DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 2011

WEDNESDAY, JUNE 23, 2010

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

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

Present: Senators Inouye and Cochran.

NONDEPARTMENTAL WITNESSES

OPENING STATEMENT OF CHAIRMAN DANIEL K. INOUYE

Chairman INOUYE. I would like to welcome everyone to this hearing where we receive public testimony pertaining to various issues related to the fiscal year 2011 Defense appropriations request.

Because we have so many witnesses today, I would like to remind each witness that they will be limited to no more than 4 minutes apiece. But I can assure you that your full statements will be made part of the record.

And at this point, I would like to recognize the vice chairman of this subcommittee, Senator Cochran of Mississippi.

STATEMENT OF SENATOR THAD COCHRAN

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

I am very pleased to join you and welcome our witnesses who are here today to talk about their views in connection with the Defense Department's fiscal year 2011 budget.

We appreciate your assistance and the time you have taken to prepare your remarks and to present them to us today. Thank you very much.

Chairman INOUYE. The subcommittee has divided the witnesses into four panels. And the first panel consists of Mr. H. James Gooden; Rear Admiral Casey Coane of the Navy, retired; Ms. Janet Hieshetter; and Mr. John R. Davis.

Mr. Gooden, are you prepared?

STATEMENT OF H. JAMES GOODEN, CHAIRMAN, BOARD OF DIRECTORS, AMERICAN LUNG ASSOCIATION

Mr. GOODEN. Yes, I am.

Chairman INOUYE. Please proceed.

Mr. GOODEN. Mr. Chairman, Mr. Vice Chairman, and members of the subcommittee, my name is Jim Gooden, and I am the chair-

man of the board of directors of the American Lung Association. I am honored to testify today.

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 fiscal year 2011 budget. Number one, the terrible burden on the military caused by tobacco use and the need for the Department to aggressively combat it by implementing recommendations from the Institute of Medicine. Two, the importance of restoring the original intent and full funding for the Peer-Reviewed Lung Cancer Research Program. And number three, addressing the health threat posed by burn pits in Iraq and Afghanistan.

First, I would like to speak to the need for the Department of Defense to better combat tobacco use. Tobacco use remains a significant problem for the military. The Department of Defense has started moving in the right direction with making submarines smoke free, as well as other positive actions. But much more is needed to curb tobacco use in the military. Here are a few statistics to point out to what the Department of Defense is up against.

While smoking rates among Active Duty personnel have essentially remained steady since 2002, rates among deployed personnel are significantly higher, and alarmingly, more than 1 in 7, or 15 percent, of Active Duty personnel began smoking after joining the service. This alarming use of tobacco in the military has severe consequences and impacts troop readiness. It impairs physical capacity, vision, and hearing, and increases the chance of physical injury and hospitalization.

Furthermore, the healthcare expenses associated with these behaviors have cost the Department of Defense billions of dollars. The Pentagon spends over $1.6 billion on tobacco-related medical care, increased hospitalization, and lost days of work. Lost productivity costs are primarily caused by smoking breaks and greater absenteeism.

Last summer, the prestigious Institute of Medicine, or IOM, issued a report entitled "Combating Tobacco Use in Military and Veteran Populations." The IOM recommendations include commonsense approaches to eliminating the use of tobacco in the U.S. military. Some of the IOM's recommendations include tobacco-free policies should be phased in, starting with military academies and officer candidate training programs, followed by new enlisted accessions and then all Active Duty personnel.

Also, end the sale of tobacco products on all military installations. Ensure that all DOD personnel have barrier-free access to tobacco cessation services and that healthcare and health promotion staff are trained 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, and we ask for this subcommittee's leadership in ensuring that that happens. Second, the American Lung Association strongly supports the Lung Cancer Research Program (LCRP)

in the Congressionally Directed Medical Research Program and its original intent to research the scope of lung cancer in our military.

We urge this subcommittee to restore the funding level to the fiscal year 2009 level of $20 million, and we request that the 2011 governing language for the LCRP be returned to its original intent as directed by the 2009 program, which directed the funds to be awarded competitively and to identify, treat, and manage early curable lung cancer.

We urge that the national registry be established to track all personnel who were exposed to burn pits while in Iraq. The American Lung Association also recommends that the DOD begin immediately to find alternatives to this method of waste disposal.

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.

Thank you for this opportunity.

Thank you very much, Mr. Chairman.

Chairman INOUYE. Just a matter of curiosity, when I was a young soldier, we were given K-rations for lunches, and in each pack, there was a little pack of cigarettes. And then you were able to buy cigarettes, if you wished to, for 5 cents a pack. When were these practices ceased?

Mr. GOODEN. To that, I will have to defer to my other specialists that are here with me from the American Lung Association, and if they cannot answer at this time, we will gladly be able to put that on the record.

Chairman INOUYE. Thank you very much.

Mr. GOODEN. Thank you, sir.

[The statement follows:]

PREPARED STATEMENT OF JAMES GOODEN

Mr. Chairman and members of the Committee, my name is James Gooden and I am the Chairman of the Board of Directors of the American Lung Association. I am honored to testify today.

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 2011 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-Review Lung Cancer Research Program to $20 million; and the health threat posed by burn pits in Iraq and Afghanistan.

First, the American Lung Association is concerned about the use of tobacco products by troops within the military. The effects of both the health and performance of our troops are significantly hindered by the prevalence of smoking and 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). We were disappointed that this critical public health research program was cut in fiscal year 2010 by $5 million and ask that the funding return to $20 million. Finally, the American Lung Association is deeply troubled by reports of the use of burn pits and the negative effects on lung health on soldiers in both Iraq and Afghanistan. Thus, we urge the DOD to immediately find alternatives to this method of waste disposal.

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 started moving in the right direction with its recent smoking ban on submarines and other positive actions, but much more is needed to curb tobacco use in the military.

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]

This alarming use of tobacco in the military has severe consequences. First, tobacco use compromises military readiness. Studies have found that smoking is one of the best predictors of training failure and smokers also report significantly more stress from military duty than non-smokers. Smoking is also shown to impair a person's physical capacity, vision, or hearing and increase their chances of physical injury and hospitalization.[2] In addition; if a soldier experiences nicotine withdrawal while on active duty; depression, anxiety, and difficulty concentrating on cogitative tasks can develop.[3] All of these consequences have a negative impact on the performance of our men and women in our armed forces.

Furthermore, the healthcare expenses associated with these behaviors have cost the DOD billions of dollars. The Pentagon spends over $1.6 billion on tobacco-related medical care, increased hospitalization and lost days of work. Lost productivity costs are primarily caused by smoking breaks (estimated at 30 minutes over 220 work days a year) and greater absenteeism. There are also great costs associated with the failure of new recruits to complete basic training. It is clear that more must be done to reduce smoking rates and tobacco use among active duty personnel.

Last summer, the prestigious Institute of Medicine (IOM) issued a report entitled, Combating Tobacco Use in Military and Veterans 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 use 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; and

—Ensure that all DOD personnel have barrier-free access to tobacco cessation services.

According to the IOM, the authority for the implementation of all the recommendations should rest with the highest levels of the Department, including the surgeon general of each armed service and the individual installation commander. The American Lung Association asks for the Committee's leadership to ensure this occurs.

The United States military cannot fight two wars without ready and healthy troops to successfully complete each mission. With tobacco use causing a decrease of troop readiness, performance and health, the DOD can no longer afford to stand idly by.

---

[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.

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

Therefore, 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 that its recommendations be implemented without 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. It is for that reason that we were deeply disappointed by changes made by Congress in fiscal year 2010 to the both the LCRP's governing language and funding.

First, LCRP's funding was cut by 25 percent—$5 million—which may diminish the effectiveness of this crucial research. 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 last fiscal year. The language change not only has consequences for the LCRP in the future but also hampered the implementation of the 2009 LCRP. We request that the 2011 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 Concern in Iraq and Afghanistan

The American Lung Association is extremely troubled by reports of soldiers who were exposed to burn pits in Iraq and Afghanistan, and are now returning home with lung illnesses including asthma, chronic bronchitis and sleep apnea. Civilians are also at risk.

Emissions from burning waste contain fine particulate matter, sulfur oxides, carbon monoxide, volatile organic compounds, and various irritant gases such as nitrogen oxides that can scar the lungs. Emissions also contain chemicals that are known or suspected to be carcinogens.

For vulnerable populations, such as people with cardiovascular diseases, diabetes, asthma and chronic respiratory disease, exposure to these burn pits is particularly harmful. Even short exposures can kill. However, the health impact of particle pollution is not limited to individuals with pre-existing conditions. Healthy, young adults who work outside—such as our young men and women in uniform—are also at higher risk.

EPA has just concluded that particulate matter causes heart attacks, asthma attacks, and early death. The particles are extremely small and are unable to be filtered out of our respiratory system. Instead, these small particles end up deep in the lungs where they remain for months, causing structural damage and chemical changes. In some cases, the particles can move through the lungs and penetrate the bloodstream. Larger particles will end up in the upper respiratory system, causing coughs.

Given what we know about the health effects of burning refuse, the American Lung Association recommends that the DOD begin immediately to find alternatives to this method of waste disposal. It is important that the short- and long-term consequences of exposure to these burn pits be monitored by DOD in conjunction with the VA. Finally, we urge that a national registry be established to track all personnel who were exposed to burn pits while in Iraq and Afghanistan.

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. We can ill afford to fight a third war against tobacco and unsafe air conditions with their severe consequences. Thank you for this opportunity.

Chairman INOUYE. Our next witness is Rear Admiral Casey Coane. Admiral.

STATEMENT OF REAR ADMIRAL CASEY COANE, UNITED STATES NAVY (RETIRED), EXECUTIVE DIRECTOR, ASSOCIATION OF THE UNITED STATES NAVY

Admiral COANE. Mr. Chairman, Senator Cochran, the Association of the United States Navy is once again very pleased to have this opportunity to testify before you.

Our Veterans Service Organization focuses a majority of its legislative activity on personnel issues and the equipment necessary for the Navy to carry out its missions. It is only through the attention of Congress and committees such as yours that we can be sure that the needs of our young men and women are being met. We are grateful to take this particular opportunity to speak to you about equipment.

With the pressing personnel needs of the services, it may seem a bit cold for me to be here speaking about ships and aircraft. Nonetheless, the equipment of which I am speaking is vital to the conduct of this war and directly supports the thousands of Navy men and women serving on the ground in Afghanistan, Iraq, or other places in the theater, such as the Horn of Africa. Today, 14,000 Navy people are ashore in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), including Active Duty and reservists.

We are pleased with the increased emphasis that the House has recently shown toward the Navy's ship building plan in order to meet the Nation's maritime strategy. We urge the Senate to do the same.

I invite the subcommittee's attention to the recently released National Guard and Reserve equipment report for fiscal year 2011, signed out by the Assistant Secretary of Defense for Reserve Affairs. In the Navy section of this report, the point is made that the Navy has successfully and fully integrated its Reserve component.

The significance here is that all the Navy's overused and aging organic airlift aircraft are in the Reserve component. The Navy Reserves electronic attack squadron right here at Andrews Air Force Base is a critical and frequently deployed component of the Navy's arsenal and is badly in need of new F–18G Growler aircraft to replace its aged A–6Bs.

The Secretary's report lists aircraft as the top Navy equipping challenge. The aircraft programs listed are the C–40 replacement for the C–9s, the P–8, the Growlers I mentioned, and the KC–130J airlifters. Our association could not agree more.

The issue, as Secretary McCarthy indicates on page 14 of the report, is not just newer aircraft, it is that the current aircraft have aged and turned the maintenance expense curve to the extent that prudent business practices, on behalf of the taxpayer, dictate replacement now.

The Navy needs six more C–40s to finish the program, and it needs some of them this year. The P–8 is an on-time, on-budget program to replace aging and grounded P–3s, the backbone of the Navy's overland reconnaissance effort in theater. Anything that this subcommittee could do to accelerate that program, perhaps by utilization of the NGREA account, would be most beneficial.

The Navy and Air Force have testified to the unfunded need for electronic attack aircraft in fiscal year 2012 and beyond. Without

the transition of the Navy Reserve squadron to the Growler, the Navy will—and I quote from the report—"lose critical operational and strategic Reserve airborne electronic attack capability and capacity." We urge the subcommittee to ensure this does not happen.

The Navy's 30-year aircraft program, the Naval Aviation Plan 2030, has the requirement for the replacement of the C–130T airlifters with the new KC–130Js. Currently, this essential tactical, intra-theater airlift is operating five aircraft short of its requirement.

Each year that the new aircraft is delayed will force the Navy to spend more money to upgrade worn-out aircraft to meet new European aviation aircraft standards without which they cannot fly across Europe. We urge the subcommittee to bring the KC–130J forward in the future year defense plan (FYDP) or by adding to the NGREA account.

Again, the Association of the United States Navy thanks the subcommittee for their tireless efforts on behalf of our services and for providing this opportunity to be heard.

Thank you.

Chairman INOUYE. Thank you very much, Admiral.

Do you have any questions?

Thank you very much, sir.

[The statement follows:]

PREPARED STATEMENT OF REAR ADMIRAL CASEY COANE

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, VA. 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 newly 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 on-going 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 for appropriations reasons within the Service, not because people are not needed and their benefits are not a requirement.

