouse is to notify the Department of Defense of the death. The Defense Department's finance arm, Defense Finance and Accounting Service (DFAS) then stops payment on the retirement account, recalculates the final payment to cover only the days in the month the retiree was alive, forwards a check for those days to the surviving spouse (beneficiary) and, if not reported in a timely manner, recoups any payment(s) made covering periods subsequent to the retiree's death. The recouping is made without consideration of the survivor's financial status.

At a most painful time, the surviving spouse is faced with the task of arranging and paying for the deceased retiree's interment and that difficulty is only amplified by the loss of retirement income when it is needed most.

That is why FRA is supporting "The Military Retiree Survivor Comfort Act," (H.R. 493) sponsored by Rep. Walter Jones (North Carolina).

The measure is related to a similar pay policy enacted by the Department of Veterans Affairs (VA). Congress passed a law in 1996 that allows a surviving spouse to retain the veteran's disability and VA pension payments issued for the month of the veteran's death. FRA believes military retired pay should be no different.

To offset some of the costs, if the spouse is entitled to survivor benefit annuities (SBP) on the retiree's death, there will be no payment of the annuity for the month the retirement payment is provided the surviving spouse. If authorized, FRA urges this subcommittee to provide adequate funding to correct inequities associated with this policy.

DEFENSE BUDGET

FRA supports a defense budget of at least 5 percent of GDP to fund both people and weapons programs. The current level of defense spending (4.7 percent including supplemental spending in fiscal year 2010) is significantly lower than past wartime periods as a percentage of GDP and the Association is concerned that the adminis-

tration's 5-year spending plan of 1 percent above inflation may not be enough for both people programs and weapon systems.

ACTIVE DUTY PAY

The military has been appropriately excluded from the pay freeze for Federal employees announced by President Obama on November 29, 2010 and FRA strongly supports the proposed 1.6 percent pay increase that equals the 2010 Employment Cost Index (ECI). The United States however, is in the 10th year of war and there is no more vital morale issue for our current warriors than adequate pay.

A total of 92 percent of active duty personnel who responded to FRA's recent quality of life issues survey consider pay as "very important," which was the highest rating. The Association appreciates the strong support from this distinguished Subcommittee in reducing the 13.5 percent pay gap to 2.4 percent since 1999 and reiterates the fact that the ECI lags 15 months behind the effect date of pay adjustments due to budget preparation and associated Congressional action on annual authorizing and appropriations legislation. It should also be noted that the enacted fiscal year 2011 1.4 percent pay increase and the proposed fiscal year 2012 adjustment are the smallest pay increases in recent memory and do not further reduce the pay gap .

The Association recommends that this distinguished Subcommittee provide funding for an active duty pay increase at least equal to the ECI so as not to increase the pay gap between civilian and military pay.

END STRENGTHS

Sufficient funding to support adequate end strengths for the military is vital for success in Afghanistan and to sustaining other operations vital to our national security. FRA is concerned about calls for reducing end strength in the out-years to save money on the defense budget while still engaged for almost 10 years of war in Iraq and Afghanistan, a third war in Libya, renewed violence in Korea late last year, and support for the natural disaster in Japan. The strain of repeated deployments continues and is reflected in troubling stress-related statistics that include alarming suicide rates, prescription drug abuse, alcohol use and military divorce rates. These are also related to the adequacy of end strengths and the need for adequate dwell time between deployments—issues that have been repeatedly addressed in Congressional oversight hearings.

RESERVE ISSUES

FRA stands foursquare in support of the Nation's Reservists. Due to the demands of the War on Terror, Reserve units are increasingly mobilized to augment active duty components. As a result, the Reserve component is no longer a strategic Reserve, but is an essential operational Reserve that is an integral part of the total force that has been at war for almost a decade. And because of these increasing demands, including missions abroad over longer periods of time, it is essential to ensure adequate funding for military 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 (H.R. 181). 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 after the effective date (January 28, 2008) leaving out more than 600,000 Reservists mobilized since 9/11 for duty in Afghanistan and Iraq.

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 these recommendations to this distinguished Subcommittee. The Association reiterates its gratitude for the extraor-

dinary progress this Subcommittee has made in funding a wide range of military personnel and retiree benefits and quality-of-life programs for all uniformed services personnel and their families and survivors.

Chairman INOUYE. Thank you very much, Mr. Davis.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, I think we should express our appreciation to Mr. Davis for being here and helping us understand the recommendations of his organization. We know it's one of the oldest organizations supporting active duty military personnel and has a record of achievement. We thank you for your continued interest.

Mr. DAVIS. Thank you.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, I already thanked him. I got ahead of the panel a minute ago. But I will reiterate that.

Mr. DAVIS. You can thank me again.

Senator SHELBY. We appreciate you being here.

Mr. DAVIS. Thank you.

Senator SHELBY. Thank you.

Chairman INOUYE. Thank you.

Now may I call upon Ms. Leighton. Ms. Leighton.

STATEMENT OF SUSAN LEIGHTON ON BEHALF OF THE OVARIAN CANCER NATIONAL ALLIANCE

Ms. LEIGHTON. Good morning, Mr. Chairman, Mr. Vice Chairman, and Senator Shelby. I'm honored to appear before you in support of the Ovarian Cancer National Alliance's request of $20 million for the Department of Defense ovarian cancer research program, which I will henceforth refer to as the "OCRP."

My name is Susan Leighton. I'm from Huntsville, Alabama, where my husband and I settled after his retirement from the United States Army as a chief warrant officer 3. I am also a veteran.

In the summer of 1997, at the age of 48, I was diagnosed with stage 3C ovarian cancer. Women diagnosed in later stages like myself have only a 20 percent chance of surviving 5 years. In an instant, I went from preparing to take my daughter to college to wondering whether I would see her graduate.

I was treated at the University of Alabama in Birmingham. My healthcare was paid for by my husband's military health plan. I was fortunate to enter treatment the year after two chemotherapeutic agents had been approved for use as first-time treatment of ovarian cancer. The combination of surgery and those two agents put me into remission. With the exception of one recurrence, I have remained with no evidence of disease.

The research that led to the discovery of those two agents saved my life. I saw my daughter graduate from Auburn University, begin a career, and walk down the aisle to marry. Unfortunately, the majority of women diagnosed do not have this fairy tale ending.

Ovarian cancer is a heterogeneous disease. Many women do not respond to the type of chemotherapy that helped me. The survival rate for this disease has remained fairly stable. Fewer than 50 percent of the approximately 21,000 women diagnosed each year will be alive in 5 years.

The solution to improving the survival rates is simple: Research. Being one of the handful of long-term survivors, I feel a responsibility to speak for other ovarian cancer patients. I have participated as a consumer reviewer on the OCRP panels for 2 years, bringing the patient's perspective to the table. As a reviewer, I help decide which research will benefit women diagnosed with ovarian cancer and those at risk of developing it in the future.

I have seen the focus move toward studying cellular pathways of cancer. We are on the precipice of understanding how ovarian cancer develops, grows, and spreads, and ultimately eliminating it.

I recently returned from the annual meeting of the American Society of Clinical Oncology, where I heard about studies of PARP inhibitors and anti-angiogenesis agents, which are showing promising results for ovarian cancer survivors. Many of those studies were funded by grants from the OCRP.

We are very aware of the current economic climate and understand the constraints you face when determining where best to allocate funds. For that reason, we are asking for flat funding of the OCRP in fiscal year 2012.

My cancer support group in Alabama has a memorial statue in our garden of life and remembrance. I have watched over the years as we have added name after name to that statue. The young man who engraves those names for us each year refuses to take payment, telling us that the only payment he wants is a call telling him that we have no new names to add. The only way this will happen is by eliminating ovarian cancer.

The situation in Alabama is no different than in Hawaii, Tennessee, Texas, or any other State. By flat funding the OCRP we will be able to maintain our current level of research and move closer to that goal.

Thank you for the opportunity to speak on behalf of women battling ovarian cancer today, and I'm happy to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF SUSAN LEIGHTON

Good morning, Mr. Chairman, Mr. Vice Chair and Members of the Subcommittee. I am honored to appear before you in support of the Ovarian Cancer National Alliance's request of $20 million for the Department of Defense Ovarian Cancer Research Program (DOD OCRP), which I will henceforth refer to as the OCRP. My name is Susan Leighton. I am from Huntsville, Alabama, where my husband and I settled after his retirement from the United States Army as a Chief Warrant Officer, Three.

The Ovarian Cancer National Alliance (the Alliance) thanks the Subcommittee for the opportunity to submit comments for the record regarding the Alliance's fiscal year 2012 funding recommendations. We believe these recommendations are critical to ensure that advances can be made to help reduce and prevent suffering from ovarian cancer. For the last 14 years, the ovarian cancer community has worked to increase awareness of ovarian cancer and advocated for additional Federal resources to support research that would lead to more effective diagnostics and treatments.

As an umbrella organization representing more than 50 State and local groups, the Alliance unites the efforts of grassroots activists, women's health advocates and healthcare professionals to bring national attention to ovarian cancer.

As part of these efforts, Alliance advocates for continued Federal investment in the Department of Defense Congressionally Directed Medical Research Programs (CDMRP). The Alliance respectfully requests that the Senate Appropriations Subcommittee on Defense maintain the fiscal year 2011 funding level of $20 million for the DOD OCRP in fiscal year 2012.

In the summer of 1997, at the age of 48, I was diagnosed with stage IIIC ovarian cancer. Women diagnosed in later stages, like me, have only a 20 percent chance

of surviving 5 years. In an instant, I went from preparing to take my daughter to college to wondering whether I would see her graduate.

I was treated at the University of Alabama. I was fortunate to enter treatment the year after two chemotherapeutic agents had been approved for use as first line treatment of ovarian cancer. The combination of surgery and those two agents put me into remission. With the exception of one recurrence, I have remained with no evidence of disease. The research that led to the discovery of those two agents saved my life. I saw my daughter graduate from Auburn University, begin a great career and walk down the aisle to marry. Unfortunately, the majority of women diagnosed do not have this fairy tale ending.

Ovarian cancer is a heterogeneous disease. Many women do not respond to the type of chemotherapy that helped me. The survival rate for this disease has remained relatively stable; fewer than 50 percent of the approximately 21,000 women diagnosed each year will be alive in 5 years. The solution to improving these survival rates is simple: research.

Being one of a handful of long-term survivors, I feel a responsibility to speak for other ovarian cancer patients. I have participated as a consumer reviewer on the OCRP panels for 2 years, bringing the patient's perspective to the table. As a reviewer, I help decide which research will benefit women diagnosed with ovarian cancer and those at risk of developing it in the future. I have seen the focus move toward studying cellular pathways of cancer. We are on the precipice of understanding how ovarian cancer develops, grows and spreads—and ultimately eliminating it. I recently returned from the annual meeting of the American Society of Clinical Oncology, where I heard about studies of PARP inhibitors and anti-angiogenesis agents, which are showing promising results for ovarian cancer survivors. Many of those studies were funded by grants from the OCRP.

The DOD OCRP, which belongs to U.S. Army Medical Research and Materiel Command (USAMRMC), complements but does not duplicate the important ovarian cancer research carried out by the National Cancer Institute (NCI). There are three critical differences between these research programs.

First, the OCRP funds innovative, high risk, high reward research which many large, non-DOD Federal research agencies do not have the flexibility to engage in.

Second, the OCRP is designed to prevent funding research that overlaps with other ovarian cancer research that has been funded by the NCI or other agencies. Before funding an award, OCRP grant managers are required to thoroughly check all sources of information to determine if a proposal is redundant of a previous OCRP grant or a grant awarded by another Federal agency such as the NCI.

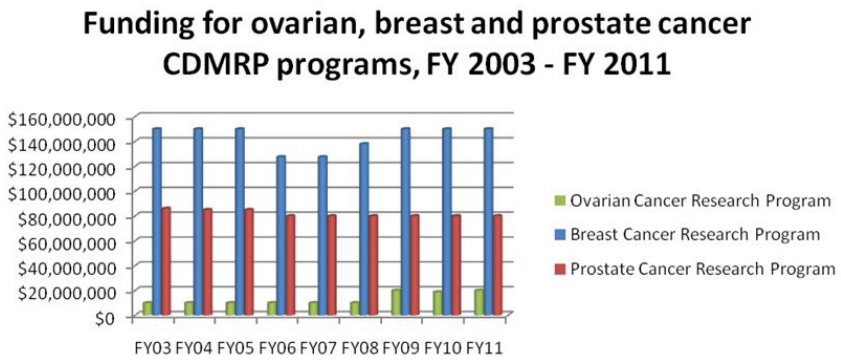
Third, the OCRP pushes investigators to make rapid progress in their research by requiring them to reapply every funding cycle. Because proposal reviews conducted by the OCRP are double-blinded by investigator and research institution, an investigator's progress is evaluated on its own merit and must have sufficient new findings, data or ideas to warrant new funding. The OCRP's unique method of funding ovarian cancer research has yielded tremendous breakthroughs in the fight against ovarian cancer, including:

—a new treatment using nanoparticles to deliver diphtheria toxin-encoding DNA to ovarian cancer cells, leaving healthy cells unaffected;
—the discovery of a compound that potentially inhibits a form of ovarian cancer that makes up 40 percent of ovarian cancer tumors;
—the finding that ovarian cancer cells are sensitive to glucose deprivation and resveratrol treatment; and
—identification of the earliest molecular changes associated with BRCA1- and BRCA2-related ovarian cancers, leading to biomarker identification for early detection.

Cancer research performed by the DOD has been responsible for fundamentally changing the way cancer research is conducted. Many innovative practices and methods created by the CDRMPs have been adopted by the NCI, such as the use of cancer patients as consumer reviewers in the proposal review process. Furthermore, the CDRMP has created funding mechanisms to incentivize research that would fill voids in our understanding of cancer, which NCI has closely duplicated. One such example is the Idea Award Other awards originated by CDRMPs that have been duplicated by NCI are the Era of Hope Scholar and Concept Award mechanisms.

A Modest Research Program that Creates Jobs

The OCRP remains a modest program compared to the other cancer programs in the CDMRP:



However, even with limited funding, the OCRP has been able to make vast strides in the fight against ovarian cancer. With flat funding for fiscal year 2012, the program can maintain current levels of research regarding screening, early diagnosis and treatment of ovarian cancer.

In a time that necessitates fiscal constraint, the OCRP has been designed to fund ovarian cancer research with extremely low overhead: only 4 to 8 percent of the Federal funding is used for administrative costs.

Additionally, biomedical research like that conducted through the DOD OCRP, is a major provider of jobs in the United States economy. A 2008 Families USA study found that for every NIH dollar invested in States, $2 of economic output were created. Additionally, the report estimated that approximately 350,000 jobs were supported by medical research in 2007.

Ovarian Cancer's Deadly Statistics

In the 40 years since the War on Cancer was declared, ovarian cancer mortality rates have not significantly improved. We are very concerned that without continued funding in fiscal year 2012 for the DOD OCRP to continue ovarian cancer research efforts, the Nation will see growing numbers of women losing their battle with ovarian cancer.

The American Cancer Society estimates that in 2011, more than 21,000 American women will be diagnosed with ovarian cancer, and approximately 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 one-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.

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 mothers, daughters, sisters and friends have lost their lives to ovarian cancer.

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 promptly. Unfortunately, we know that this does not always happen. Too many women are diagnosed at late stage 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.

Our organization exists to ensure that women are diagnosed early, receive appropriate treatments, are active participants in their care and not just survive, but thrive. All women should have access to treatment by a gynecologic oncology specialist. All women should have access to a valid and reliable detection test. We must deliver new and better treatments to patients and the physicians and nurses who treat them. Until we have a test, we must continue to increase awareness and educate women and health professionals about the signs and symptoms associated with this disease.

Even with Limited Funding, OCRP Expands

Large ovarian cancer research teams do not exist in many academic medical or research centers. In order to provide much-needed mentoring, networking and a peer group for young ovarian cancer researchers, the OCRP created an Ovarian Cancer Academy award in fiscal year 2009. The OCRP Ovarian Cancer Academy is intended to develop a unique, interactive virtual academy that will provide intensive mentoring, national networking and a peer group for junior faculty. The overarching goal of this award is to develop young scientists into the next generation of successful and highly productive ovarian cancer researchers within a collaborative and interactive research training environment.

Additionally, in fiscal year 2010 the OCRP allowed ovarian cancer researchers to compete for the Consortium Award. The Consortium Development Award is an infrastructure development mechanism that provides support to create a Coordinating Center and establish the necessary collaborations at potential research sites for the development of a multi-institutional ovarian cancer research team. Participants in these consortiums will be scientists and/or clinicians who have made significant contributions to the field of ovarian cancer or who have a specific expertise related to the early changes associated with ovarian cancer progression.

Senate Support for Fiscal Year 2012 Appropriation Request

This year, the ovarian cancer community has been proactive in securing support for our fiscal year 2012 appropriation request. A letter addressed to you in support of the $20 million appropriation for the OCRP was signed by Senators Robert Menendez and Olympia Snowe, who were joined by Richard Blumenthal, Susan Collins, Dick Durbin, Kirsten Gillibrand, Kay Hagan, John F. Kerry, Herb Kohl, Jeffrey Merkley, Debbie Stabenow and Ron Wyden.

A letter from Senator Robert Casey addressed to you in support of all medical research conducted by the Department of Defense through the Congressionally Directed Medical Research Program (CDMRP) was signed by Senators Barbara Boxer, Al Franken, Kirsten Gillibrand, Tim Johnson, John Kerry, Patrick Lautenberg, Jack Reed, Olympia Snowe, Jon Tester and Ron Wyden.

Summary

The Alliance maintains a long-standing commitment 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 the funding to maintain ovarian cancer research efforts, the Nation will continue to see many women lose their lives to this terrible disease.

We are very aware of the current economic climate, and understand the constraints you face when determining where best to allocate funds. For that reason, we are asking for flat funding of the OCRP in fiscal year 2012 at $20 million.

My cancer support group in Alabama has a memorial statue in our Garden of Life and Remembrance. I have watched over the years as we added name after name to the statue. The young man who engraves those names each year refuses to take payment, telling us that the only payment he wants is a call telling him that we have no new names to add. The only way this will happen is by eliminating ovarian cancer. The situation in Alabama is no different than that in Hawaii, Tennessee, Texas or any other State. By flat-funding the Ovarian Cancer Research Program, we will be able to maintain our current level of research and move closer to that goal.

Thank you for this opportunity to speak on behalf of women battling ovarian cancer today. I am happy to answer any questions.

Chairman INOUYE. I thank you very much, Ms. Leighton.

Ms. LEIGHTON. Thank you.

Chairman INOUYE. Senator Cochran.

Senator COCHRAN. Mr. Chairman, I am reminded of the leadership that you and former Chairman Senator Ted Stevens have given to research in many different areas of troubling concern, not only to traditional threats to the life and good health of men and women in active duty situations, but to families and how they can be affected by misfortune and illness.

So I think of Ted Stevens and you working together over the years to make sure that funds are found where there is a need that

exists. I think this is an indication of one of those instances and we should respond in a favorable way.