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.

Carriers, submarines, and Naval Aviation are more relevant than ever—as proven by initial and 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.

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 recognize that there are many issues that need to be addressed by this Committee and this Congress. The Association of the United States Navy supports the Navy's fiscal year 2011 budget submission and the 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 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 unite 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 war fighting 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 2011 NDAA in order to maintain optimally qualified and trained Navy and Navy Reserve forces.

Pay, Promotion, and Pride

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 pay raise

discussions of 1.9 percent is woefully inadequate when the Nation considers what service members, Navy members, are doing in defense of this nation. The risks and sacrifices of every service member, to defend this great nation, make it illogical to formulate a direct comparison of civil pay to military pay. It just does not make common sense.

Promotions need to be fairly regular, and attainable.

Pride is a combination of professionalism, parity and awards: doing the job well with requisite equipment, and being recognized for one's sacrifices and efforts.

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 the 9 Navy Ships provided for in the House fiscal year 2011 NDAA.

—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.

—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.

—Increase funding for Naval Reserve equipment in NGREA: Increase Navy Reserve NGREA by $100 million; and Naval Expeditionary Combat Equipment.

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. Our next witness is Ms. Kathy Rentfrow. Ms. Rentfrow.

STATEMENT OF KATHY RENTFROW, VOLUNTEER, DYSTONIA MEDICAL RESEARCH FOUNDATION

Ms. RENTFROW. Mr. Chairman and members of the Senate Appropriations Defense Subcommittee, thank you for allowing me the opportunity to testify today.

My name is Kathy Rentfrow, and I am a volunteer with the Dystonia Medical Research Foundation, or DMRF. 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. More importantly, I am a proud military spouse and the mother of a child suffering from dystonia.

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, affecting all major muscle groups, resulting in twisting, repetitive movements, and abnormal postures, or focal, affecting a specific part of the body, such as the legs, arms, hands, neck, face, mouth, eyelids, or vocal cords.

At this time, no known cure exists, 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.

At age 6, while our family was stationed in Washington, my daughter Melissa was diagnosed with generalized dystonia at Madigan Army Medical Center. What began as muscle spasms in her left shoulder, progressed throughout her entire arm, her right hand, legs, and vocal cords.

Now, at age 15, Melissa is luckier than many dystonia patients, and this is in large part to the superior care she receives as a military dependent. Due to my husband's position as a permanent military professor at the United States Naval Academy, our daughter is able to receive care at Walter Reed Army Medical Center.

Melissa responds well to treatment with medications, but still needs to take upwards of 20 pills per day. Unlike many dystonia sufferers, Melissa's extensive costs are covered by TRICARE. Although she does not have use of her left arm, she is able to walk and talk without more invasive treatments like botulinum toxin injections, or DBS. This not only affects Melissa's quality of life, but also that of our entire family.

Dystonia is not a discriminatory condition. It affects people of all backgrounds, and this increasingly includes military personnel. Conservative estimates suggest that dystonia affects no less than 300,000 Americans. However, the incidence of dystonia has seen a noticeable increase 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 head injuries, other traumatic injuries, and the onset of dystonia.

Until a cure for dystonia can be discovered, it remains vital we learn more about the exact causes of the condition and develop more effective and efficient treatments. Although Federal dystonia research is conducted through a number of medical and scientific agencies, the DOD's Peer-Reviewed Medical Research Program remains the most essential program in studying dystonia in military and veteran populations.

The DMRF has been receiving increasing reports of dystonia from service personnel and family members, as well as increased anecdotal evidence from medical professionals linking dystonia to traumatic brain injury, or TBI. As the subcommittee is aware, TBI has emerged as a trademark injury of the current war efforts in Iraq and Afghanistan, often sustained as the result of improvised explosive devices.

More and more, TBI and other traumatic injuries are serving as the catalyst for the onset of dystonia. As military personnel remain deployed for longer periods, we can expect dystonia prevalence in military and veterans populations to increase.

Thank you for allowing me the opportunity to address the subcommittee today. As the mother of a child suffering from dystonia and as a military spouse concerned with the well-being of our troops, I hope you will continue to include dystonia as a condition eligible for the DOD Peer-Reviewed Medical Research Program.

Chairman INOUYE. May I assure you that the subcommittee will most seriously consider your request. That, I can assure you.

Ms. RENTFROW. Thank you.

Chairman INOUYE. Do you have any——

Senator COCHRAN. I wish we had more time to go into questions and discussions, but I think you can be assured that we take everybody's testimony seriously. And we want you all to know that we appreciate your being here and keeping us up to date on the needs that we face through our medical programs in the military.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF KATHY RENTFROW

Mr. Chairman and members of the Senate Appropriations Defense Subcommittee, thank you for allowing me the opportunity to testify before you today. My name is Kathy Rentfrow, and I am a volunteer with the Dystonia Medical Research Foundation or "DMRF". 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. Most importantly, I am a proud military spouse and the mother of a child suffering from dystonia.

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, affecting all major muscle groups, and resulting in twisting repetitive movements and abnormal postures or focal, affecting a specific part of the body such as the legs, arms, hands, neck, face, mouth, eyelids, or vocal chords. At this time, no known cure exists 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.

At age 6, while our family was stationed in Washington State, my daughter Melissa was diagnosed with generalized dystonia at Madigan Army Medical Center. What began as muscle spasms in her left shoulder and progressed throughout the entire arm, her right hand, legs, and vocal chords. Now at age 15, Melissa is luckier than many dystonia patients, and this is in large part to the superior care she receives as a military dependent. Due to my husband's position as a permanent military professor at the U.S. Naval academy, our daughter is able to receive care at Walter Reed Army Medical Center. Melissa responds well to treatment with medications, but still needs to take upwards of 20 pills per day. Unlike many dystonia sufferers, Tricare covers the extensive costs of her medications. Although she does not have use of her left arm, she is able to walk and talk without more invasive treatments like botulinum toxin injections or DBS. Dystonia affects not only Melissa's quality of life, but also that of our entire family.

Dystonia is not a discriminatory condition, as it affects people of all backgrounds and this increasingly includes military personnel. Conservative estimates suggest that dystonia affects no less than 300,000 Americans. However, the incidence of dystonia has seen a noticeable increase 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 head injuries, other traumatic injuries, and the onset of dystonia. Until a cure for dystonia is discovered, it remains vital we learn more about the exact causes of the condition and develop more effective and efficient treatments for patients.

Although Federal dystonia research is conducted through a number of medical and scientific agencies, the DOD's Peer-Reviewed Medical Research Program remains the most essential program studying dystonia in military and veteran populations. The DMRF has been receiving increasing reports of dystonia from service personnel and family members, as well as increased antidotal evidence from medical professionals linking dystonia to traumatic brain injury or "TBI". As the committee

is aware, TBI has emerged as a trademark injury of the current war efforts in Iraq and Afghanistan, often sustained as the result of improvised explosive devices. More and more, TBI and other traumatic injuries are serving as the catalyst for the onset of dystonia. As military personnel remain deployed for longer periods, we can expect dystonia prevalence in military and veterans populations to increase, particularly in combat personnel.

Dystonia severity and symptoms can vary dramatically from person to person, often drastically effecting quality of life. A June 2006 article in Military Medicine, titled Post-Traumatic Shoulder Dystonia in an Active Duty Soldier reported that, "Dystonia after minor trauma can be as crippling as a penetrating wound, with disability that renders the soldier unable to perform his duties." The article goes on to say that although battlefield treatment may not be practical, "awareness of this disorder [dystonia] is essential to avoid mislabeling, and possibly mistreating, a true neurological disease."

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 DOD Appropriations bill. Unlike other Federally funded medical research programs, conditions eligible for study through the Peer-Reviewed Medical Research Program must affect members of the armed services and their families. As traumatic injuries and dystonia among service personnel increases, it is critical that we develop a better understand of the mechanisms connecting TBI and dystonia. We urge Congress to maintain dystonia as a condition deemed eligible for study through the Peer-Reviewed Medical Research Program, as the number of current military members and veterans with dystonia swells.

Thank you again for allowing me the opportunity to address the Subcommittee today. As the mother of a child suffering from dystonia, and as a military spouse concerned with the well-being of our troops and veterans, I hope you will continue to include dystonia as condition eligible for study under the DOD Peer-Reviewed Medical Research Program.

Chairman INOUYE. And now, may I recognize Mr. John Davis. Mr. Davis.

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

Mr. DAVIS. Thank you, Mr. Chairman.

My name is John Davis, and I want to thank you for the opportunity to express the views of the Fleet Reserve Association. The association appreciates the administration's second consecutive request for full funding of the TRICARE program without a fee increase.

We believe we need to look at other cost-saving options first before looking at a TRICARE fee increase. Further, FRA believes that raising TRICARE fees during wartime would send the wrong message that could impact recruitment and retention. A recent FRA survey indicates that more than 90 percent of all Active Duty, retired, and veteran respondents cited healthcare as their top quality of life benefit.

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 (VA) and for the rest of their lives. Oversight notwithstanding, adequate funding for an effective delivery system between DOD and VA to guarantee a seamless transition and quality services for wounded personnel is very important to our membership.

The association appreciates President Obama's support for authorizing chapter 61 retirees to receive full military retired pay and full veterans' disability compensation. FRA continues to seek authorization of funding of full concurrent receipt for all disabled retirees. An FRA survey indicates that more than 70 percent of military retirees cite concurrent receipt among their top priorities.

The association strongly supports the fiscal year 2011 budget request of $408 million to cover the first phase of the 5-year cost of concurrent receipt for chapter 61 beneficiaries that are 90 percent or more disabled and supports provisions in the so-called "tax extenders bill"—that is H.R. 4213—that expands the concurrent receipt of military retired pay and the VA disability compensation.

Family support is also important and should include full funding for compensation, training and certification, and respite care for family members functioning as full-time caregivers for wounded warriors. The recently enacted Caregivers and Veterans Omnibus Health Services Act—that is S. 1963—and parallel provision in the Senate version of the Defense authorization bill improves compensation, training, and assistance for caregivers of severely disabled Active Duty service members. And if authorized, FRA supports funding for these enhancements.

FRA strongly supports the funding of a 1.9 percent pay increase, which is 0.5 percent above the administration's request for fiscal year 2011. Pay increases in recent years have helped close the pay gap and contributed to improved morale, readiness, and retention. Pay and benefits must reflect the fact that military service is very different from the work in the private sector.

If authorized, FRA supports funding retroactive eligibility for early retirement benefits to include reservists who have supported contingency operations since 9/11/2001. The 2008 Defense authorization act reduces the Reserve retirement age, which is age 60, by 3 months for each cumulative 90 days ordered to Active Duty. This applies only to servicemen after the effective date of legislation, which is January 28, 2008, and leaves out more than 600,000 reservists mobilized since 9/11.

Again, thank you for allowing FRA to submit its views to the subcommittee.

Chairman INOUYE. Mr. Davis, I can assure you that the subcommittee is well aware that the men and women who serve in uniform are all volunteers. And as far as we are concerned, anyone who is willing to stand in harm's way on our behalf deserves the very best. We give it the highest priority.

Thank you very much.

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

We appreciate your testimony and the reminders of the real-life challenges that many of our servicemen and women face, and I hope this subcommittee can respond in a way that shows our concern and support for their efforts and their unselfish service.

[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. Dur-

ing the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

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

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

FRA celebrated 85 years of service in November 2009. For over eight decades, dedication to its members has resulted in legislation enhancing quality of life programs for Sea Services personnel, other members of the uniformed services plus their families and survivors, while protecting their rights and privileges. CHAMPUS, now TRICARE, was an initiative of FRA, as was the Uniformed Services Survivor Benefit Plan (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 of funding essential programs for active duty, Reserve Component, and retired members of the uniformed services, their families, and survivors. The Subcommittee's work in funding important 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 constant high priority for FRA is full funding of the Defense Health Program (DHP) to ensure quality care for active duty, retirees, Reservists, and their families.

FRA's other 2010 priorities include annual active duty pay increases that are at least a half percent above the Employment Cost Index (ECI), to help close the pay gap between active duty and private sector pay, full concurrent receipt of military retired pay and VA disability compensation, 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, and introduction and enactment of legislation to eliminate inequities in the Uniformed Service Former Spouses Protection Act (USFSPA).

The Administration's fiscal year 2011 proposed budget for a second consecutive year fully funds the DHP budget without shifting additional cost burdens to military retirees. FRA appreciates this and strongly supports efforts to fully implement electronic health records that will follow service members as they transition from DOD to the VA. FRA also supports additional improvements in concurrent receipt to expand the number of disabled military retirees receiving both their full military retired pay and VA disability compensation. The fiscal year 2011 budget also calls for a 1.4-percent active duty pay increase that equals the Employment Cost Index (ECI). The budget further increases care for wounded warriors by 5.8 percent, enhances family support by 3 percent, adds $87 million to child development centers, and boosts family counseling/relocation assistance by $37 million over the current fiscal year 2010 budget.