Ms. LEIGHTON. Thank you.

Chairman INOUYE. Thank you.

Senator Shelby.

Senator SHELBY. Mr. Chairman, I appreciate my constituent testifying here today. I also appreciate her sharing her story, because she is a survivor where a lot of women with ovarian cancer have not. As she said in her testimony, her written testimony, she was fortunate to enter a treatment the year after two breakthrough agents had come through, through research, for the treatment.

She also mentions in her—answers one of my questions that I posed to the subcommittee earlier, whether or not we were duplicating any of these things. She points out in her testimony—I think it's very important—that a lot of this research complements, but does not duplicate, the important ovarian research, cancer research, carried out by the National Cancer Institute, and the differences there. I think that's very, very important.

I'm proud to have her testify here. I like her story and what she's doing is trying to save other people's lives.

Thank you.

Ms. LEIGHTON. Thank you.

Chairman INOUYE. I thank the panel very much. Thank you very much.

Our last panel: Dr. John Elkas, Society of Gynecologic Oncologists; and Mr. Jonathan Schwartz, representing ZERO—The Project to End Prostate Cancer.

May I call upon Dr. Elkas.

STATEMENT OF JOHN C. ELKAS, M.D., COMMANDER, U.S. NAVAL RESERVE, ON BEHALF OF THE SOCIETY OF GYNECOLOGIC ONCOLOGISTS

Dr. ELKAS. Chairman Inouye, Senator Cochran, Senator Shelby: Thank you for inviting me to testify in today's hearing. My name is Dr. John Elkas and I am here today on behalf of the Society of Gynecologic Oncologists and the millions of Americans touched each year by ovarian cancer, including our military families.

I practice medicine in the D.C. metropolitan area, where I am an associate clinical professor in the department of obstetrics and gynecology at the George Washington University Medical Center, and I am also a commander in the United States Naval Reserve and an adjunct associate professor of obstetrics and gynecology at the Uniformed Services University of the Health Sciences.

I am honored to be here and pleased that this subcommittee is focusing attention on the Department of Defense congressionally directed medical research program in ovarian cancer. Since its inception 14 years ago, the OCRP has targeted the highest needs in ovarian cancer research, funding high-risk, high-reward research on a range of issues from early cancer detection to personalized treatment and quality of life.

One in 69 women will develop ovarian cancer and less than one-half will survive for 5 years. One woman dies of ovarian cancer every hour in our country. It is expected that more than 22,000 women will be diagnosed with the disease this year and 14,000 women will die from the disease in 2011.

During the last 5 years, over 2600 members of our military or their families have been hospitalized for ovarian cancer or suspected ovarian cancer. These individuals have spent over 14,000 bed-days in military treatment facilities.

The Department of Defense ovarian cancer research program, which belongs to the U.S. Army Medical Research and Material Command, supports the forward momentum of critical research to understand, prevent, and treat this disease that affects the warfighter, military beneficiaries, and the general public.

The DOD OCRP is able to facilitate collaboration between civilian and military research programs and because of this it is able to share successes, such as raising the standard of care of both military and civilian populations, lowering the incidence, mortality, and burden of ovarian cancer, while in turn reducing the economic drain on society.

The OCRP's unique method of funding ovarian cancer research has yielded tremendous breakthroughs in the fight of ovarian cancer, such as a new treatment using nanoparticles to attack ovarian cancer cells while leaving healthy cells unaffected, the finding that ovarian cancer cells are sensitive to glucose deprivation, leading to more targeted treatments, and identifying the earliest molecular changes associated with BRCA1- and BRCA2-related ovarian cancers, leading to biomarker identification, again for early detection.

Today ovarian cancer researchers are still struggling to develop the first ovarian cancer screening test. With traditional research models largely unsuccessful, the innovator grants awarded by the DOD OCRP are integral in moving this field of research forward.

The Society of Gynecologic Oncology joins with the Ovarian Cancer National Alliance and the American Congress of Obstetricians and Gynecologists to urge this subcommittee to maintain Federal funding for the OCRP at $20 million for fiscal year 2012. Military beneficiaries will benefit in the same way the American general public stands to gain from research on this deadly disease. For every dollar that is saved from reducing the cost of cancer care for our military, another dollar can be used to support the warfighter. The DOD ovarian cancer research program is making a difference in the lives of our military beneficiaries and the general public.

Thank you again for your attention to this request and for allowing me to testify before you today.

[The statement follows:]

PREPARED STATEMENT OF JOHN C. ELKAS

Mr. Chairman, Ranking Member and members of the subcommittee, thank you for inviting me to testify at today's hearing. My name is Dr. John C. Elkas and I am here today on behalf of the Society of Gynecologic Oncology. I practice medicine in the D.C. metropolitan area, where I am an associate clinical professor in the department of obstetrics and gynecology at the George Washington University Medical Center and in private practice in Annandale, Virginia. I am also a Commander in the U.S. Naval Reserve and an adjunct associate professor of obstetrics and gynecology for the Uniformed Services University of the Health Sciences in Bethesda, Maryland.

I am honored to be here and pleased that this subcommittee is focusing attention on the Department of Defense (DOD) Congressionally Directed Medical Research Program in Ovarian Cancer (OCRP). Since its inception now 14 years ago, the OCRP has targeted the highest needs in ovarian cancer research, funding high-risk, high-reward research on a range of issues from early cancer detection to personalized treatment and quality of life.

This morning, I will try to outline some of the important contributions this DOD program has made to ovarian cancer research, the well-being of our patients, and its relevance to our military and to their families. In fact, it is quite easy to demonstrate that this investment by the Federal Government has resulted in substantial benefits and value to medicine, to science and most importantly improved patient care.

As this subcommittee may know, ovarian cancer usually arises from the cells on the surface of the ovary and can be extremely difficult to detect. According to the American Cancer Society, in 2010, more than 22,000 women were diagnosed with ovarian cancer and approximately 14,000 lost their lives to this terrible disease. Ovarian cancer causes more deaths than all the other cancers of the female reproductive tract combined, and is the fourth highest cause of cancer deaths among American women. One of our biggest challenges lies in the fact that only 19 percent of all ovarian cancers are detected at a localized stage, when the 5-year relative survival rate approaches 93 percent. Unfortunately, most ovarian cancer is diagnosed at late or advanced stage, when the 5-year survival rate is only 31 percent.

Nationally, biomedical research funding has grown over the last decade through increased funding to the National Institutes of Health, in no small part to the amazing efforts of members of this Subcommittee. Yet funding for gynecologic cancer research, especially for the deadliest cancer that we treat, ovarian cancer, has been relatively flat. Since fiscal year 2003, the funding levels for gynecologic cancer research and training programs at the NIH, NCI, and CDC have not kept pace with inflation, with the funding for ovarian cancer programs and research training for gynecologic oncologists actually suffering specific cuts in funding due to the loss of an ovarian cancer Specialized Project of Research Excellence (SPORE) in 2007 that had been awarded to a partnership of DUKE and the University of Alabama-Birmingham. Were it not for the DOD OCRP, many researchers might have abandoned their hopes of a career in basic and translation research in ovarian cancer and our patients and the women of America would be waiting even longer for reliable screening tests and more effective therapeutic approaches.

As a leader in the Society of Gynecologic Oncology (SGO) and as a gynecologic oncologist who has provided care to women affiliated with the United States Navy, I believe that I bring a comprehensive perspective to our request for increased support. The SGO is a national medical specialty organization of physicians who are trained in the comprehensive management of women with malignancies of the reproductive tract. Our purpose is to improve the care of women with gynecologic cancer by encouraging research, disseminating knowledge which will raise the standards of practice in the prevention and treatment of gynecologic malignancies and cooperating with other organizations interested in women's healthcare, oncology and related fields. More information on the SGO can be found at www.sgo.org.

We, the members of the SGO, along with our patients who are battling ovarian cancer every day, depend on the DOD OCRP research funding. It is through this type of research funding that a screening and early detection method for ovarian cancer can be identified which will allow us to save many of the 14,000 lives that are lost to this disease each year.

During the last 5 years, over 2,600 members of our military or their families have been hospitalized for ovarian cancer or suspected ovarian cancer. These individuals have spent over 14,000 bed days of care in military treatment facilities.

The Department of Defense Ovarian Cancer Research Program (DOD OCRP) which belongs to U.S. Army Medical Research and Materiel Command (USAMRMC) supports the forward momentum of critical research to understand, prevent, and treat this disease that affects the warfighter, military beneficiaries, and the general public. DOD OCRP is able to facilitate collaboration between civilian and military research programs. Because the military is involved in research performed at civilian health facilities nationwide, the DOD OCRP is able to share successes and assist in raising the standard of care for both military and civilian populations, lowering the incidence, mortality and burden of this cancer, while in turn reducing the economic drain on society.

Therefore, on behalf of the SGO, I respectfully request that the Senate Appropriations Subcommittee on Defense maintain the fiscal year 2011 funding level of $20 million for the OCRD for fiscal year 2012.

Department of Defense Ovarian Cancer Research Program: Building an Army of Ovarian Cancer Researchers

New Investigators Join the Fight

Since its inception in fiscal year 1997, the DOD OCRP has funded 236 grants totaling more than $160 million in funding. The common goal of these research grants has been to promote innovative, integrated, and multidisciplinary research that will

lead to prevention, early detection, and ultimately control of ovarian cancer. Much has been accomplished in the last decade to move us forward in achieving this goal.

In Senator Mikulski's home State of Maryland, where many of my patients also live, the DOD OCRP has funded research on important questions such as:

—Defining biomarkers of serous carcinoma, using molecular biologic and immunologic approaches, which are critical as probes for the etiology/pathogenesis of ovarian cancer. Identifying biomarkers is fundamental to the development of a blood test for diagnosis of early stage disease and also ovarian cancer-specific vaccines;

—Developing and evaluating a targeted alpha-particle based approach for treating disseminated ovarian cancer. Alpha-particles are short-range, very potent emissions that kill cells by incurring damage that cannot be repaired; one to three alpha-particles tracking through a cell nucleus can be enough to kill a cell. The tumor killing potential of alpha-particles is not subject to the kind of resistance that is seen in chemotherapy; and

—Understanding of the molecular genetic pathways involved in ovarian cancer development leading to the identification of the cancer-causing genes ("oncogenes") for ovarian cancer.

In Senator Murray's home State of Washington, the DOD OCRP has funded five grants in the last 5 years to either the University of Washington or to the Fred Hutchinson Cancer Center to study research questions regarding:

—The usefulness of two candidate blood-based microRNA markers for ovarian cancer detection, and the identification of microRNAs produced by ovarian cancer at the earliest stages, which may also be the basis for future blood tests for ovarian cancer detection;

—The first application of complete human genome sequencing to the identification of genes for inherited ovarian cancer. The identification of new ovarian cancer genes will allow prevention strategies to be extended to hundreds of families for which causal ovarian cancer genes are currently unknown; and

—Proposed novel technology, stored serum samples, and ongoing clinical studies, with the intend of developing a pipeline that can identify biomarkers that have the greatest utility for women; biomarkers that identify cancer early and work well for the women in most need of early detection, that can immediately be evaluated clinically.

One of the first, and very successful, grant recipients from the DOD OCRP hails from the Fred Hutchinson Cancer Research Center in Seattle, Washington, Dr. Nicole Urban. Dr. Urban has worked extensively in the field of ovarian cancer early detection biomarker discovery and validation. Her current program in translational ovarian cancer research was built on work funded in fiscal year 1997 by the OCRP, "Use of Novel Technologies to Identify and Investigate Molecular Markers for Ovarian Cancer Screening and Prevention." Working with Beth Karlan, M.D. at Cedars-Sinai and Leroy Hood, Ph.D., M.D. at the University of Washington, she identified novel ovarian cancer biomarkers including HE4, Mesothelin (MSLN), and SLPI using comparative hybridization methods. These discoveries lead to funding in 1999 from the National Cancer Institute (NCI) for the Pacific Ovarian Cancer Research Consortium (POCRC) Specialized Program of Research Excellence (SPORE) in ovarian cancer.

The DOD and NCI funding allowed her to develop resources for translational ovarian cancer research including collection, management, and allocation of tissue and blood samples from women with ovarian cancer, women with benign ovarian conditions, and women with healthy ovaries. The DOD grant provided the foundation for what is now a mature specimen repository that has accelerated the progress of scientists at many academic institutions and industry.

In Senator Feinstein's home State of California, 25 grants have been funded by the DOD OCRP since the program was created in 1997 to study research questions such as:

—Strategies for targeting and inhibiting a protein called focal adhesion kinase (FAK) that promotes tumor growth-metastasis. With very few viable treatment options for metastatic ovarian cancer, this research could lead to drug development targeting these types of proteins;

—Developing a tumor-targeting drug delivery system using Nexil nanoparticles that selectively adhere to and are ingested by ovarian carcinoma cells following injection into the peritoneal cavity. The hypothesis for this research is that the selectivity of Nexil can be substantially further improved by attaching peptides that cause the particle to bind to the cancer cells and that this will further increase the effectiveness of intraperitoneal therapy; and

—Using several avenues of investigation, based on our understanding of the biology of stem cells, to identify and isolate cancer stem cells from epithelial ovar-

ian cancer. This has significant implications for our basic scientific understanding of ovarian cancer and may drastically alter treatment strategies in the near future. Therapies targeted at the cancer stem cells offer the potential for long-term cures that have eluded most patients with ovarian cancer.

In Senator Hutchinson's home State of Texas, 20 grants have been funded since the inception of the DOD OCRP in 1997, to study research questions regarding:

—Understanding the pre-treatment genomic profile of ovarian cancer to then isolate the predictive response of the cancer to anti-vasculature treatment, possibly leading to the identification of targets for novel anti-vasculature therapies;

—Ovarian cancer development directly in the specific patient and her own tumor. While this process has lagged behind in ovarian cancer and improving patient outcomes, it has shown great promise in other solid, tumor cancers; and

—Identifying the earliest molecular changes associated with BRCA1- and BRCA2-related and sporadic ovarian cancers, leading to biomarker identification for early detection.

As you can see from these few examples, the 236 grants have served as a catalyst for attracting outstanding scientists to the field of ovarian cancer research. In the 4 year period of fiscal year 1998–fiscal year 2001 the OCRP enabled the recruitment of 29 new investigators into the area of ovarian cancer research.

Federally Funding is Leveraged Through Partnerships and Collaborations

In addition to an increase in the number of investigators, the dollars appropriated over the last 13 years have been leveraged through partnerships and collaborations to yield even greater returns, both here and abroad. Past-President of the SGO, Dr. Andrew Berchuck of Duke University Medical Center leveraged his OCRP DOD grants to form an international Ovarian Cancer Association Consortium (OCAC) that is now comprised of over 20 groups from all across the globe. The consortium meets biannually and is working together to identify and validate single nucleotide polymorphisms (SNPs) that affect disease risk through both candidate gene approaches and genome-wide association studies (GWAS). OCAC reported last year in Nature Genetics the results of the first ovarian cancer GWAS, which identified a SNP in the region of the BNC2 gene on chromosome 9 (Nature Genetics 2009, 41:996–1000.)

Dr. Berchuck and his colleagues in the association envision a future in which reduction of ovarian cancer incidence and mortality will be accomplished by implementation of screening and prevention interventions in women at moderately increased risk. Such a focused approach may be more feasible than population-based approaches, given the relative rarity of ovarian cancer.

The DOD OCRP program also serves the purpose of strengthening U.S. relationships with our allies, such as Australia, the United Kingdom, and Canada. Dr. Peter Bowtell, from the Peter MacCallum Cancer Centre in Melbourne, Australia, was awarded a fiscal year 2000 Ovarian Cancer Research Program (OCRP) Program Project Award to study the molecular epidemiology of ovarian cancer. With funds from this award, he and his colleagues formed the Australian Ovarian Cancer Study (AOCS), a population-based cohort of over 2,000 women with ovarian cancer, including over 1,800 with invasive or borderline cancer. With a bank of over 1,100 fresh-frozen tumors, hundreds of formalin-fixed, paraffin-embedded (FFPE) blocks, and very detailed clinical follow-up, AOCS has enabled over 60 projects since its inception, including international collaborative studies in the United States, United Kingdom, and Canada. AOCS has facilitated approximately 40 publications, most of which have been released in the past 2 years.

One last important example of the value of the DOD OCRP's contribution to science is the program's focus on inviting proposals from the Historically Black Colleges and Universities and Minority-Serving Institutions. This important effort to reach beyond established clinical research partnerships expands the core research infrastructure for these institutions which helps them to attract new investigators, leveraging complementary initiatives, and supporting collaborative ventures.

Over the decade that the OCRP has been in existence, the 236 grantees have used their DOD funding to establish an ovarian cancer research enterprise that is much greater in value than the annually appropriated Federal funding.

Opportunities are Lost Because of Current Level of Federal Funding

These examples of achievement are obscured to a great degree by opportunities that have been missed. At this current level of funding, this is only a very small portion of what the DOD OCRP program could do as we envision a day where through prevention, early detection, and better treatments, ovarian cancer is a manageable and frequently curable disease. Consistently, the OCRP receives over 500 letters of intent for the annual funding cycle. Of this group, about 50 percent are

invited to submit full proposals. Prior to fiscal year 2009, the OCRP was only able to fund approximately 16 grants per year, a pay line of less than 7 percent. With an increase in funding to $20 million in fiscal year 2009, $18.75 million in fiscal year 2010 and $20 million in fiscal year 2011, the program had been able to consistently fund more grants with the DOD being able to account for every dollar and how it is used.

Department of Defense Ovarian Cancer Research Program: Exemplary Execution with Real World Results

Integration Panel Leads to Continuous Evaluation and Greater Focus

By using the mechanism of an Integration Panel to provide the two-tier review process, the OCRP is able to reset the areas of research focus on an annual basis, thereby actively managing and evaluating the OCRP current grant portfolio. Gaps in ongoing research can be filled to complement initiatives sponsored by other agencies, and most importantly to fund high risk/high reward studies that take advantage of the newest scientific breakthroughs that can then be attributed to prevention, early detection and better treatments for ovarian cancer. An example of this happened in Senator Mikulski's and my home State of Maryland regarding the development of the OVA1 test, a blood test that can help physicians determine if a woman's pelvic mass is at risk for being malignant. The investigator, Zhen Zhang, Ph.D. at Johns Hopkins School of Medicine, received funding from an Idea Development Award in fiscal year 2003. Dr. Zhang discovered and validated five serum biomarkers for the early detection of ovarian cancer. This bench research was then translated and moved through clinical trials. The OVA test was approved by the FDA and is now available to clinicians for use in patient care.

More Than a Decade of Scientific Success

The program's successes have been documented in numerous ways, including 469 publications in professional medical journals and books; 576 abstracts and presentations given at professional meetings; and 24 patents, applications and licenses granted to awardees of the program. Investigators funded by the OCRP have succeeded with several crucial breakthroughs in bringing us closer to an algorithm for use in prevention and early detection of ovarian cancer.