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

HEALTH CARE

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

Efforts to enact a national healthcare reform coupled with inaccurate and widespread information on the associated impact on retiree healthcare benefits has created unease and a sense of uncertainty for our members. FRA opposes any effort to integrate TRICARE and VA healthcare into any national healthcare program. The Association is concerned about proposed Medicare spending cuts associated with reform legislation and scheduled cuts for physician reimbursement rates for Medicare and TRICARE beneficiaries that could negatively impact availability of care, and quality of services. It's also important to note that healthcare costs both in the military and throughout society have continued to increase faster than the Consumer Price Index (CPI) making this a prime target for those wanting to cut the DOD budget.

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

DOD must continue to investigate and implement other TRICARE cost-saving options as an alternative to shifting costs to retiree beneficiaries. FRA notes progress in this area in expanding use of the mail order pharmacy program, Federal pricing for prescription drugs, 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.

CONCURRENT RECEIPT

The Association appreciates President Obama's support for authorizing Chapter 61 retirees to receive their full military retired pay and veteran's disability compensation and continues to seek timely and comprehensive implementation of legislation that authorizes the full concurrent receipt for all disabled retirees. As with last year's budget, the proposed fiscal year 2011 budget does not provide funding or identify spending offsets for these improvements and does not comply with House budgeting rules. The above referenced FRA survey indicates that more than 70 percent of military retirees cite concurrent receipt among their top priorities. The Association strongly supports the fiscal year 2011 budget request of $408 million to cover the first phase of the 5-year cost for concurrent receipt for Chapter 61 beneficiaries that are 90 percent or more disabled and supports the provisions in the so-called "tax-extenders" bill (H.R. 4213) that expands the concurrent receipt of military retired pay and VA disability compensation. The measure would authorize service members who are medically retired with less than 20 years of service (Chapter 61 retirees) and have a disability rating of 90 to 100 percent to receive both payments, without offset, starting on January 1, 2011. The following year concurrent receipt would be expanded to those with 70- to 80-percent disability ratings.

WOUNDED WARRIORS

FRA appreciates the substantial Wounded Warriors provisions in the fiscal year 2008 National Defense Authorization Act (NDAA). Despite jurisdictional challenges, considerable progress has been made in this area. However, the enactment of authorizing legislation is only the first step in helping wounded warriors. Sustained funding is also critical for successful implementation. Jurisdictional challenges notwithstanding adequate funding for an effective delivery system between DOD and VA to guarantee seamless transition and quality services for wounded personnel, particularly those suffering from Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBI) is very important to our membership. Family support is

also critical for success, and should include full funding for compensation, training, and certification, and respite care for family members functioning as full-time caregivers for wounded warriors. FRA supported the recently enacted "Caregivers and Veterans Omnibus Health Services Act" (S. 1963), and parallel legislation included in the Senate's version of the fiscal year 2011 Defense Authorization bill (S. 3454) to improve compensation, training and assistance for caregivers of several disabled active-duty service members.

ADEQUATE PERSONNEL END STRENGTH

Funding for adequate service end strengths is essential to success in Iraq and Afghanistan and to sustaining other operations vital to our national security. FRA notes the Marine Corps' success in attaining its current end strength level and strongly supports the proposed Navy end strength increase in 2011. A recent Navy Times story entitled "Sailor shortage," cites too much work to do in the Navy and not enough people to do it—and lists the associated effects which include little time for rest, fewer people to maintain and repair shipboard equipment, crew members with valuable skills being pulled for other jobs and not replaced and lower material ship readiness.

The strain of repeated deployments continues and is also related to the adequacy of end strengths—and FRA is tracking disturbing indicators of the effects which include increased prescription drug and alcohol use, increasing mental healthcare appointments, alarming suicide rates plus more military divorces. Stress on service members and their families was addressed during a recent Senate Personnel Subcommittee hearing along with serious and continuing concerns about associated effects which can include morale, readiness and retention challenges. FRA urges this distinguished Subcommittee to ensure funding for adequate end strengths and people programs consistent with the Association's DOD funding goal of at least 5 percent of the GDP.

ACTIVE DUTY PAY IMPROVEMENTS

Our Nation is at war and there is no more critical morale issue for active duty warriors than adequate pay. This is reflected in the more than 96 percent of active duty respondents to FRA's recent survey indicating that pay is "very important." The Employment Cost Index for fiscal year 2011 is 1.4 percent and based on statistics from 15 months before the effective date of the proposed active duty pay increase. The Association appreciates the strong support from this distinguished Subcommittee in funding pay increases that have reduced the 13.5 percent pay gap (1999) to the current level of 2.4 percent. In addition, FRA notes that even with a fiscal year 2011 pay increase that is 0.5 percent above the ECI, the result will be the smallest pay hike since 1958. FRA urges the Subcommittee to continue the fund pay increases at least 0.5 percent above the ECI until the remaining 2.4 percent pay gap is eliminated.

RESERVE ISSUES

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

Retirement.—If authorized, FRA supports funding retroactive eligibility for the early retirement benefit to include Reservists who have supported contingency operations since 9/11/2001 (H.R. 208/S. 831/S.644). The fiscal year 2008 Defense Authorization Act (H.R. 4986) reduces the Reserve retirement age (age 60) by 3 months for each cumulative 90-days ordered to active duty 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 funding recommendations to this distinguished Subcommittee. The Association reiterates its profound gratitude for the extraordinary 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. Thank you again for the opportunity to present the FRA's views on these critically important topics.

Chairman INOUYE. I would like to thank the first panel, and may I now call upon the second panel made up of Mr. Terry C. Wicks, Ms. Karen Mason, Ms. Katie Savant, and Dr. Dan Putka.

Welcome, and may I first call upon Mr. Terry Wicks.

STATEMENT OF TERRY C. WICKS, CERTIFIED REGISTERED NURSE ANESTHETIST, MHS, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Mr. WICKS. Chairman Inouye, Vice Chairman Cochran, good morning. My name is Terry Wicks.

Chairman INOUYE. Will you put on the mike, please?

Mr. WICKS. My name is Terry Wicks. I am past president of the 40,000 member American Association of Nurse Anesthetists, and while on Active Duty in the military, I also served as president of the Hawaii Association of Nurse Anesthetists.

The quality of healthcare America provides our servicemen and servicewomen and their dependents has long been this subcommittee's high priority. Today, I report to you the contributions that certified registered nurse anesthetists, or CRNAs, make toward our services' mission, and I will also provide you our recommendations to further improve military healthcare for these challenging times.

I also ask unanimous consent that our written statement be entered in the record.

Chairman INOUYE. Without objection.

Mr. WICKS. America's CRNAs provide some 32 million anesthetics annually in every healthcare setting requiring anesthesia care, and we provide that care safely. The Institute of Medicine reported in 2000 that anesthesia is 50 times safer than it was in the early 1980s.

For the United States armed forces, CRNAs are particularly critical. In 2009, over 500 Active Duty and more than 750 reservist CRNAs provided anesthesia care indispensable to our armed forces' current mission.

Not long ago, one CRNA, Major General Gale Pollock, served as acting Surgeon General of the United States Army. Today, CRNAs serve in major military hospitals, at educational institutions, aboard ships, and in isolated bases abroad and at home. And as members of forward surgical teams, they serve as close to the tip of the spear as they can be.

In most of these environments, CRNAs provide anesthesia services alone—without anesthesiologists—enabling surgeons and other clinicians to safely deliver lifesaving care. But in recent years, the number of CRNAs in the armed forces has fallen below the number needed. The private market for CRNA services is very, very strong, and the military has struggled to compete.

The services, this subcommittee, and the authorizing committees have responded with increased benefits to CRNAs, incentive specialty pay, and the Health Professions Loan Repayment Program, focusing on incentives for multi-year agreements.

The profession of nurse anesthesia has likewise responded. The Counsel on Certification of Nurse Anesthetists reported that in 2009, our schools produced 2,228 graduates, double the number since 2000. And 2,386 nurse anesthetists were certified. That growth is expected to continue.

The Counsel on Accreditation of Nurse Anesthesia Educational Programs projects that CRNA schools will produce over 2,400 graduates in 2010. These combined actions have helped strengthen the services' readiness and the quality of healthcare available to our servicemen and servicewomen.

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

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

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

Thank you, and I would be happy to take any questions.

Chairman INOUYE. Thank you very much.

I can assure that this subcommittee is well aware of the shortage of nurse anesthetists. We are also aware that if it weren't for nurse anesthetists, we won't have any anesthesia in rural America because 85 percent of that is administered by nurse anesthetists.

Mr. WICKS. Yes, sir.

Chairman INOUYE. So we are going to do our very best.

Mr. WICKS. Thank you.

Chairman INOUYE. Do you have any questions?

I thank you very much, sir.

[The statement follows:]

PREPARED STATEMENT OF TERRY C. WICKS

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

CRNAS AND THE ARMED FORCES: A TRADITION OF SERVICE

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

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

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

NURSE ANESTHETISTS IN THE MILITARY

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

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

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

Data gathered from the U.S. Armed Forces anesthesia communities reveal that CRNAs have often been the sole anesthesia providers at certain facilities, both at home and while forward deployed. For decades CRNAs have staffed ships, isolated U.S. bases, and forward surgical teams without physician anesthesia support. The U.S. Army Joint Special Operations Command Medical Team and all Army Forward Surgical Teams are staffed solely by CRNAs. Military CRNAs have a long proud his-

tory of providing independent support and quality anesthesia care to military men and women, their families and to people from many nations who have found themselves in harms way.

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

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

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

It is essential to understand that while there is strong demand for CRNA services in the public and private healthcare sectors, the profession of nurse anesthesia is working effectively to meet this workforce challenge. The AANA anticipates growing demand for CRNAs. Our evidence suggests that while vacancies exist, the demand for anesthesia professionals can be met if appropriate actions are taken. As of January 2010, there are 108 accredited nurse anesthesia schools to support the profession, and the number of qualified registered nurses applying to these schools continues to climb. The growth in the number of schools, number of applicants, and production capacity has yielded significant growth in the number of student nurse anesthetists graduating and being certified into the profession. The Council on Certification of Nurse Anesthetists reports that in 2009 our schools produced 2,228 graduates, a 66 percent increase since 2003, and 2,386 nurse anesthetists became certified. This growth is expected to continue. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) projects that the 108 CRNA schools will produce 2,430 graduates in 2010.

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

INCENTIVE SPECIAL PAY FOR NURSES

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

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

There have been positive results from the Nurse Corps and Surgeons General initiatives to increase incentive special pays for CRNAs. In testimony before the House Armed Services Committee in 2007, Gen. Pollock stated, "We have . . . increased the Incentive Special Pay (ISP) Certified Registered Nurse Anesthetist, and ex-

panded use of the Health Professions Loan Repayment Program (HPLRP). The . . . Nurse Anesthetist bonuses have been very successful in retaining these providers who are critically important to our mission on the battlefield." She also stated in that same statement, "In 2004, we increased the multi-year bonuses we offer to Certified Registered Nurse Anesthetists with emphasis on incentives for multi-year agreements. A year's worth of experience indicates that this increased bonus, 180-day deployments, and a revamped Professional Filler system to improve deployment equity is helping to retain CRNAs."

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

AANA thanks this Committee for its support of the annual ISP for nurse anesthetists. AANA strongly recommends the continuation in the annual funding for ISP at $50,000 or more for fiscal year 2011, which recognizes the special skills and advanced education that CRNAs bring to the DOD healthcare system, and supports the mission of our U.S. Armed Forces.

BOARD CERTIFICATION PAY FOR NURSES

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

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

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

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

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

This VA nurse anesthesia program started in June 2004 with three openings for VA registered nurses to apply to and earn a Master of Science in Nursing (MSN) in anesthesia granted through the University of Texas Houston Health Science Center. In the future, the program is granting degrees through the Northeastern University Bouve College of Health Sciences nurse anesthesia educational program in Boston, Massachusetts. At a time of increased deployments in medical military personnel, this type of VA–DOD partnership is a cost-effective model to fill these gaps in the military healthcare system. At Fort Sam Houston, the VA faculty director has covered her Army colleagues' didactic classes when they are deployed at a moments notice. This benefits both the VA and the DOD to ensure the nurse anesthesia students are trained and certified in a timely manner to meet their workforce obligation to the Federal government as anesthesia providers. We are pleased to note that

the Department of Veterans' Affairs Acting Deputy Under Secretary for Health and the U.S. Army Surgeon General approved funding to start this VA nurse anesthesia school in 2004. In addition, the VA director has been pleased to work under the direction of the Army program director LTC Joseph O'Sullivan, CRNA, Ph.D., to further the continued success of this U.S. Army-VA partnership. With modest levels of additional funding in the VA EISP, this joint U.S. Army-VA nurse anesthesia education initiative can grow and thrive, and serve as a model for meeting other VA workforce needs, particularly in nursing.

CONCLUSION

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

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

Thank you. If you have further questions, please contact the AANA Federal Government Affairs Office at 202–484–8400.

Chairman INOUYE. And our next witness is Ms. Karen Mason.

STATEMENT OF KAREN MASON, REGISTERED NURSE, OVARIAN CANCER NATIONAL ALLIANCE

Ms. MASON. Good morning, Mr. Chairman and Mr. Vice Chairman. I am honored to appear before you in support of the Ovarian Cancer National Alliance's request of $30 million for the Department of Defense Ovarian Cancer Research Program.