The Society of Gynecologic Oncology joins with the Ovarian Cancer National Alliance and the American Congress of Obstetricians and Gynecologists to urge this Subcommittee to maintain Federal funding for the OCRP at $20 million for fiscal year 2012. Military beneficiaries will benefit in the same way the general American public stands to gain from research in these deadly diseases. For every dollar that is saved from reducing the cost of cancer care for our military, another dollar can be used to support the warfighter. The DOD Ovarian Cancer Research Program is making a difference in the lives of military beneficiaries and the general public. I thank you for your leadership and the leadership of the Subcommittee on this issue.

Chairman INOUYE. I thank you very much, Dr. Elkas.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, we appreciate very much Dr. Elkas being here and bringing us up to date on the ovarian cancer research program. This subcommittee has supported this. Interesting how many women members of our Committee on Appropriations are mentioned in the testimony. It just reminds us that throughout not only the military, but our civilian population, more and more of our leaders are women, and it's certainly appropriate that this insidious illness is being targeted by your organization. We wish you well.

Dr. ELKAS. Thank you, sir.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, I just want to pick up on some of his testimony.

One of our biggest challenges, you say, lies in the fact that only 19 percent of all ovarian cancers are detected at a localized and early stage, when the 5-year relative survival rate then would approach 93 percent. You point out most ovarian cancer is diagnosed

at a later, advanced stage when the 5-year survival rate drops down to 31 percent.

Tell me what research is being done and what promise is there to help do the early detection when the survival rate could be so high?

Dr. ELKAS. Thank you for your question, Senator. I'm excited because I think what makes the DOD OCRP program so unique and so wonderful is its ability to fund programs that would be otherwise very difficult to get funded through the NIH funding mechanism. Very recently, the FDA approved a screening test, a serum, a blood test that was developed through these dollars, that now better allows us to screen and detect ovarian cancer. It's not a perfect test, but it's certainly a step forward.

In the coming weeks, in my practice at Fairfax I'll operate on 20 women in the coming weeks and find one ovarian cancer. That's 19 unnecessary surgeries. From my 14 years on active duty service, bringing women back from overseas for surgeries, many of which unnecessary, but certainly had to be done because of our lack of a screening modality—we hope that advances like we've already made will continue to be made, and it's certainly your help that allows us to do that.

Senator SHELBY. What is your approach to the early treatment? If you could diagnose something or indications real early, would it, one, save a lot of lives? Obviously. It would save a lot of money, too, would it not?

Dr. ELKAS. Oh, absolutely, absolutely, Senator. Our survival for early stage ovarian cancer, stage 1 and stage 2, approaches 88, 85 percent.

Senator SHELBY. Something else that got my attention in here because, as I said earlier, I'm the ranking Republican on another subcommittee dealing with NIH and so forth, and I'm new as far as ranking. But you're pointing out that funding for this cancer research in this area has remained flat, if not declined, through that; and that there was one ovarian cancer specialized project of research excellence that had been awarded to Duke and the University of Alabama-Birmingham and it was cancelled. What happened there? Was it not promising or what happened, because I'd be very interested in that.

Dr. ELKAS. The specific details of that I will certainly forward you.

Senator SHELBY. Will you send it to me?

Dr. ELKAS. Absolutely.

Senator SHELBY. And I'll share it with the subcommittee.

Dr. ELKAS. Please.

Senator SHELBY. Thank you so much.

Dr. ELKAS. Thank you. Thank you for your time.

Chairman INOUYE. Thank you very much.

Now may I call on Mr. Schwartz.

STATEMENT OF JONATHAN D. SCHWARTZ, CHAIRMAN, BOARD OF DIRECTORS, ZERO—THE PROJECT TO END PROSTATE CANCER

Mr. SCHWARTZ. Thank you. Mr. Chairman and distinguished members of the subcommittee: Thank you for the opportunity to

share my thoughts. I know this has been a long session and I admire your dedication. Hopefully the last is not least here.

My name is Jonathan Schwartz and I am the Chairman of the Board of Directors of ZERO—The Project to End Prostate Cancer. I'm here to stress the importance of research and the congressionally directed medical research program, and particularly the prostate cancer research program.

ZERO is a patient advocacy organization that raises awareness and educates men and their families about prostate cancer. Of particular importance to us is the issue of early detection. Not only do we operate a mobile screening program, we also work with policymakers in Congress and throughout Government and other organizations to ensure that men have access to information and services to make decisions that are in the best interest of their health.

My dad was William Schwartz. He was diagnosed with prostate cancer at the age of 55. We thought he'd be okay because the cancer was detected early. Unfortunately, his cancer was very aggressive and had already spread to his lymph nodes. The doctors gave him just 2 years to live because back then there were very few treatment options for prostate cancer.

Thankfully, new treatments became available that extended his life. He fought the disease for 8 years, and during that gift of time he saw all his children get married, became a grandfather, and between chemo sessions was able to travel and enjoy the company of family and friends. He also volunteered as the first CEO of the National Prostate Cancer Coalition, which is now ZERO. He worked tirelessly to increase Federal research funding because he knew that research would help him and countless other men.

As a family, we enjoyed much of my dad's last years. But he also experienced great suffering. We saw firsthand the impact of this cruel disease.

My dad died at age 63, younger than when most people retire. We all miss him dearly and wonder what it would be like to have him in our lives today. I still find it hard to accept that he will never get to meet my two daughters and they'll never get to know their "Papa Bill."

Our family's experience has led me, my brother and sister, and of course our mom to care deeply about dad's cause. We don't want other families to go through this. We want the number of men suffering from prostate cancer to be as small as possible. Eventually we want that number to be zero.

I'm here today because of my dad. I'm here today because prostate cancer affects the family, not just the man. And as I mentioned, I'm here today because I want to stress the importance of research at the prostate cancer research program.

Prostate cancer is a disease that's diagnosed in over 200,000 American men each year and will kill nearly 34,000 men in 2011. It's the second leading cause of cancer-related deaths among men. One in six men, one in four African American men, will get prostate cancer, and some of them will be in their 30s. It is not just an old man's disease.

There is much controversy about prostate cancer and particularly the controversy over testing, when men should start getting tested, how often they should be tested, what type of treatment a man

should undergo when diagnosed. I recently met with my Georgia Senators on this topic. Senator Chambliss, a prostate cancer survivor whose live was saved by early detection, said it well when he said: "You have to know you have it to have a choice about treatment."

Despite what some people call overdiagnosis, the number of men dying from prostate cancer is rising. So, Mr. Chairman, the problem isn't the number of men we are or should be testing. The problem is knowing whether they have aggressive or indolent disease and whether or not they should be treated. The only way doctors will ever really know the answer to these questions is through advances that may be closer than we think.

Last year, research partially funded by the prostate cancer research program identified 24 different types of prostate cancer. Eight of these are aggressive forms of the disease. If we could identify what type of prostate cancer a man has, we could more effectively determine if he needs treatment and how aggressive that treatment should be. This would render moot the argument some make about the disease being overtreated and ultimately save men's lives.

Another innovative funding mechanism of the prostate cancer research program is the Clinical Trials Consortium. To address the significant logistical challenges of multi-center clinical research, the Clinical Trials Consortium was started to promote rapid phase 1 and phase 2 trials of promising new treatments for prostate cancer. Since 2005, nearly 90 trials with more than 2,600 patients have taken place, leading to potential treatments that will soon be available to patients. Two recently approved drugs, Xgeva and Zytiga, benefited from the consortium, accelerating their approval time by over 2 years.

Today, without adequate funding, the program could not support this award mechanism.

The prostate cancer research program is funding some of the most critical work in cancer today. The program uses innovative approaches to funnel research dollars directly into the best research to accelerate discovery, translate discoveries into clinical practice, and improve the quality of care and quality of life of men with prostate cancer. It is the only federally funded program that focuses exclusively on prostate cancer, which enables them to identify and support research on the most critical issues facing prostate cancer patients today. The program funds innovative, high-impact studies, the type of research most likely to make a difference.

I understand that the subcommittee is working under extremely tight budgetary constraints this year and the many tough decisions are ahead. This program is important to the millions of men who are living with the disease, those who have survived the disease, and those who are at risk for the disease, including our veterans and active duty military personnel.

Active duty males are twice as likely to develop prostate cancer as their civilian counterparts. While serving their country, the United States armed forces are exposed to deleterious contaminants such as Agent Orange and depleted uranium. These contaminants are proven to cause prostate cancer in American veterans. Unfortunately, the genomes of prostate cancer caused by Agent Or-

ange are the most aggressive strands of the disease and they also appear earlier in a man's life. In addition, a recent study showed that Air Force personnel were diagnosed with prostate cancer at an average age of just 48.

In closing, I ask that you support our fight against all cancers and in particular prostate cancer. Prostate cancer can and should be a 100 percent detectable and treatable cancer, and hopefully some day a preventable one. Please support the research conducted through the congressionally directed medical research program and the prostate cancer research program by maintaining their funding levels.

Thank you very much for your time. I'll be happy to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF JONATHAN D. SCHWARTZ

Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to share my thoughts. My name is Jonathan Schwartz, and I am Chairman of the Board of Directors of ZERO—The Project to End Prostate Cancer (ZERO). I am the son of William Schwartz, who fought prostate cancer for 8 years and volunteered as the first CEO of the National Prostate Cancer Coalition, which is now ZERO.

My dad was diagnosed at the age of 55. We thought that he would be okay since the cancer was detected early. The strain of prostate cancer that he was diagnosed with was very aggressive and had spread to his lymph nodes. Thankfully there were new treatments that extended his life. During that 8 year gift, he was there to see his children get married, become a grandfather, travel, and enjoy family and friends. He worked tirelessly because he knew that research would help him and countless other men.

My dad enjoyed much of his last years, but we also experienced great suffering. We saw firsthand the impact of this cruel disease. We all miss him dearly, and we are so saddened by all he has missed, including five more grandchildren. We often wonder what it would be like to have him in our lives today. Our family's experience has led me and my brother and sister to care deeply about dad's cause. We don't want other men and their families to go through this. We want the number of men suffering from prostate cancer to be as small as possible. Eventually, we want that number to be ZERO.

I am here today because of my dad. I am here today because prostate cancer affects the family, not just the man. I am here today because I want to stress the importance of research and particularly the Prostate Cancer Research Program and the other programs of the Congressionally Directed Medical Research Program.

Prostate cancer is a disease that is diagnosed in over 200,000 men each year and will kill nearly 34,000 men in 2011. It is the second leading cause of cancer related deaths among men and will inflict 1 in 6 men in their lifetime.

There are too many questions that continue to surround prostate cancer and too many uncertainties for us to just ignore this disease. It has been well publicized that cancer is killing less people every year, but the same cannot be said for prostate cancer. Prostate cancer deaths have continued to increase.

The answers to these questions are found in research. The Congressionally Directed Medical Research Program and the Prostate Cancer Research Program are funding some of the most critical work in cancer today. The program uses innovative approaches to funnel research dollars directly into the best research to accelerate discovery, translate discoveries into clinical practice, and improve the quality of care and life of men with prostate cancer.

An example of the innovative nature of the PCRP is the Clinical Trials Consortium. To address the significant logistical challenges of multicenter clinical research, the PCRP began support of a clinical trials consortium for rapid Phase I and Phase II clinical trials of promising new treatments for prostate cancer.

Since their first PCRP award in 2005, each site has fulfilled key responsibilities in clinical trials design and recruitment. Nearly 70 trials with more than 1,800 patients have taken place, leading to potential treatments that will soon be at patients' bedsides. Two recently approved drugs (XGEVA and ZYTIGA) benefited from PCRP funding and the consortium accelerating their approval time by over 2 years.

The PCRP has played a unique role by identifying two key research gaps inhibiting forward movement of clinical trials, multicenter intellectual property and regulatory issues. The program developed and funded mechanisms to reduce those barriers resulting in unprecedented accomplishments for recruiting participants over an 18-month period.

Today, without adequate funding, the PCRP cannot support this award mechanism.

I understand that the committee is working under extremely tight budgetary constraints this year and that many tough decisions are ahead. This program is important to the millions of men who are living with the disease, those who have survived the disease and those who are at risk for the disease including our veterans and active duty military personnel.

Active duty males are twice as likely to develop prostate cancer as their civilian counterparts. While serving our country, the United States' Armed Forces are exposed to deleterious contaminants such as Agent Orange and Depleted Uranium. These contaminants, particularly Agent Orange, are proven to cause prostate cancer in American Veterans. Unfortunately, the genomes of prostate cancer caused by Agent Orange are the more aggressive strands of the disease and appear earlier in a man's life. Studies have shown that military personnel at risk for the disease are also more likely to be diagnosed earlier in life.

In closing, I ask that you support our fight against all cancers and in my case in particular, prostate cancer. Support the research conducted through the Congressionally Directed Medical Research Program and the Prostate Cancer Research Program by maintaining their funding levels.

Chairman INOUYE. Thank you, Mr. Schwartz.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, I think it's important to note that the testimony here reminds us that, while we are learning more about cancer, we are wondering why cancer is killing more people every year in the general population, including more prostate cancer. Prostate cancer seems to be on the rise. Some other life-threatening cancers seem to be on the decline.

Another thing I think in the witness's testimony that's appropriate for this subcommittee to consider when we decide how much funding is available, if any, for this program is that Agent Orange has been identified as a causal connector with prostate cancer for those who have been exposed to that substance. This is something I think is peculiarly of interest to the military and appropriate for this subcommittee's attention. So I'm hopeful that we can find a way to support, as this witness suggests, an increase in funding for prostate cancer research.

We appreciate your bringing these facts to the attention of the subcommittee.

Chairman INOUYE. Senator Shelby.

Senator SHELBY. Mr. Chairman, I'll be brief, but I would be remiss if I didn't—I'm a 17-year-old—"17-year-old"—I'm a 17-year survivor of prostate cancer. I've been through that, as you went through it with your father and your family. A lot of people don't survive. It's my understanding that—I've been told that prostate cancer is the number two killer of men in this country. Research in new surgery procedures, everything, early diagnosis, has helped save a lot of lives.

I agree with Senator Cochran. We don't need to cut back on this because if we do break through the research, we're going to not only save lives, but on a policy level we will save money down the road. You can do both if we do it right.

Thank you, Mr. Chairman, for calling this hearing. This has been a very good hearing for me. As I've pointed out, I am the ranking

Republican over on the other subcommittee dealing with NIH and all the other, and I'm curious as to how this works and I've found out a lot today.

Thank you, Mr. Chairman.

Chairman INOUYE. I thank you very much.

Three organizations have submitted testimony. Without objection, the testimony of Cummins, Incorporated, Washington State Neurofibromatosis Families, and the American Foundation for Suicide Prevention will be made part of the record along with any other statements that the subcommittee may receive.

On behalf of the subcommittee, I thank all the witnesses for their testimony, and the subcommittee will take these issues in consideration and I can assure you will look at it very seriously.

[The statements follow:]

PREPARED STATEMENT OF DR. WAYNE A. ECKERLE, VICE PRESIDENT, RESEARCH AND TECHNOLOGY, CUMMINS INC.

Cummins Inc., headquartered in Columbus, Indiana, is a corporation of complementary business units that design, manufacture, distribute and service engines and related technologies, including fuel systems, controls, air handling, filtration, emission solutions and electrical power generation systems. The funding requests outlined below are critically important to Cummins' research and development efforts, and would also represent a sound Federal investment toward a cleaner environment and improved energy efficiency for our Nation. We request that the Committee fund the programs as identified below.

DEPARTMENT OF THE ARMY

Other Procurement

Budget Activity 03, Other Support Equipment, Line No. 177, Generators and Associated Equipment (MA9800), Medium generator Sets (5–60 kW) (M53500), Advanced Medium Mobile Power System (AMMPS).—Increase the Administration's request of $11.6 million by $28.4 million to bring the program total to $40 million in fiscal year 2012. $40 million was appropriated in fiscal year 2011 and fiscal year 2010. This program is critical to providing our troops with the latest technology in power generation. AMMPS generators are the latest generation of Prime Power Generators for the DOD and will replace the obsolete Tactical Quiet Generators (TQG's) developed in the 1980s. The AMMPS gensets are 21 percent more fuel-efficient, 15 percent lighter, 35 percent quieter, and 40 percent more reliable than the TQG. Generators are the Army's biggest consumer of diesel fuel in current war theatres. When AMMPS gensets are fully implemented, the Army and Marines will realize annual fuel savings of approximately 52 million gallons of JP–8 fuel and over $745 million in savings based on fuel costs and current use pattern. This will mean fewer fuel convoys to bases in active war zones resulting in saved lives of military and civilian drivers. AMMPS generators are fully EPA compliant and will result in annual carbon emissions reductions of 509,698 metric tons CO_2 or 7.7 million metric tons over the expected life of the generators.

Research and Development Test and Evaluation Programs

Volume V–B, Budget Activity 05, System Development & Demonstration, Line No. 120, Program Element No. 0604854A: Artillery Systems, Paladin Integrated Management (PIM).—Support the Administration's request of $120.1 million in fiscal year 2012. The M109A6 Paladin is the primary indirect fire weapons platform in the U.S. Army's Heavy Brigade Combat Team (HBCT) and is expected to be in the Army inventory through 2050. This request is to further develop Paladin Integrated Management (PIM) vehicles and conclude testing. The PIM effort is a program to ensure the long-term viability and sustainability of the M109A6 Paladin and its companion ammunition resupply vehicle, the M992 Field Artillery Ammunition Support Vehicle (FAASV). PIM is vital to ensuring the long-term viability and sustainability of the M109 family of vehicles (Paladin and FAASV). The program will significantly reduce the logistics burden placed on our soldiers, and proactively mitigate obsolescence. The system will feature improved mobility (by virtue of Bradley-based automotive systems), allowing the fleet to keep pace with the maneuver force.

Volume VII, Budget Activity 07, Operational Systems Development, Line No. 163, Program Element No. 0203735A: Combat Vehicle Improvement Program, Armored Multi-Purpose Vehicle (AMPV).—Support Administration's request of $53.3 million in fiscal year 2012. The Armored Multi-Purpose Vehicle (AMPV) is a new Army initiated program to replace the M113 platforms, which cannot be optimized for future U.S. Army combat operations. The Army has identified a significant capability gap within the Heavy Brigade Combat Team (HBCT) formation. The Bradley Family of Vehicles are the most capable and cost effective platform for replacement of the M113. Along with established production, the recapitalized Bradley vehicles bring combat-proven mobility, survivability, and adaptability to a variety of missions. The Army currently has approximately 1,900 Bradley hulls that could be inducted into the production process. This low cost, low risk, Military-off-the-Shelf (MOTS) to replace the M113 addresses the significant capability shortfalls within the HBCT formation and is an efficient use of existing Government owned assets and existing Public-Private Partnership arrangements to bridge the modernization gap. Recapitalizing existing Bradley chassis provides the most survivable, mobile and protected solution for our soldiers at a significant lower cost.