My name is Karen Mason, and I am an intensive care nurse from Pitman, New Jersey. I also serve as an integration panel member for the Ovarian Cancer Research Program, which I will refer to as the OCRP for the remainder of my testimony.

As a 9 year survivor of late-stage ovarian cancer, I feel a strong sense of responsibility to my community and sit before you today as the voice of all women with this disease—past, present, and future.

During my 9 years of survivorship, I have befriended many women who also had late-stage ovarian cancer. One by one, I have watched most of these women die. Today, in the Delaware Valley, I know of no other woman diagnosed at a late stage who has survived as long as I have.

I still speak to women newly diagnosed to offer them hope, but now I must hold a piece of my heart in reserve. It is my hope that today I can beseech you to share this responsibility to fund research conducted by the OCRP to find new treatments and early detection for women with or at risk of ovarian cancer.

This year, approximately 20,000 women will be diagnosed with ovarian cancer, and 15,000 women will die of this disease. Ovarian cancer has no test like the mammogram for breast cancer or the Pap test for cervical cancer. Because there is no reliable early detection test, women must rely on their and their doctor's knowledge of ovarian cancer symptoms.

However, most women and even their physicians do not know the symptoms of ovarian cancer, which are often confused with less-threatening conditions. Even with symptom awareness, by the time a woman has symptoms, she will already have late-stage cancer. Two out of three women with ovarian cancer are diagnosed when their cancer is late stage as mine was.

Current treatments are brutal and consist of long debulking surgeries, followed by months of chemotherapies. Even when the initial treatment response seems positive, around 70 to 95 percent of women diagnosed at stages III or IV will have a recurrence.

The OCRP has one bold aim—to eliminate ovarian cancer. Since 1997, the OCRP has funded out-of-the-box, innovative research focused on detection, diagnosis, prevention, and control of ovarian cancer. Many of the funded proposals can be characterized as high risk and high reward. Although we take risk in the research we fund, we believe that investing in innovative research will result in a great breakthrough in the fight against ovarian cancer.

I have volunteered my time for the past 3 years to serve as an integration panel member for the OCRP. I work alongside physicians, scientists, and other patient advocates, and together, we select proposals that we think merit funding. This spring, we received approximately 350 pre-applications. Sadly, we will only be able to fund approximately 30 full proposals. We worry that the cure could be heading into the trash can.

The ovarian cancer community was extremely disappointed when we found out that the OCRP funding was reduced from $20 million in 2009 to $18.75 million in 2010. This cut is shocking when you consider our mortality rate has not decreased, and new treatments and an early detection test are still so desperately needed.

By increasing the OCRP's funding to $30 million for 2011 so that more research can be carried out, you not only help women currently battling this deadly beast, but future generations of women at risk.

Thank you for this opportunity, and I am happy to answer any questions.

Chairman INOUYE. I thank you very much for your testimony.

This subcommittee, about 25 years ago, took a step that was considered rather courageous. We began the cancer research programs for breast cancer. And although women who wear the uniform are required to take physicals, and if they do have breast cancer, that should be somehow detected before they take the oath. We felt that since Defense Department had the money, we would begin our research programs.

It may interest you to know that at this moment, DOD funds more research money than the National Institutes of Health. So I can assure you that your request is given our highest priority.

Ms. MASON. Thank you.

Senator COCHRAN. I was reminded, Mr. Chairman, that you and Senator Stevens led the way for this subcommittee in recommending these funding levels, and I am sure that we will continue to be guided by your good judgment and your serious request for continued funding.

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

[The statement follows:]

PREPARED STATEMENT OF KAREN MASON

Good morning, Mr. Chairman, Ranking Member and Members of the Subcommittee. I am honored to appear before you in support of the Ovarian Cancer National Alliance's request of a minimum of $30 million for the Department of Defense Ovarian Cancer Research Program in fiscal year 2011. My name is Karen Mason and I am an intensive care nurse from Pitman, New Jersey. I also serve as an Inte-

gration Panel member for the Ovarian Cancer Research Program, which I will refer to as the OCRP for the remainder of my testimony.

As a 9 year survivor of late stage ovarian cancer, I feel a strong sense of responsibility to my community and sit before you today as the voice of all women with this disease, past, present and future. It is my hope that today I can beseech you to share this responsibility to fund research conducted by the OCRP that works to find new treatments and an early detection test for ovarian cancer.

This year, approximately 20,000 women will be diagnosed with ovarian cancer and 15,000 women will die of this disease.[1] Ovarian cancer has no test like the mammogram for breast cancer or pap test for cervical cancer. Because there is no reliable early detection test, women must rely on their—and their doctors'—knowledge of ovarian cancer symptoms.

However, most women, and even their doctors, do not know the symptoms of ovarian cancer, which are bloating, pelvic or abdominal pain, urinary urgency or frequency, and difficulty eating or feeling full quickly. These symptoms are often confused with less threatening conditions.

Unfortunately, even with symptom awareness, by the time a woman has symptoms, she will already have late stage cancer. Two out of three women with ovarian cancer are diagnosed when their cancer is late stage, as mine was.[2] Current treatments are brutal and consist of long "debulking" surgeries followed by months of chemotherapies. Even when the initial treatment response seems positive, around 70–95 percent of women diagnosed at stages 3 or 4 will have a recurrence.[3]

During my 9 years of survivorship, I have befriended many women who also had late-stage ovarian cancer. One by one, I have watched most of these women die. Today in the Delaware Valley, I know of no other woman diagnosed at a late stage who has survived as long as I have. I still speak to woman newly diagnosed to offer them hope, but now I must hold a piece of my heart in reserve.

The OCRP has one bold aim: to eliminate ovarian cancer. Since 1997, the OCRP has funded out of the box, innovative research focused on detection, diagnosis, prevention and control of ovarian cancer. Many of the funded proposals can be characterized as high risk and high reward. Although we take risks in the research we fund, we believe that investing in innovative research will result in great breakthroughs in the fight against ovarian cancer.

An example of a scientific breakthrough that came out of the OCRP was the creation of the OVA1 test for risk stratification. This test was recently brought to the market and has received much media attention, most notably in the March 9 edition of the Wall Street Journal.[4] In 2003, Dr. Zhen Zhang, an investigator at John Hopkins School of Medicine received an Idea Development Award from the OCRP in the amount of $563,022. Dr. Zhang's research eventually led to the creation of OVA1, which is a blood test that can help physicians determine if a woman's pelvic mass is at risk for being malignant. While OVA1 is not an early detection test, it is a step in the right direction.

The OCRP is also special in that it involves patient advocates at all levels. I have volunteered my time for the past 3 years to serve as an Integration Panel Member for the OCRP. I work alongside physicians, scientists and other patient advocates and together, we select proposals that we believe merit funding. Patient advocates hold equal weight with scientists and physicians when funding proposals and deciding the program's vision for the future.

Last fall during our vision setting day, I suggested that if the OCRP was truly seeking innovative out of the box researchers, perhaps the reviewers should be blinded as to who the researchers were and what institutions they represent. Imagine my delight when the panel agreed. Because researchers and institutions were blinded to us, a relatively unknown researcher from a lesser institution could conceivably be invited to submit a full proposal based solely on his or her idea.

However, one of my community's biggest fears is that the relatively low incidence of ovarian cancer (lifetime risk of developing invasive ovarian cancer is 1 in 71) versus other types of cancers (lifetime risk of developing breast cancer is 1 in 8) has

---

[1] "Ovarian Cancer." National Cancer Institute. May 4, 2010 <http://www.cancer.gov/cancertopics/types/ovarian>.

[2] M.J. Horner, L.A. G. Ries, M. Krapcho, N. Neyman, R. Aminou, N. Howlader, S.F. Altekruse, E.J. Feuer, L. Huang, A. Mariotto, B.A. Miller, D.R. Lewis, M.P. Eisner, D.G. Stinchcomb, E.K. Edwards, eds. SEER Cancer Statistics Review 1975–2006. National Cancer Institute, 2009. http://seer.cancer.gov/csr/1975_2006.

[3] Armstrong, M.D., Deborah. "Treatment of Recurrent Disease Q&A." John Hopkins Pathology. May 9, 2010 <http://ovariancancer.jhmi.edu/recurrentqa.cfm>.

[4] Johannes, Laura. "Test to Help Determine If Ovarian Masses Are Cancer." The Wall Street Journal March 9, 2010. <http://online.wsj.com/article/SB10001424052748704869304575109703066893506.html>.

resulted in a much smaller investment in ovarian cancer research, thus dissuading young scientists from studying ovarian cancer and instead choosing to head into other organ sites for their careers in order to secure research funding.[5] [6]

Additionally, Michael Seiden, M.D, Ph.D, President and CEO of Fox Chase Cancer Center and a fellow Integration Panel Member aptly stated that:

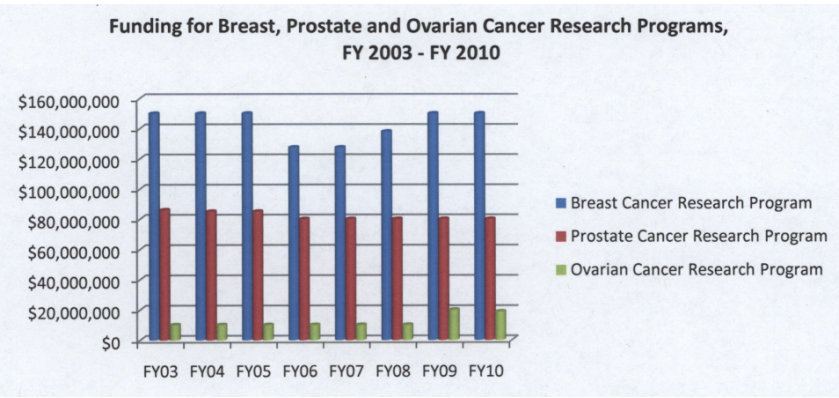
"Reducing the burden of ovarian cancer requires recruiting and, more importantly, mentoring a group of scientists and clinicians who are committed to building sustained and productive careers in ovarian cancer research. Few academic medical or research centers have the large ovarian cancer research teams and the number of junior faculty focused on developing careers that are supported through peer-reviewed, competitively funded ovarian cancer research. Often junior faculty have few if any peers at their research center with common interests; thus, this group often lacks specific mentoring and networking opportunities that would maximize the pace of their career development."

The OCRP addressed this concern last year. We voted to award funding for the creation of an Ovarian Cancer Academy. The Academy puts the African proverb "it takes a village to raise a child" into action by training the next generation of ovarian cancer researchers. This award will develop a unique, interactive virtual academy that will provide intensive mentoring, national networking, and a peer group for junior faculty. Under the guidance of mentors and a chosen Academy Dean, it is hoped that successful, highly productive ovarian cancer researchers will emerge.

But in order to continue supporting innovative research, the OCRP needs increased funding. This spring, we received approximately 350 pre-applications. In the end, we will only be able to fund approximately 30 full proposals. The ovarian cancer community worries that the cure could be heading to the trash can. Only with increased funding can the OCRP grow and continue to contribute to the fight against ovarian cancer.

OVARIAN CANCER COMMUNITY CONCERNED BY FUNDING CUTS TO THE OCRP

The ovarian cancer community was extremely disappointed when we found out that OCRP funding was reduced from $20 million in 2009 to $18.75 in 2010. It is shocking when you consider our mortality rate has not decreased and new treatments and an early detection test are still so desperately needed.



The OCRP remains a modest program compared to the other cancer programs in the Congressionally-Directed Medical Research Programs, and yet has made vast strides in the fight against ovarian cancer with relatively few resources. With an increase in funding, the program can support more research into screening, early diagnosis and treatment of ovarian cancer.

---

[5] "What Are the Key Statistics About Ovarian Cancer?" American Cancer Society. May 2, 2010 <http://www.cancer.org/docroot/cri/content/cri_2_4_1x_what_are_the_key_statistics_for_ovarian_cancer_33.asp>.

[6] "Probability of Breast Cancer in American Women." American Cancer Society. May 3, 2010 <http://www.cancer.gov/cancertopics/factsheet/Detection/probability-breast-cancer>.

CONGRESSIONAL SUPPORT FOR FISCAL YEAR 2011 APPROPRIATION REQUEST

This year, the ovarian cancer community has been proactive in securing support for our fiscal year 2011 appropriation request. A letter addressed to you in support of the $30 million appropriation for the OCRP was signed by Senator Robert Menendez and Senator Olympia Snowe, who were joined by Senators Daniel Akaka, Barbara Boxer, Sherrod Brown, Roland Burris, Ben Cardin, Bob Casey, Susan Collins, Chris Dodd, Richard Durbin, Kirsten Gillibrand, John Kerry, Kay Hagan, Ted Kaufman, Herb Kohl, Frank Lautenberg, Joe Lieberman, Blanche Lincoln, Jack Reed, Bernard Sanders, Charles Schumer, Debbie Stabenow, Sheldon Whitehouse, and Ron Wyden.