Procurement of Weapons and Tracked Combat Vehicles (W&TCV)

Activity No. 01 Tracked Combat Vehicles, Line No. 07, Howitzer, Med Sp Ft 155MM M109A6 (MOD) (GA0400), Paladin Integrated Management (PIM).—Support Administration's request of $46.88 million in fiscal year 2012. This is to begin low rate initial production vehicles for Paladin Integrated Management (PIM) procurement. The M109A6 Paladin is the primary indirect fire weapons platform in the U.S. Army's Heavy Brigade Combat Team (HBCT) and is expected to be in the Army inventory through 2050. The PIM program will incorporate Bradley-based drive-train and suspension components which reduce logistics footprint and decrease operations and sustainment costs. PIM is vital to ensuring the long-term viability and sustainability of the M109 family of vehicles (Paladin and FAASV). The program will significantly reduce the logistics burden placed on our soldiers, and proactively mitigate obsolescence. The system will feature improved mobility (by virtue of Bradley-based automotive systems), allowing the fleet to keep pace with the maneuver force. The system will improve overall soldier survivability through modifications to the hull to meet increased threats.

DEPARTMENT OF THE AIR FORCE

Other Procurement

Budget Activity 04, Other Base Maintenance and Support Equip, Item No. 61, Mobility Equip, Basic Expeditionary Airfield Resources.—Maintain the Administration's request of $27 million in fiscal year 2012. Appropriations in fiscal year 2010 and fiscal year 2011 totaled $29.7 million. Basic Expeditionary Airfield Resource (BEAR) is funded by the U.S. Air Force and is administered by the PM–MEP office. The BEAR product is an 800kW prime power mobile generator used by Combat Air Forces to power mobile airfields in-theatre and around the world. The finished product will replace the existing MEP unit that is 25 years old and will offer greater fuel economy, increased fuel options (JP8), improved noise reduction, and the latest innovative control technology and functionality. With the ever increasing global reach of the U.S. military, the need for reliable mobile power is paramount. This program is currently funded for the design, development and preproduction of 8 individual BEAR units. These units will undergo a battery of validation tests. Design and development of the BEAR product is on schedule. There is interest from other branches of the military for the BEAR product as well given the increased need for mobile electric power.

PREPARED STATEMENT OF KAREN GUNSUL, VICE PRESIDENT, WASHINGTON STATE NEUROFIBROMATOSIS FAMILIES

Thank you for the opportunity to submit testimony to the Subcommittee on the importance of continued funding for research on Neurofibromatosis (NF), a terrible genetic disorder closely linked too many common diseases widespread among the American population.

On behalf of Washington State Neurofibromatosis Families (WSNF) a participant in a national coalition of NF advocacy groups, I speak on behalf of the 100,000 Americans who suffer from NF as well as approximately 175 million Americans who suffer from diseases and conditions linked to NF such as cancer, brain tumors, heart disease, memory loss and learning disabilities. I also speak from the heart as the

mother of a son who deals with NF every day. To find treatments and, ultimately, a cure, for this disorder would benefit him and countless others.

In fiscal year 2012, I am requesting $16 million to continue the Army's highly successful Neurofibromatosis Research Program (NFRP), the same amount that was included for the NFRP in fiscal year 2011. The Peer-Reviewed Neurofibromatosis Research Program, one of the Department of Defense's Congressionally Directed Medical Research Programs (CDMRP), is now conducting clinical trials at nationwide clinical trials centers created by NFRP funding. These clinical trials involve drugs that have already succeeded in eliminating tumors in humans and rescuing learning deficits in mice. Administrators of the Army program have stated that the number of high-quality scientific applications justify a much larger program.

What is Neurofibromatosis (NF)?

NF is a genetic disorder involving the uncontrolled growth of tumors along the nervous system which can result in terrible disfigurement, deformity, deafness, blindness, brain tumors, cancer, and even death. NF can also cause other abnormalities such as unsightly benign tumors across the entire body and bone deformities. In addition, approximately one-half of children with NF suffer from learning disabilities. While not all NF patients suffer from the most severe symptoms, all NF patients and their families live with the uncertainty of not knowing whether they will be seriously affected because NF is a highly variable and progressive disease.

NF is not rare. It is the most common neurological disorder caused by a single gene and three times more common than Muscular Dystrophy and Cystic Fibrosis combined, but is not widely known because it has been poorly diagnosed for many years. Approximately 100,000 Americans have NF, and it appears in approximately 1 in every 2,500 births. It strikes worldwide, without regard to gender, race or ethnicity. Approximately 50 percent of new NF cases result from a spontaneous mutation in an individual's genes and 50 percent are inherited. There are three types of NF: NF1, which is more common, NF2, which primarily involves tumors causing deafness and balance problems, and schwannomatosis, the hallmark of which is severe pain. In addition, advances in NF research stand to benefit over 175 million Americans in this generation alone because NF is directly linked to many of the most common diseases affecting the general population.

NF's Connection to the Military

Neurofibromatosis Research addresses areas of great clinical need directly affecting the health of the warfighter. NF is a complicated condition closely connected to many common diseases and disorders that can lead to unmanageable pain, learning disabilities, cancer, orthopedic abnormalities, deafness, blindness, memory loss, and amputation. NF also involves inflammation similar to that involved in wound healing.

Pain Management.—Severe and unmanageable pain is seen in all forms of NF, particularly in one form of NF called schwannomatosis. Over the past 3 years, schwannomatosis research has made significant advances and new research suggests that the molecular or root cause of schwannomatosis pain may be the same as phantom limb pain. Research is currently moving forward to identify drugs that might be able to treat this pain, and these exciting findings could have broad applications for the military.

Wound Healing, Inflammation and Blood Vessel Growth.—Wound healing requires new blood vessel growth and tissue inflammation. Mast cells are critical mediators of inflammation in wound healing, and they must be quelled and regulated in order to facilitate this healing. Mast cells are also important players in NF1 tumor growth. In the past few years, researchers have gained deep knowledge on how mast cells promote tumor growth, and this research has led to ongoing clinical trials to block this signaling. The result is that tumors grow slower. As researchers learn more about blocking mast cell signals in NF, this research could be translated to the management of mast cells in wounds and wound healing.

Orthopedic Abnormalities and Amputation.—One-third of children with NF1 are at risk of developing orthopedic abnormalities that as a result break easily. In the leg particularly, repeated injuries lead to amputation below the knee, often in very young children. Recent research has identified the molecular basis of this, and drug trials in humans will begin in the next year. This research will lead to a deeper understanding of how to heal challenging bone breaks and directly benefit warfighters with major bone breakages or recurring bone breaks that heal poorly.

Three-Dimensional Clinical Imaging Technologies.—Because NF tumors are often large and abnormally shaped, they lend themselves well to the emerging technology of volumetric MRI. This is used to monitor tumor volume and growth as well as to monitor the effectiveness of a drug treatment to induce tumor shrinkage or ces-

sation of tumor growth. It is anticipated that MRI volumetric imaging could have broad applications in military use.

Link to Other Illnesses

Researchers have determined that NF is closely linked to cancer, heart disease, learning disabilities, memory loss, brain tumors, and other disorders including deafness, blindness and orthopedic disorders, primarily because NF regulates important pathways common to these disorders such as the RAS, cAMP and PAK pathways. Research on NF therefore stands to benefit millions of Americans.

Cancer.—NF is closely linked to many of the most common forms of human cancer, affecting approximately 65 million Americans. In fact, NF shares these pathways with 70 percent of human cancers. Research has demonstrated that NF's tumor suppressor protein, neurofibromin, inhibits RAS, one of the major malignancy causing growth proteins involved in 30 percent of all cancer. Accordingly, advances in NF research may well lead to treatments and cures not only for NF patients, but for all those who suffer from cancer and tumor-related disorders. Similar studies have also linked epidermal growth factor receptor (EGF–R) to malignant peripheral nerve sheath tumors (MPNSTs), a form of cancer which disproportionately strikes NF patients.

Heart disease.—Researchers have demonstrated that mice completely lacking in NF1 have congenital heart disease that involves the endocardial cushions which form in the valves of the heart. This is because the same ras involved in cancer also causes heart valves to close. Neurofibromin, the protein produced by a normal NF1 gene, suppresses ras, thus opening up the heart valve. Promising new research has also connected NF1 to cells lining the blood vessels of the heart, with implications for other vascular disorders including hypertension, which affects approximately 50 million Americans. Researchers believe that further understanding of how an NF1 deficiency leads to heart disease may help to unravel molecular pathways involved in genetic and environmental causes of heart disease.

Learning disabilities.—Learning disabilities are the most common neurological complication in children with NF1. Research aimed at rescuing learning deficits in children with NF could open the door to treatments affecting 35 million Americans and 5 percent of the world's population who also suffer from learning disabilities. In NF1 the neurocognitive disabilities range includes behavior, memory and planning. Recent research has shown there are clear molecular links between autism spectrum disorder and NF1; as well as with many other cognitive disabilities. Tremendous research advances have recently led to the first clinical trials of drugs in children with NF1 learning disabilities. These trials are showing promise. In addition because of the connection with other types of cognitive disorders such as autism, researchers and clinicians are actively collaborating on research and clinical studies, pooling knowledge and resources. It is anticipated that what we learn from these studies could have an enormous impact on the significant American population living with learning difficulties and could potentially save Federal, State, and local governments, as well as school districts, billions of dollars annually in special education costs resulting from a treatment for learning disabilities.

Memory loss.—Researchers have also determined that NF is closely linked to memory loss and are now investigating conducting clinical trials with drugs that may not only cure NF's cognitive disorders but also result in treating memory loss as well with enormous implications for patients who suffer from Alzheimer's disease and other dementias. Indeed, one leading Army funded researcher is pursuing parallel research into both NF and Alzheimer's simultaneously.