A companion letter in the House supporting the $30 million request was sent to Chairman Dicks and Ranking Member Young from Congresswoman Rosa DeLauro and Congressman Dan Burton, who were joined by 84 Representatives from both sides of the aisle: Representatives Andrews, Baldwin, Berkley, Berman, Blumenauer, Boswell, Boucher, Corrine Brown, Capuano, Carney, Carson, Castor, Cleaver, Cohen, Conyers, Crowley, Cummings, Susan Davis, DeGette, Delahunt, Doggett, Donna Edwards, Ellison, Farr, Frank, Gerlach, Gene Green, Grijalva, Gutierrez, John Hall, Halvorson, Hastings, Hirono, Hodes, Holt, Eddie Bernice Johnson, Kildee, Kilroy, Kind, Peter King, Kucinich, Lance, Levin, LoBiondo, Loebsack, Lynch, Maloney, Edward Markey, Marshall, McDermott, McGovern, Meeks, Michaud, George Miller, Brad Miller, Dennis Moore, Gwen Moore, Christopher Murphy, Patrick Murphy, Nadler, Norton, Oberstar, Pascrell, Peterson, Rahall, Richardson, Rush, Schakowsky, Bobby Scott, David Scott, Sestak, Shea-Porter, Snyder, Mike Thompson, Tierney, Tonko, Tsongas, Van Hollen, Velazquez, Walz, Wasserman Schultz, Waxman, Wu and Yarmuth.

APPROPRIATION REQUEST FOR FISCAL YEAR 2011

On behalf of the entire ovarian cancer community—patients, family members, clinicians and researchers—we greatly appreciate your leadership and support of Federal programs that seek to reduce and prevent suffering from ovarian cancer. Thank you in advance for your support of a minimum of $30 million in fiscal year 2011 funding for the Department of Defense Ovarian Cancer Research Program.

Chairman INOUYE. Our next witness, Ms. Katie Savant, Deputy Director of Government Relations, National Military Family Association.

STATEMENT OF KATIE SAVANT, GOVERNMENT RELATIONS DEPUTY DIRECTOR, NATIONAL MILITARY FAMILY ASSOCIATION

Ms. SAVANT. Chairman Inouye, Senator Cochran, the National Military Family Association would like to thank you for the opportunity to present testimony on the quality of life of military families.

Many families have faced the challenge of deployment for 8 plus years. It is imperative that programs and services that provide a firm foundation for our families are fully funded.

Programs must continue to adapt to the changing needs of service members and their families as they cope with multiple deployments, react to separations, balance reintegration, adjust to a wounded or ill service member, or grieve the loss of a fallen service member. Programs should provide for families in all stages of deployment and reach out to them in all geographical locations.

Our association would like to thank the subcommittee for showing strong support for military families by funding essential programs that support today's dynamic and diverse military family, but more needs to be done. In this statement, our association will address areas that require additional funding or new funding.

In May 2008, our association commissioned the RAND Corporation to conduct a longitudinal study on the deployment experiences of 1,500 families. The baseline findings were presented to Congress earlier this year. As a result of this research, our association be-

lieves we need dedicated resources, such as additional youth or teen centers, to support the needs of our older youth and teens during deployment.

National Guard and Reserve component families appreciate the implementation of the Yellow Ribbon Program. Our association asked Congress to fully fund the Yellow Ribbon Program so it is consistent across the Nation and accessible to all families.

The National Defense Authorization Act (NDAA) for Fiscal Year 2010 established the Office of Community Support for military families with special needs. The new office will go a long way in identifying and addressing special needs services. In order for this office to be successful, it will require funding.

Military families place a high priority on the education of our military children. With States facing major budget cuts, Impact Aid will be a critical component to help school districts. We urge Congress to fully fund Impact Aid to its authorized levels.

Military families are monitoring national healthcare reform and its potential impact in our population. We thank Congress for legislation that recognizes TRICARE meets minimal essential coverage under healthcare reform. However, we request your continued vigilance to ensure quality healthcare for military families.

We suggest additional funding and flexibility in hiring practices when our military doctors deploy. We also recommend additional funding to DOD for possible civilian provider shortages due to reduced Medicare reimbursement rates and potential decreased provider availability due to healthcare reform.

Our association applauds the recent passage of the Caregivers and Veterans Health Services Act. We would like to highlight two additional areas that will support our wounded service members. In last year's NDAA, it provided compensation for service members with assistance in everyday living. Unfortunately, this DOD mandate was not funded.

For a seamless transition from Active Duty to veteran status, the service member's compensation amount should match the aid and attendance level the wounded service member would be eligible for by the Veterans Administration (VA). Additionally, current law permits the Secretary of the VA to provide a caregiver stipend. Caregivers have been shown to play an important role in maintaining the well-being of service members, and this provision should be funded.

Our association has long advocated for enhanced benefits for survivors. Over 90 percent of families attended the ceremony at Dover to witness the dignified transfer of remains. Currently, the services are funding the travel out of pocket. We ask that funding be appropriated for travel costs for surviving family members to attend.

Our association recognizes and appreciates the many resources and programs that support our military families during this time of war. The need will not go away when the war ends. We ask for you to help the Nation sustain and support our military families.

Thank you.

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

We are well aware that in World War II and Korea and Vietnam, the words "military family" were not used too often because when

I was a little soldier, in my regiment, 4 percent had dependents, 96 percent were single.

Ms. SAVANT. Wow.

Chairman INOUYE. Today, in a typical regiment, 70 percent have dependents. So we know that this is an important part of army life and military life. So I can assure you that if we are to maintain this strong military posture, we will have to look into military families.

Ms. SAVANT. Thank you.

Senator COCHRAN. Mr. Chairman, thank you for your leadership in providing sensitive and meaningful assistance to families. And I know with programs like the Yellow Ribbon Program and others, families are doing a great job with self help and contributions that are very, very important to the morale of our troops, men and women.

Ms. SAVANT. Thank you.

Chairman INOUYE. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF KATIE SAVANT

The National Military Family Association is the leading nonprofit organization committed to improving the lives of military families. Our 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 Representatives in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteer Representatives are our "eyes and ears," bringing shared local concerns to national attention.

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

Our website is: www.MilitaryFamily.org.

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

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

FAMILY READINESS

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

We appreciate provisions in the National Defense Authorization Acts 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, times when a new program was initiated before looking to see if an existing pro-

gram could be adapted to answer an evolving need. Service members and their families are continuously in the deployment cycle, anticipating the next separation, in the throes of deployment, or trying to reintegrate when the service member returns. Dwell times seem shorter and shorter as training, schools, and relocation impede on time that is spent in the family setting.

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

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

Child Care

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

Innovative strategies are needed to address the non-availability of after-hours child care (before 6 a.m. and after 6 p.m.) and respite care. We applaud the partnership between the Services and the National Association of Child Care Resource and Referral Agencies (NACCRRA) that provides subsidized child care to families who cannot access installation based child development centers. Families often find it difficult to obtain affordable, quality care especially during hard-to-fill hours and on weekends. Both the Navy and the Air Force have programs that provide 24/7 care. These innovative programs must be expanded to provide care to more families at the same high standard as the Services' traditional child development programs. The Army, as part of the funding attached to its Army Family Covenant, has rolled out more space for respite care for families of deployed soldiers. Respite care is needed across the board for the families of the deployed and the wounded, ill, and injured. We are pleased the Services have rolled out more respite care for special needs families, but are concerned when we hear that some installations are already experiencing shortfalls of funding for respite care early in the year.

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

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

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

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.

Our Association is working to meet this pressing need through our Operation Purple® (OPC) summer camps. Unique in its ability to reach out and gather military

children of different age groups, Services, and components, our Operation Purple program provides a safe and fun environment in which military children feel immediately supported and understood. For the second year, with the support of private donors, we achieved our goal of sending 10,000 military children to camp in 2009. We also provided the camp experience to families of the wounded. This year, we expect to maintain those numbers by offering 92 weeks of camp in 40 states, Guam and Germany. In 2009, we introduced a new program under our Operation Purple umbrella, offering family reintegration retreats in the National Parks. They have been well received by our families and more apply than can attend. We are offering 10 retreats this year.

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

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

How are school-age military children faring?

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

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

—As the months of parental deployment increased so did the child's challenges.

—The total number of months away mattered more than the number of deployments.

—Older children experienced more difficulties during deployment.

—There is a direct correlation between the mental health of the caregiver and the well-being of the child.

—Girls experienced more difficulty during reintegration, the period of months readjusting after the service member's homecoming.

—About one-third of the children reported symptoms of anxiety, which is somewhat higher than the percentage reported in other national studies of children.

—In these initial findings, there were no differences in results between Services or Components.

What are the implications? Families facing longer deployments need targeted support—especially for older teens and girls. Supports need to be in place across the entire deployment cycle, including reintegration, and some non-deployed parents may need targeted mental health support. One way to address these needs would be to create a safe, supportive environment for older youth and teens. Dedicated Youth Centers with activities for our older youth would go a long way to help with this.

Our Association feels that more dedicated resources, such as youth or teen centers, would be beneficial to address the needs of our older youth and teens during deployment.

Families Overseas

Families stationed overseas face increased challenges when their service member is deployed into theater. One such challenge we have heard from families stationed in European Command (EUCOM) concerns care for a family member, usually the spouse, who may be injured or confined to bed for an extended illness during deployment. Instead of pulling the service member back from theater, why not provide transportation for an extended family member or friend to come from the States to care for the injured or ill family member? This has been a recommendation from the EUCOM Quality of Life conference for several years.

National Guard and Reserve

The National Military Family Association has long recognized the unique challenges our Reserve Component families face and their need for additional support. National Guard and Reserve families are often geographically dispersed, live in rural areas, and do not have the same family support programs as their active duty

counterparts. The final report from the Commission on the National Guard and Reserve confirmed what we have always asserted: "Reserve Component families face special challenges because they are often at a considerable distance from military facilities and lack the on-base infrastructure and assistance available to active duty families."

This is especially true when it comes to accessing the same level of counseling and behavioral health support as active duty families. However, our Association applauds the innovative counseling and behavioral health support to National Guard and Reserve families, in the form of Military OneSource counseling, the TRICARE Assistance Program (TRIAP), and Military Family Life Consultants (MFLC). Combined, these valuable resources are helping to address a critical need for our Reserve Component families.

In the past several years, great strides have been made by both Congress and the Services to help strengthen our National Guard and Reserve families. Our Association wishes to thank Congress for authorizing these important provisions. We urge you to fully fund these vital quality of life programs critical to our Reserve Component families, who have sacrificed greatly in support of our Nation.

In addition, our Association would like to thank Congress for the provisions allowing for the implementation of the Yellow Ribbon Program, and for including reporting requirements on the program's progress in the NDAA fiscal year 2010. We continue to urge Congress to make the funding for this program permanent. In addition, we ask that you conduct oversight hearings to ensure that Yellow Ribbon services are consistent across the nation. We also ask that the definition of family member be expanded to allow non-ID card holders to attend these important programs, in order to support their service member and gain valuable information.

Our Association asks Congress to fully fund the Yellow Ribbon Program, and provide oversight hearings to ensure that Yellow Ribbon services are consistent across the nation, and are accessible to all Reserve Component families. We also ask for funding for those persons designated by the service member to attend Yellow Ribbon Program events.

FAMILY HEALTH

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

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

Military Health System

Improving Access to Care

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

Our Association continues to examine military families' experiences with accessing the Military Health System (MHS). Families' main issues are: access to their Primary Care Managers (PCM); getting someone to answer the phone at central ap-

pointments; having appointments available when they finally got through to central appointments; after hours care; getting a referral for specialty care; being able to see the same provider or PCM; and having appointments available 60, 90, and 120 days out in our MTFs. Families familiar with how the MHS referral system works seem better able to navigate the system. Those families who are unfamiliar report delays in receiving treatment or sometimes decide to give up on the referral process and never obtain a specialty appointment. Continuity of care is important to maintain quality of care. The MTFs are stressed from 9 years of provider deployments, directly affecting the quality of care and contributing to increased costs. Our Association thanks Congress for requiring, in the NDAA fiscal year 2009, a report on access to care and we look forward to the findings. This report must distinguish between access issues in the MTFs, as opposed to access in the civilian TRICARE networks.

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

Support for Special Needs Families

Case management for military beneficiaries with special needs is not consistent because the coordination of the military family's care is being done by a non-synergistic MHS. 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 is further exacerbated when a special needs family member is involved. Families need a seamless transition and a warm handoff between TRICARE regions and a universal case management process across the MHS. The current case management system is under review by DOD and TRICARE Management Activity (TMA). Each TRICARE Managed Care Contractor has created different case management processes.

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

There has been discussion over the past years by Congress and military families regarding the ECHO program. The NDAA fiscal year 2009 included a provision to increase the cap on certain benefits under the ECHO program and the NDAA fiscal year 2010 established the Office of Community Support for Military Families with Special Needs. The ECHO program was originally designed to allow military families with special needs to receive additional services to offset their lack of eligibility for state or Federally provided services impacted by frequent moves. We suggest that before making any more adjustments to the ECHO program, Congress should direct DOD to certify if the ECHO program is working as it was originally designed and if it has been effective in addressing the needs of this population. We need to make the right fixes so we can be assured we apply the correct solutions. This new office will go a long way in identifying and addressing special needs. However, we must remember that our special needs families often require medical, educational,

and family support resources. This new office must address all these various needs in order to effectively implement change.