Deafness.—NF2 accounts for approximately 5 percent of genetic forms of deafness. It is also related to other types of tumors, including schwannomas and meningiomas, as well as being a major cause of balance problems.

The Army's Contribution to NF Research

While other Federal agencies support medical research, the Department of Defense (DOD) fills a special role by providing peer-reviewed funding for innovative, high-risk/high-reward medical research through the CDMRP. CDMRP research grants are awarded to researchers in every State in the country through a competitive two-tier review process. These well-executed and efficient programs, including the NFRP, demonstrate the government's responsible stewardship of taxpayer dollars.

Recognizing NF's importance to both the military and to the general population, Congress has given the Army's NF Research Program strong bipartisan support. From fiscal year 1996 through fiscal year 2011 funding for the NFRP has amounted to $230.05 million, in addition to the original $8 million appropriation in fiscal year

1992. In addition, between fiscal year 1996 and fiscal year 2009, 245 awards have been granted to researchers across the country.

The Army program funds innovative, groundbreaking research which would not otherwise have been pursued, and has produced major advances in NF research, including conducting clinical trials in a nationwide clinical trials infrastructure created by NFRP funding, development of advanced animal models, and preclinical therapeutic experimentation. Because of the enormous advances that have been made as a result of the Army's NF Research Program, research in NF has truly become one of the great success stories in the current revolution in molecular genetics. In addition, the program has brought new researchers into the field of NF. However, despite this progress, Army officials administering the program have indicated that they could easily fund more applications if funding were available because of the high quality of the research applications received.

In order to ensure maximum efficiency, the Army collaborates closely with other Federal agencies that are involved in NF research, such as the National Institutes of Health (NIH). Senior program staff from the National Institute of Neurological Disorders and Stroke (NINDS), for example, sits on the Army's NF Research Program Integration Panel which sets the long-term vision and funding strategies for the program. This assures the highest scientific standard for research funding, efficiency and coordination while avoiding duplication or overlapping of research efforts.

Thanks in large measure to this Subcommittee's support; scientists have made enormous progress since the discovery of the NF1 gene. Major advances in just the past few years have ushered in an exciting era of clinical and translational research in NF with broad implications for the general population. These recent advances have included:

—Phase II and Phase III clinical trials involving new drug therapies for both cancer and cognitive disorders;
—Creation of a National Clinical and Pre-Clinical Trials Infrastructure and NF Centers;
—Successfully eliminating tumors in NF1 and NF2 mice with the same drug;
—Developing advanced mouse models showing human symptoms;
—Rescuing learning deficits and eliminating tumors in mice with the same drug;
—Determining the biochemical, molecular function of the NF genes and gene products;
—Connecting NF to more and more diseases because of NF's impact on many body functions.

Fiscal Year 2012 Request

The Army's highly successful NF Research Program has shown tangible results and direct military application with broad implications for the general population. The program has now advanced to the translational and clinical research stages, which are the most promising, yet the most expensive direction that NF research has taken. The program has succeeded in its mission to bring new researchers and new approaches to research into the field. Therefore, continued funding is needed to take advantage of promising avenues of investigation, to continue to build on the successes of this program, and to fund this promising research thereby continuing the enormous return on the taxpayers' investment.

I respectfully request an appropriation of $16 million in the fiscal year 2012 Department of Defense Appropriations bill for the Army's Neurofibromatosis Research Program.

In addition to providing a clear military benefit, the DOD's Neurofibromatosis Research Program also provides hope for the 100,000 Americans who suffer from NF, as well as over 175 million Americans who suffer from NF's related diseases and disorders. Leading researchers now believe that we are on the threshold of a treatment and a cure for this terrible disease. With this Subcommittee's continued support, we will prevail. Thank you for your support.

PREPARED STATEMENT OF THE AMERICAN FOUNDATION FOR SUICIDE PREVENTION

Chairman Inouye, Ranking Member Cochran and members of the Subcommittee. My name is John Madigan, Senior Director of Public Policy with The American Foundation for Suicide Prevention (AFSP). AFSP thanks you for the opportunity to provide testimony on the funding needs of programs within the Department of Defense that play a critical role in suicide prevention efforts.

AFSP is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy,

and to reaching out to people with mental disorders and those impacted by suicide. You can find more information at www.asfp.org and www.spanusa.org.

More than 1.9 million warriors have deployed for Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), two of our Nation's longest conflicts (IOM, 2010). The physical and psychological demands on both the deployed and non-deployed warriors are enormous. From 2005 to 2009, more than 1,100 members of the Armed Forces took their own lives, an average of 1 suicide every 36 hours. In that same period, the suicide rates among Marines and Soldiers sharply increased; the rate in the Army more than doubled. Numerous commissions, task forces, and research reports have documented the "hidden wounds of war"—the psychological and emotional injuries that have so affected our military members and their families. The years since 2002 have placed unprecedented demands on our Armed Forces and military families. Military operational requirements have risen significantly, and manning levels across the Services remain too low to meet the ever-increasing demand. This current imbalance places strain not only on those deploying, but equally on those who remain in garrison. The cumulative effects of all these factors are contributing significantly to the increase in the incidence of suicide and without effective action will persist well beyond the duration of the current operations and deployments. Heightened concern regarding this increase in suicides has led to development of scores of initiatives across the DOD to reduce risk (Final Report of DOD Task Force on the Prevention of Suicide by Members of the Armed Forces, August, 2010).

In testimony before this Subcommittee on May 18, Secretary of the Army John McHugh and General Martin Dempsey, Chief of Staff of the United States Army, called for the sustainment of $1.7 billion to fund vital Soldier and Family programs. These programs provide a full range of essential services and include the Army Campaign for Health Promotion, Risk Reduction, and Suicide Prevention. Additionally, The fiscal year 2012 budget request includes adding 24 behavioral health officers and enlisted technicians to the National Guard Brigade Combat Teams and expands the Reserve component substance abuse program. It also included additional funding for 54 Suicide Prevention Program managers for the National Guard, 38 Suicide Prevention Program Managers for Army Reserve, and Applied Suicide Intervention Skills Training (ASIST) and kits for the Reserve component. AFSP commends the Department of the Army for their efforts to reduce suicides within their ranks, and urges this Subcommittee to provide the $1.7 billion requested to sustain their important efforts.

While there is sufficient funding for suicide prevention research within DOD right now, these efforts need to be sustained to ensure sufficient resources are devoted to research in the long term. We believe that funding needs to be sustained for confidential treatment programs like the Army Confidential Alcohol Treatment and Education Pilot (CATEP) and TRICARE Assistance Program (TRIAP) which are helping to change the culture and decrease stigma toward behavioral health treatment. AFSP also urges this Subcommittee to fully fund the OSD Office for Suicide Prevention that was created this month.

In addition to Secretary McHugh and General Dempsey's request, AFSP urges this Subcommittee to fund the following programs or initiatives at the highest levels possible to address the unacceptably high rates of suicide among our military personnel.

Comprehensive Behavioral Health System of Care (CBHSOC)

General Eric Shoomaker outlined this program in his testimony before this Subcommittee on April 6. CBHSOC is based on outcome studies that demonstrate the profound value of using the system of multiple touch points in assessing and coordinating health and behavioral health for a soldier and Family. The CBHSOC creates an integrated, coordinated, and synchronized behavioral health service delivery system that will support the total force through all ARFORGEN (Army Force Generation) phases by providing full spectrum behavioral healthcare.

The CBHSOC is a system of systems built around the need to support an Army engaged in repeated deployments and its intent is to optimize care and maximize limited behavioral health resources to ensure the highest quality of care to Soldiers and Families through a multi-year campaign with a long-term goal of preventing suicide.

Yellow Ribbon Reintegration Campaign (YRRP)

The Yellow Ribbon Reintegration Program provides information, services, referrals, and proactive outreach to Soldiers, spouses, employers, and youth through the different stages of mobilization: pre-alert, alert, pre-deployment, deployment, post-deployment and reintegration.

Public Law 111–84, Section 595 gave the YRRP Office the responsibility for establishing a program to provide Reserve and National Guard Service members, and their families, training in suicide prevention, community healing, and response to suicide. The YRRP Office has engaged several national associations to provide ongoing assistance in coordinating with community based behavioral health providers and conducted a needs and gap analysis of all the Reserve Components existing suicide prevention programs. Continuation of these efforts will be vital in lowering the rate of suicides among our National Guard and Reserve personnel.

Air Force Suicide Prevention Efforts

In testimony before this Subcommittee on April 6, Lt. General (Dr.) Charles Green discussed numerous efforts on behalf of the United States Air Force that AFSP believes will reduce the rate of suicide in the Air Force. This includes the additional support the Air Force provides its most at-risk airmen with frontline supervisor's suicide prevention training given to all supervisors in career fields with elevated suicide rates, expanded counseling services beyond those available through chaplains and mental health clinics, Military Family Life Consultants and Military OneSource which provides counseling to active duty members off-base for up to 12 sessions.

Chairman Inouye, Ranking Member Cochran and Members of the Committee, AFSP once again thanks you for the opportunity to provide testimony on the funding needs of programs within the Department of Defense that play a critical role in suicide prevention efforts. With your help, we can assure those tasked with leading the Department of Defense's response to the unacceptably high rate of suicide among our military personnel will have the resources necessary to effectively prevent suicide.

CONCLUSION OF HEARINGS

Chairman INOUYE. The subcommittee will stand in recess, but we will reconvene on Tuesday, June 28, at which time we'll meet in closed session to receive testimony on the fiscal year 2012 budget for intelligence activities. The subcommittee is recessed.

[Whereupon, at 1:06 p.m., Wednesday, June 22, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]