We ask for funding for the Office of Community Support for Military Families with Special Needs so this important new office can begin helping our special needs families.

National Guard and Reserve Member Family Health Care

National Guard and Reserve families need increased education about their healthcare benefits. We also believe that paying a stipend (NDAA fiscal year 2008) to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan may prove to be more cost-effective for the government than subsidizing 72 percent of the costs of TRICARE Reserve Select for National Guard or Reserve members not on active duty.

Grey Area Reservist

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

TRICARE Reimbursement

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

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

Pharmacy

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

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

We believe it is imperative that all medications available through TRICARE Retail Pharmacy (TRRx) should also be made available through TRICARE Mail Order Pharmacy (TMOP). Medications treating chronic conditions, such as asthma, diabetes, and hypertension should be made available at the lowest level of co-payment regardless of brand or generic status. We agree with the recommendations of The Task Force on the Future of Military Health Care that over-the-counter (OTC) drugs be a covered pharmacy benefit without a co-payment for TMOP Tier 1 medications.

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

National Health Care

We thank Congress for legislation that recognizes that TRICARE meets minimal essential coverage under National Health Care reform. However, we request your continued vigilance to ensure quality healthcare for military families. The perfect storm is brewing. TMA will institute the new T3 contact at the same time

healthcare reform changes are implemented. Currently, at least one out of three TRICARE Managed Care Contractors could change. This means that the contracts of those TRICARE providers would need to be renegotiated. Healthcare reform and Medicare reimbursement rate changes are adding to the demands and uncertainty of our providers. Our Association is concerned that providers will be unwilling to remain in the TRICARE network and it will become very difficult to recruit new providers. The unintended consequence may be a decrease in access of care due the lack of available healthcare providers. DOD will need additional funding to increase reimbursement rates if provider shortages develop.

DOD Must Look for Savings

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

—Requiring the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality healthcare in a cost-effective manner;

—Creating an oversight committee, similar in nature to the Medicare Payment Advisory Commission, which provides oversight to the Medicare program and makes annual recommendations to Congress. The Task Force on the Future of Military Health Care often stated it was unable to address certain issues not within their charter or the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.

—Establishing a Unified "Joint" Medical Command structure, which was recommended by the Defense Health Board in 2006.

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

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

We recommend additional funding to DOD for potential civilian provider shortages within the community due to reduced Medicare reimbursement rates and potential decreased provider availability due to healthcare reform.

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

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

Behavioral Health Care

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

Full Spectrum of Care

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

Access to Behavioral Health Care

Our Association is concerned about the overall shortage of psychological health providers in TRICARE's direct and purchased care network. DOD's Task Force on Mental Health stated timely access to the proper psychological health provider remains one of the greatest barriers to quality mental health services for service members and their families. The Army Family Action Plan (AFAP) identified mental health issues as their number three issue for 2010. While families are pleased more

psychological health providers are available in theater to assist their service members, they are disappointed with the resulting limited access to providers at home. Families are reporting increased difficulty in obtaining appointments with social workers, psychologists, and psychiatrists at their MTFs and clinics. The military fuels the shortage by deploying some of its child and adolescent psychology providers to combat zones. Providers remaining at home report they are overwhelmed by treating active duty members and are unable to fit family members into their schedules. This can lead to compassion fatigue, creating burnout and exacerbating the provider shortage problem.

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

Families must be included in mental health counseling and treatment programs for service members. Family members are a key component to a service member's psychological well-being. We recommend an extended outreach program to service members, veterans, and their families of available psychological health resources, such as DOD, VA, and State agencies.

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

Availability of Treatment

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

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

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

—using and funding alternative treatment methods, such as telemental health;

—modifying licensing requirements in order to remove geographic practice barriers that prevent psychological health providers from participating in telemental health services outside of a VA facility;

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

National Guard and Reserve Members

The National Military Family Association is especially concerned about fewer mental healthcare services available for the families of returning National Guard and Reserve members as well as service members who leave the military following the end of their enlistment. They are eligible for TRICARE Reserve Select, but as we know, National Guard and Reserve members are often located in rural areas where there may be no mental health providers available. Policy makers need to address the distance issues that families face in linking with military mental health resources and obtaining appropriate care. Isolated National Guard and Reserve families do not have the benefit of the safety net of services provided by MTFs and installation family support programs. Families want to be able to access care with a provider who understands or is sympathetic to the issues they face. We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture. We hear the National Guard Bureau's Psychological Health Services (PHS) is not working as designed to address their mental health issues. This program needs to be re-evaluated to determine its effectiveness.

Children

Our Association is concerned about the impact deployment and/or the injury of the service member is having on our most vulnerable population, children of our military and veterans. Our study on the impact of the war on caregivers and children found deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not "rock the boat." They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve members face unique challenges since there are no military installations for them to utilize. They find themselves "suddenly military" without resources to support them. School systems are generally unaware of this change in focus within these family units and are ill prepared to lookout for potential problems caused by these deployments or when an injury occurs. Also vulnerable, are children who have disabilities that are further complicated by deployment and subsequent injury of the service members. Their families find stress can be overwhelming, but are afraid to reach out for assistance for fear of retribution to the service member's career. They often choose not to seek care for themselves or their families. We appreciate the inclusion of a study on the mental health needs of our children in the NDAA fiscal year 2010 and hope the research we commissioned will provide useful information as the study is designed.

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

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

phase of their lives. School systems must become more involved in establishing and providing supportive services for our nation's children.

Caregiver Burnout

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

Education

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

The families of service members and veterans must be educated about the effects of mTBI and PTSD in order to help accurately diagnose and treat the service member/veteran's condition. These families are on the "sharp end of the spear" and are more likely to pick up on changes attributed to either condition and relay this information to their healthcare providers. 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.

Reintegration Programs

Reintegration programs become a key ingredient in the family's success. Our Association believes we need to focus on treating the whole family with programs offering readjustment information; education on identifying mental health, substance abuse, suicide, and TBI; and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties. We appreciate the inclusion in the NDAA fiscal year 2010 for education programs targeting pain management and substance abuse for our families. As Services roll out suicide prevention programs, we need to include our families, communities, and support personnel.

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

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

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

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

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

Wounded Service Members Have Wounded Families

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

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

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

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

The Vet Centers are an available resource for veterans' families providing adjustment, vocational, and family and marriage counseling. The VA healthcare facilities and the community-based outpatient clinics (CBOCs) have a ready supply of mental health providers. We recommend DOD partner with the VA to allow military families access to mental health services. We also believe Congress should require the VA, through its Vet Centers and healthcare facilities to develop a holistic approach to care by including families when providing mental health counseling and programs to the wounded, ill, and injured service member or veteran.

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

Transitioning for the Wounded and Their Families

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

Transition of healthcare coverage for our wounded, ill, and injured and their family members is a concern of our Association. These service members and families desperately need a healthcare bridge as they deal with the after effects of the injury and possible reduction in their family income. We have created two proposals. Service members who are medically retired and their families should be treated as active duty for TRICARE fee and eligibility purposes for 3 years following medical retirement. This proposal will allow the family not to pay premiums and be eligible for certain programs offered to active duty, such as ECHO for 3 years. Following that period, they would pay TRICARE premiums at the rate for retirees. Service members medically discharged from service and their family members should be allowed to continue for 1 year as active duty for TRICARE and then start the Continued Health Care Benefit Program (CHCBP) if needed.

Caregivers

Caregivers need to be recognized for the important role they play in the care of their loved one. 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 and these services must be funded.

The VA has made a strong effort in supporting veterans' caregivers. The DOD should follow suit and expand their definition. We appreciate the inclusion in NDAA fiscal year 2010 of compensation for service members with assistance in everyday living. This provision will need funding.

Compensation of caregivers should be a priority for DOD and the Secretary of Homeland Security for our Coast Guard. Caregivers must be recognized for their sacrifices and the important role they play in maintaining the quality of life of our wounded, ill, and injured service members and veterans. Current law allows the Secretary of the VA to provide a caregiver stipend, however it is an unfunded mandate. Our Association strongly believes this stipend needs to be fully funded.

Consideration should also be given to creating innovative ways to meet the healthcare and insurance needs of the caregiver, with an option to include their family. Current law does not include a "family" option.

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

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

Relocation Allowance and Housing

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

Our Association suggests that legislation be passed to allow medically retired single service members the opportunity to have their caregiver's household goods moved as a part of the medical retired single service member's PCS move. This should be allowed for the qualified caregiver of the wounded, ill, and injured 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 Federal Recovery Coordinator (case manager), the service member's medical physician, the service member, and the caregiver. All aspects of care for the medically retired service member and their caregiver shall be considered. These include a holistic examination of the medically retired service member, the caregiver, and the caregiver's family for, but not limited to, their needs and opportunities for 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. This relocation provision will require DOD funding.

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

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

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

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

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

Senior Oversight Committee

Our Association is appreciative of the provision in the NDAA fiscal year 2010 establishing a DOD Task Force on the Care, Management, and Transition of Recovery, Wounded, Ill, and Injured Members of the Armed Forces to access policies and programs. This Task Force will be independent and in a position to monitor DOD and VA's partnership initiatives for our wounded, ill, and injured service members and their families.

The National Military Family Association encourages the all committees with jurisdiction over military personnel and veterans matters to talk on these important issues. We can no longer continue to create policies in a vacuum and be content on focusing on each agency separately because this population moves too frequently between the two agencies, especially our wounded, ill, and injured service members and their families.

FAMILY TRANSITIONS

Survivors

In the past year, the Services have been focusing on outreach to surviving families. In particular, the Army's SOS (Survivor Outreach Services) program makes an effort to remind these families that they are not forgotten. DOD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need, through all of VA's venues. New legislative language governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement or grief counseling. The goal is the right care at the right time for optimum treatment effect. DOD and the VA need to better coordinate their mental health services for survivors and their children.

We thank Congress for extending the TRICARE Dental benefit to surviving children. We ask that eligibility be expanded to those active duty family members who had not been enrolled in the active duty TRICARE Dental benefit prior to the service member's death.

Our Association recommends that eligibility be expanded to active duty survivors who had not been enrolled in the TRICARE Dental Program prior to the service member's death. We also recommend that grief counseling be more readily available to survivors.

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.

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 pleased that the requirement for a report to assess the adequacy of DIC payments was included in the NDAA fiscal year 2009. We are awaiting the overdue report. We support raising DIC payments to 55 percent of VA Disability Compensation. When changes are made, ensure that DIC eligibles under the old system receive an equivalent increase.

We ask the DIC offset to SBP be eliminated to recognize the length of commitment and service of the career service member and spouse. We also request that SBP benefits be allowed to be paid to a Special Needs Trust in cases of disabled family members.

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

Education of Military Children

The National Military Family Association would like to thank Congress for including a "Sense of Congress" in regards to the Interstate Compact on Educational Opportunity for Military Children in last year's National Defense Authorization Act. The Compact has now been adopted in 30 states and covers over 84 percent of our military children. The Interstate Commission, the governing body of the Compact, is working to educate military families, educators, and states on the appropriate usage of the Compact. The adoption of the Compact is a tremendous victory for military families who place a high value on education.

However, military families define the quality of that education differently than most states or districts that look only at issues within their boundaries. For military families, it is not enough for children to be doing well in their current schools, they must also be prepared for the next location. The same is true for children in underperforming school systems. Families are concerned that they will lag behind students in the next location. With many states cutting educational programs due to the economic downturn, this concern is growing. A prime example is Hawaii, which opted to furlough teachers on Fridays, cutting 17 days from the school calendar. With elementary schools already on a shortened schedule for Wednesday, these students are only getting approximately 3½ days of instruction every other week. In addition, the recent cuts have made it increasing hard for schools to meet IEP re-

quirements for special needs students. Furthermore, Hawaii is requiring parents to pay more for busing, and the cost of school meals have gone up 76 percent. Our Association believes that Hawaii's cuts are just the "tip of the iceberg" as we are beginning to see other states make tough choices as well. Although Hawaii's educational system has long been a concern for military families, many of whom opt for expensive private education, Hawaii is not the only place where parents have concerns. The National Military Family Association believes that our military children deserve to have a good quality education wherever they may live. However, our Association recognizes that how that quality education is provided may differ in each location.

We urge Congress to encourage solutions for the current educational situation across the nation and recognize that service members' lack of confidence that their children may receive a quality education in an assignment location can affect the readiness of the force in that location.

While our Association remains appreciative for the additional funding Congress provides to civilian school districts educating military children, Impact Aid continues to be under-funded. We urge Congress to provide appropriate and timely funding of Impact Aid through the Department of Education. In addition, we urge Congress to increase DOD Impact Aid funding for schools educating large numbers of military children to $60 million for fiscal year 2011. We also ask Congress to include an additional $5 million in funding for special needs children. The DOD supplement to Impact Aid is critically important to ensure school districts provide quality education for our military children.

As increased numbers of military families move into new communities due to Global Rebasing and BRAC, their housing needs are being met further and further away from the installation. Thus, military children may be attending school in districts whose familiarity with the military lifestyle may be limited. Educating large numbers of military children will put an added burden on schools already hard-pressed to meet the needs of their current populations. We urge Congress to authorize an increase in this level of funding until BRAC and Global Rebasing moves are completed.

Once again, we thank Congress for passing the Higher Education Opportunity Act of 2008, which contained many new provisions affecting military families. Chief among them was a provision to expand in-state tuition eligibility for military service members and their families, and provide continuity of in-state rates if the service member receives Permanent Change of Station (PCS) orders out of state. However, family members have to be currently enrolled in order to be eligible for continuity of in-state tuition. Our Association is concerned that this would preclude a senior in high school from receiving in-state tuition rates if his or her family PCS's prior to matriculation. We urge Congress to amend this provision.

We ask Congress to increase the DOD supplement to Impact Aid to $60 million to help districts better meet the additional demands caused by large numbers of military children, deployment-related issues, and the effects of military programs and policies. We also ask Congress to include an additional $5 million for school districts with Special Needs children.

Spouse Education & Employment

Our Association wishes to thank Congress for recent enhancement to spouse education opportunities. In-state tuition, Post 9/11 G.I. bill transferability to spouses and children, and other initiatives have provided spouses with more educational opportunities than previous years.

Since 2004, our Association has been fortunate to sponsor our Joanne Holbrook Patton Military Spouse Scholarship Program, with the generosity of donors who wish to help military families. Our 2010 application period closed on January 31, 2010. We saw a 33 percent increase in applications from previous years with more than 8,000 military spouses applying to our program. Military spouses remain committed to their education and need assistance from Congress to fulfill their educational pursuits.

We have heard from many military spouses who are pleased with the expansion of the Military Spouse Career Advancement Accounts, now called MyCAA. Unfortunately the abrupt halt of the program on February 16, 2010 created a financial burden and undue stress for military spouses. We are pleased DOD has reinstated the program for the 136,583 spouses enrolled in the program prior to February 16, 2010. We ask Congress to push DOD to fully restart this critical program for all eligible spouses as soon as possible. We also ask Congress to fully fund the MyCAA program, which is providing essential educational and career support to military spouses. The MyCAA program is not available to all military spouses. We ask Congress to work with the appropriate Service Secretary to expand this funding to the

spouses of Coast Guard, the Commissioned Corps of NOAA and U.S. Public Health Service.

Our Association thanks you for establishing a pilot program to secure internships for military spouses with Federal agencies. Military spouses look forward to enhanced career opportunities through the pilot program. We hope Congress will monitor the implementation of the program to ensure spouses are able to access the program and eligible spouses are able to find Federal employment after successful completion of the internship program.

To further spouse employment opportunities, we recommend an expansion to the Workforce Opportunity Tax Credit for employers who hire spouses of active duty and Reserve component service members, and to provide tax credits to military spouses to offset the expense in obtaining career licenses and certifications when service members are relocated to a new duty station within a different state.

The Services are experiencing a shortage of medical, mental health and child care providers. Many of our spouses are trained in these professions or would like to seek training in these professions. We think the Services have an opportunity to create portable career opportunities for spouses seeking in-demand professions. In addition to the MyCAA funding, what can the Services do to encourage spouse employment and solve provider shortages? We would like to see the Services reach out to military spouses and offer affordable, flexible training programs in high demand professions to help alleviate provider shortages.

Our Association urges Congress to recognize the value of military spouses by fully funding the MyCAA program, and by creating training programs and employment opportunities for military spouses in high demand professions to help fill our provider shortages.

Families on the Move

A 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. 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 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 bare for government ordered moves.

Military Families—Our Nation's Families

We thank you for your support of our service members and their families and we urge you to remember their service as you work to resolve the many issues facing our country. Military families are our Nation's families. They serve with pride, honor, and quiet dedication. Since the beginning of the war, government agencies,

concerned citizens and private organizations have stepped in to help. This increased support has made a difference for many service members and families, yet, some of these efforts overlap while others are ineffective. In our testimony, we believe we have identified improvements and additions that can be made to already successful programs while introducing policy or legislative changes that address the ever changing needs of our military population. Working together, we can improve the quality of life for all these families

Chairman INOUYE. Our next witness is Dr. Dan Putka, American Psychological Association. Am I correct, Putka?

STATEMENT OF DAN PUTKA, Ph.D., ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Dr. PUTKA. Good morning, Mr. Chairman and Ranking Member Cochran.

I am Dr. Dan Putka from HumRRO, the Human Resources Research Organization. I am submitting testimony on behalf of the American Psychological Association, or APA, a scientific and professional organization of more than 152,000 psychologists.

For decades, clinical and research psychologists have used their unique and critical expertise to meet the needs of our military and its personnel, playing a vital role within the Department of Defense. My own military-oriented research and consulting focus on the recruitment and retention of committed high-performing military personnel.

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

In the President's proposed fiscal year 2011 budget, defense S&T would fall from the estimated fiscal year 2010 level of $14.7 billion to $12.3 billion, a decrease of 16.3 percent. All military labs would see cuts to their 6.2 and 6.3 applied research accounts, with some cuts as high as 49 percent, namely, the Army's 6.3 account.

Defense supported basic research, the 6.1 account, would fare better under the President's budget, and APA supports the substantial increase proposed for the Defense-wide basic research program. But we are very concerned about the deep cuts to near-term research supported by the 6.2 and 6.3 program accounts.

This is not the time to reduce support for research that is vital to our Nation's continued security in a global atmosphere of uncertainty and asymmetric threats. APA urges the subcommittee to reverse this cut to the critical defense science program by providing $15 billion for defense S&T in fiscal year 2011.

Within the S&T program, APA encourages the subcommittee to follow the recommendations from the National Academies and the Defense Science Board to fund priority research in the behavioral sciences in support of national security. Psychological scientists supported by the military labs address a broad range of important issues and problems vital to our national defense, with expertise in modeling behavior of individuals and groups, understanding and optimizing cognitive functioning, perceptual awareness, complex decisionmaking, stress resilience, recruitment and retention, military family functioning, and human systems interactions.

Psychological scientists also have critical expertise in understanding extremist ideologies, radicalization processes, and

counterinsurgencies. And we hope you will join the House in renewing your strong support for the DOD Minerva Initiative to address these and other compelling challenges.

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

Thank you for this opportunity.

Chairman INOUYE. Doctor, as you may be well aware, it wasn't too long ago when DOD did not fully recognize the worth of psychologists. They were not considered good enough to be in the star rank.

But this subcommittee took the step to give psychologists the recognition they deserve. And as a result, we have much psychological research and psychologists on our staffs. So you can be assured that we won't take a back seat to anything.

Senator COCHRAN. Mr. Chairman, I think it is interesting to observe that the Minerva Initiative was established by Secretary Gates I think with the realization that a better understanding of extremist ideologies in the world today need the attention of the Department of Defense.

So we have hopes that through funding programs like that, making sure there is enough money there to achieve our goals, we can improve the safety factor of service and of citizenship in our great country.

Chairman INOUYE. I thank you very much, and I thank the panel.

[The statement follows:]

PREPARED STATEMENT OF DAN J. PUTKA

The American Psychological Association (APA) is a scientific and professional organization of more than 152,000 psychologists and affiliates.

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

DOD RESEARCH

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

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

BEHAVIORAL RESEARCH WITHIN THE MILITARY SERVICE LABS AND DOD

Within DOD, the majority of behavioral, cognitive and social science is funded through the Army Research Institute (ARI) and Army Research Laboratory (ARL);

the Office of Naval Research (ONR); and the Air Force Research Laboratory (AFRL), with additional, smaller human systems research programs funded through the Office of the Secretary of Defense (OSD) and the Defense Advanced Research Projects Agency (DARPA).

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

National Academies Report Calls for Doubling Behavioral Research

The 2008 National Academies report on Human Behavior in Military Contexts recommended doubling the current budgets for basic and applied behavioral and social science research "across the U.S. military research agencies." It specifically called for enhanced research in six areas: intercultural competence; teams in complex environments; technology-based training; nonverbal behavior; emotion; and behavioral neurophysiology.

Behavioral and social science research programs eliminated from the mission labs due to cuts or flat funding are extremely unlikely to be picked up by industry, which focuses on short-term, profit-driven product development. Once the expertise is gone, there is absolutely no way to "catch up" when defense mission needs for critical human-oriented research develop. As DOD noted in its own Report to the Senate Appropriations Committee:

"Military knowledge needs are not sufficiently like the needs of the private sector that retooling behavioral, cognitive and social science research carried out for other purposes can be expected to substitute for service-supported research, development, testing, and evaluation . . . our choice, therefore, is between paying for it ourselves and not having it."

Defense Science Board Calls for Priority Research in Social and Behavioral Sciences

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

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

FISCAL YEAR 2011 DOD BUDGET FOR SCIENCE AND TECHNOLOGY

DOD

In terms of the overall DOD S&T budget, the President's request for fiscal year 2011 again represents a dramatic step backward for defense research. Defense S&T would fall from the estimated fiscal year 2010 level of $14.7 billion to $12.3 billion (a decrease of 16.3 percent). All military labs would see cuts to their 6.2 and 6.3 research accounts, with some cuts as high as 49 percent (the Army's 6.3 account). Defense-supported basic research (6.1 level accounts) would fare better under the President's budget, and APA supports the substantial increase proposed for the OSD's Defense-wide basic research program, but we are very concerned about the deep cuts to near-term research supported by the 6.2 and 6.3 program accounts.

DARPA

DARPA's overall funding would increase only slightly in the President's fiscal year 2011 budget, from $3 billion to $3.1 billion. The agency's home for basic research, the Defense Research Sciences Account, however, would be strengthened significantly. APA supports DARPA's transformative sciences priorities for this account, which include research that taps "converging technological forces and trans-

formational trends in the areas of computing and the computing-reliant subareas of social sciences, life sciences, manufacturing and commerce."

FOCUS FOR MINERVA RESEARCH

APA was pleased to see the House Armed Services Committee note (in the fiscal year 2011 National Defense Authorization Act) its support for "the use of social science to support key DOD missions such as irregular warfare, counterinsurgency, and stability and reconstruction operations" through research funded by the DOD Minerva initiative established by Secretary Gates. APA agrees with the House that DOD "has not provided enough focus for the Minerva initiative to develop a deep enough expertise in any of its seven topic areas," especially in "understanding the extremist ideologies that help fuel recruitment of terrorists." APA supports the fiscal year 2011 NDAA authorization of $96.2 million, $5 million above the President's budget request, for DOD to conduct Minerva initiative research to improve our understanding of extremist ideologies.

SUMMARY

The President's budget request for basic and applied research at DOD in fiscal year 2011 is $12.3 billion, which represents a dramatic cut of $2.4 billion or 16 percent from the enacted fiscal year 2010 level of $14.7 billion. APA urges the Subcommittee to reverse this cut to the critical defense science program by providing a total of $15 billion for Defense S&T in fiscal year 2011.

APA supports the substantial increases to DOD's and DARPA's basic research portfolios, but joins the Coalition for National Security Research in urging Congress to provide sufficient overall funding to reach the Pentagon's goal of investing 3 percent of DOD's total budget in Defense S&T.

Within the S&T program, APA encourages the Subcommittee to follow recommendations from the National Academies and the Defense Science Board to fund priority research in the behavioral sciences in support of national security. Clearly, psychological scientists address a broad range of important issues and problems vital to our national defense, with expertise in modeling behavior of individuals and groups, understanding and optimizing cognitive functioning, perceptual awareness, complex decision-making, stress resilience, recruitment and retention, and human-systems interactions. We urge you to support the men and women on the front lines by reversing another round of cuts to the overall defense S&T account and the human-oriented research projects within the military laboratories.

As our nation rises to meet the challenges of current engagements in Iraq and Afghanistan as well as other asymmetric threats and increased demand for homeland defense and infrastructure protection, enhanced battlespace awareness and warfighter protection are absolutely critical. Our ability to both foresee and immediately adapt to changing security environments will only become more vital over the next several decades. Accordingly, DOD must support basic Science and Technology (S&T) research on both the near-term readiness and modernization needs of the department and on the long-term future needs of the warfighter.

Below is suggested appropriations report language for fiscal year 2011 which would encourage the Department of Defense to fully fund its behavioral research programs within the military laboratories and the Minerva initiative:

DEPARTMENT OF DEFENSE

RESEARCH, DEVELOPMENT, TEST, AND EVALUATION

The Minerva Initiative and Behavioral Research in the Military Service Laboratories.—The Committee notes the increased demands on our military personnel, including high operational tempo, leadership and training challenges, new and ever-changing stresses on decision-making and cognitive readiness, and complex human-technology interactions. To help address these issues vital to our national security, the Committee has provided increased funding to reverse cuts to psychological research through the military research laboratories: the Air Force Office of Scientific Research and Air Force Research Laboratory; the Army Research Institute and Army Research Laboratory; and the Office of Naval Research. The Committee also notes the critical contributions of behavioral science to combating counter-insurgencies and understanding extremist ideologies, and renews its strong support for the DOD Minerva initiative.

Chairman INOUYE. And now I would like to proceed to the third panel, consisting of Dr. John C. Elkas, Mr. Richard "Rick" A. Jones, Ms. Elizabeth Cochran, and Dr. Jonathan Berman.

May I recognize Dr. John C. Elkas.

STATEMENT OF JOHN C. ELKAS, M.D., J.D., ON BEHALF OF THE SOCIETY OF GYNECOLOGIC ONCOLOGISTS

Dr. ELKAS. Mr. Chairman and Vice Chairman, thank you for inviting me to testify at today's hearing.

My name is Dr. John Elkas, and I am here on behalf of the Society of Gynecologic Oncologists. The SGO is a national medical specialty organization of physicians who are trained in the comprehensive care and management of women with gynecologic malignancies.

I also practice medicine in the D.C. metropolitan area and am a commander in the United States Naval Reserve and an adjunct associate professor of obstetrics and gynecology for the Uniformed Services University of the Health Sciences.

I spent 14 years in Active Duty service caring for women within the Department of Defense family with ovarian cancer, and I can speak personally to the impact that the OCRP is having on the care of military women with ovarian cancer.

I am honored to be here and pleased that this subcommittee is focusing its attention on the OCRP. Since its inception now 13 years ago, this DOD program has delivered benefits to ovarian cancer research that far exceed the annual level of Federal funding.

As this subcommittee knows, ovarian cancer causes more deaths than any other gynecologic malignancy and is the fourth highest cause of cancer death among American women. One of our biggest challenges lie in the fact that only 20 percent of ovarian cancer is detected at an early stage, while most of our patients are diagnosed at an advanced stage, where we heard the 5 year survival is markedly lower.

We, the members of the SGO, along with our patients who are battling this disease every day, depend on the 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 as many as 15,000 lives each year in the United States.

Since its inception in fiscal year 1997, the OCRP has funded 209 grants, totaling more than $140 million. Much of this has been accomplished with the resources that we are talking about today.

In Senator Mikulski's home State of Maryland, where many of my patients also live, the OCRP has funded research on important questions such as defining bio-markers that could be fundamental to development of a blood test for early-stage disease and developing and evaluating alpha target based approach for also treating advanced disease.

In Senator Murray's home State of Washington, where five OCRP-funded grants reside, questions such as the development of blood tests for new small molecules in the blood that might be used for detection and the examination of all women—of all of a woman's DNA to find new genes or groups of genes that may cause ovarian cancer in families.

In Senator Feinstein's home State of California, 24 grants have been funded by the OCRP since the program was created in 1997,

looking at questions such as inhibiting—strategies for targeting and inhibiting tumor growth, identification of cancer stem cells.

So, as you can see, these are just a few examples of the 209 grants that have served as a catalyst for attracting outstanding researchers to the field of ovarian cancer research. Investigators funded by the OCRP have succeeded with several crucial breakthroughs in bringing us closer in both the prevention and early detection of ovarian cancer. Were it not for this, many researchers might have abandoned their hopes of a career in basic and translational research in ovarian cancer.

Therefore, the Society of Gynecologic Oncologists joins with the Ovarian Cancer National Alliance and the American Congress of Obstetricians and Gynecologists to urge this subcommittee to increase Federal funding to a minimum of $30 million in fiscal year 2011 for the OCRP.

Thank you, gentlemen.

Chairman INOUYE. I thank you very much, Doctor.

On a personal note, 4 years ago, I lost my wife of 57 years to cancer of the liver. So this matter is a matter of personal interest. So I can assure you this subcommittee supports it.

Senator COCHRAN. Thank you very much.

I notice that the request is that we fund the program at $30 million. What is the current level of funding, do you recall?

Dr. ELKAS. $18.7 million, sir.

Senator COCHRAN. Okay. Thank you.

Chairman INOUYE. Thank you very much, Doctor.

[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 Vice Chairman of the Bylaws Committee and a former member of the Government Relations Committee of the Society of Gynecologic Oncologists (SGO). 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 13 years ago, this DOD program has delivered benefits to ovarian cancer research that far exceed the annual level of Federal funding.

This morning, I will try to outline some of the important contributions this DOD program has made to ovarian cancer research and the well-being of our patients. 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 2009, more than 21,500 women were diagnosed with ovarian cancer and approximately 15,000 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 Oncologists (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. The Society's membership, totaling more than 1,300, is comprised of gynecologic oncologists, as well as other related women's cancer healthcare specialists including medical oncologists, radiation oncologists, nurses, social workers and pathologists. SGO members provide multidisciplinary cancer treatment including surgery, chemotherapy, radiation therapy, and supportive care. 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 15,000 lives that are lost to this disease each year. Therefore, the SGO respectfully recommends that this Subcommittee provide the DOD OCRP with a minimum of $30 million in Federal funding for fiscal year 2011.

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 209 grants totaling more than $140 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 can-

cer 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, WA, 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. This discovery 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, 24 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 ovarian 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, 19 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 209 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 209 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, the OCRP was able to fund 22 awards. However, for fiscal year 2010 the program was cut by $1.25 million and so the possibility of the OCRP being able to fund even 20 grantees is in jeopardy. To provide sufficient and effective funding to enable us to do our jobs and create an environment where our scientific research can succeed, we need a minimum investment of $30 million in fiscal year 2011.

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 Oncologists joins with the Ovarian Cancer National Alliance and the American Congress of Obstetricians and Gynecologists to urge this Subcommittee to increase Federal funding at a minimum to $30 million in fiscal year 2011 for the OCRP. This will allow for the discoveries and research breakthroughs in the first decade of this program to be further developed and expanded upon, hopefully bringing us by the end of the second decade of this program to our ultimate goal of prevention, early detection and finally elimination of ovarian cancer. I thank you for your leadership and the leadership of the Subcommittee on this issue.

Chairman INOUYE. Now may I recognize Mr. Richard A. Jones.

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

Mr. JONES. Chairman Inouye, Vice Chairman Cochran, thank you for the opportunity to give our views on key issues under your consideration.

The National Association for Uniformed Services is pleased with certain aspects of the President's budget, specifically those that laser-focus on winning the wars in Iraq and Afghanistan. Choosing to win these wars, however, should not mean we must depend on aging fleets of aircraft, ships, and vehicles across the services. We must continue toward modernization.

One of the main messages our members want you to hear is really 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, and we must never cut off or unnecessarily delay critical funding for our troops in the field.

Regarding TRICARE, the provision of quality, timely healthcare is considered one of the most important earned benefits afforded to those who serve a career in the military. The TRICARE benefit reflects the commitment of a nation, and it deserves your wholehearted support. For those who give their career in uniformed service now asks you to provide full funding to secure their earned benefit.

The administration recommends a 1.4 percent across-the-board pay raise. My association asks you to seek an increase of 0.5 percent above the administration's request, to 1.9 percent. We should clearly recognize the risks our men and women in uniform face, and we should make every effort to appropriately compensate them for the job they do.

My association urges you also to provide adequate funding for military construction and family housing accounts. These funds for base allowance and housing should ensure that those serving in our military are able to afford to live in quality housing whether on or off the base.

The long war fought by an overstretched force gives us a clear warning. There are simply too many missions and too few troops. In addition to increasing troop strength, priority must be given to funding for accounts 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 train for the missions abroad.

Regarding Walter Reed—that is a matter of great interest to our members as we plan to realign our health facilities in the Nation's capital—we need to keep Walter Reed open as long as it is necessary to care for those who are at Walter Reed. We must not close Walter Reed prematurely.

My association 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.

Traumatic brain injury is the signature injury of the Iraq war. 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. The approach to this problem requires resources for hiring caseworkers, doctors, nurses, clinicians, and general caregivers if we are to meet the needs of those who are wounded and their families.

Post traumatic stress disorder (PTSD) is a very serious psychiatric disorder. Pre-deployment and post-deployment checkups are very important. Early recognition of the symptoms can serve a great deal toward recovery. We encourage the members of the subcommittee, Mr. Chairman, to provide these funds, to closely monitor their expenditure to ensure they are not directed to areas of other defense spending.

The Armed Forces Retirement Homes are important to those who have served in the military at Washington, DC, and Gulfport, Mississippi. We look forward to the reopening of the Gulfport home in October, and we ask that you continue care for those programs.

Mr. Chairman, Vice Chairman, thank you very much for the opportunity to present testimony today.

Chairman INOUYE. I thank you very much.

This subcommittee, as some may be aware, has appropriated nearly $1 trillion in the last 10 years to support our efforts in Afghanistan and Iraq. And we have done so without hesitation because we want our men to return home in as good a condition as they were when they went in there.

But this has been a costly activity, but we will keep on paying. So I can assure you that your recommendations will be seriously considered.

Mr. JONES. We thank you for the supplemental speed—supplemental bill and the speed that you handled that, sir. We hope that the House follows your suit.

Senator COCHRAN. Mr. Chairman, I can report that the Armed Forces Retirement Home in Gulfport, Mississippi, is nearing completion of the reconstruction that has been going on, and they are expecting to open that home in October 2010.

Mr. JONES. Excellent. Thank you, sir.

Chairman INOUYE. We will go to the opening.

[The statement follows:]

PREPARED STATEMENT OF RICK JONES

Chairman Inouye, Ranking Member Cochran, and members of the Subcommittee: It is a pleasure to appear before you today to present the views of The National Association for Uniformed Services on the fiscal year 2011 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 recognize as well that we must provide priority funding to keep the promises made to the generations of warriors whose sacrifice has paid for today's freedom.

Presently, we have under consideration the President's fiscal year 2011 defense budget request of $708 billion for its discretionary and war funding. According to the Defense Department, this represents an increase of 3.4 percent from the previous year. In fact, however, that's about 1.8 percent real growth after inflation.

Last year, we heard Defense Secretary Gates order the Defense Department to come up with $60 billion in cuts over the next 5 years. In fact, certain Members of Congress are calling for cuts in defense spending. In certain quarters of Congress, congressional leaders have recommended a 25 percent cut in the defense budget.

The National Association for Uniformed Services is pleased with certain aspects of the President's recommendation, specifically those that laser focus on winning the wars in Iraq and Afghanistan. Choosing to win these wars, however, should not mean our country must assume greater risk in conventional national defense challenges or neglect to consider the very real emerging threats of the future.

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 towards 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."

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

Criminal Activity Costs Medicare and TRICARE Billions of Dollars

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

Here are a couple of examples. GAO reports that one company billed Medicare for $170 million for HIV drugs. In truth, the company dispensed less than $1 million. In addition, the company billed $142 million for nonexistent delivery of supplies and parts and medical equipment.

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

TRICARE is closely tied to Medicare and its operations are not immune. According to officials at the TRICARE Program Integrity Office, approximately 10 percent of all healthcare expenditures are fraudulent. With a military health system annual cost of $51 billion, fraudulent purchase of care in the military health system would amount to more than $5 billion.

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 to medical care thieves. If one goes to the TRICARE Program Integrity Office web site, one sees a reflection of this inactivity. The most recent Fraud Report is dated 2008 and under "News," there are two items for 2010 and no items for 2009. The question we hear continually is whether anything is going on except talk about raising fees and copays.

As an example, NAUS is informed that the Department of Defense Inspector General reported fraud problems in the Philippines as long ago as 1998. Yet fraudulent payments continued for 7 years, untended, merely observed, until finally, more than a year ago, action was taken to curb the problem and order a Philippine corporation to pay back more than $100 million in fraudulent payments.

Our members tire of hearing they should pay more 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.

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—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. Root out the corruption, fraud and waste. And 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 2011, the Administration recommends a 1.4 percent across-the-board pay increase for members of the Armed Forces. The proposal is designed, according to the Pentagon, to keep military pay in line with civilian wage growth.

The National Association for Uniformed Services calls on Members of Congress to put our troops and their families first. Our forces are stretched thin, at war, yet getting the job done. We ask you to express the nation's gratitude for their critical service, increase basic pay and drill pay one-half percent above the administration's request to 1.9 percent.

Congress and the administration have done a good job over the recent past to narrow the gap between civilian-sector and military pay. The differential, which was as great as 14 percent in the late 1990s, has been reduced to just under 3 percent with the January 2010 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 reasonable and competitive.

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 Sept. 11, 2001, our Guardsmen and reservists have witnessed an upward spiral in the rate of deployment and mobilization. The mission has clearly changed, and we must recognize 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, hurricane or, God forbid, a large-scale terrorist attack, our National Guard is not going to have the basic level of resources to do the job right.

Walter Reed Army Medical Center

Another matter of great interest to our members is the plan to realign and consolidate military health facilities in the National Capital Region. The proposed plan includes the realignment of all highly specialized and sophisticated medical services

currently located at Walter Reed Army Medical Center in Washington, DC, to the National Naval Medical Center in Bethesda, MD, and the closing of the existing Walter Reed by 2011.

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

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

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

Department of Defense, Seamless Transition Between the DOD and VA

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

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

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

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

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

If our seriously wounded troops are to receive the care they deserve, the departments must do what is necessary to establish a system that allows seamless transition of medical records. It is essential if our nation is to ensure that all troops receive timely, quality 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 Sept. 11, 2001. The mission has changed and with it our reliance on these forces has risen. Congress has recognized these changes and begun to update and upgrade protections and benefits for those called away from family, home and employment to active duty. We urge your commitment to these troops to ensure that the long overdue changes made in the provision of their heath care and related benefits is adequately resourced. We are one force, all bearing a critical share of the load.

Department of Defense, Prosthetic Research

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

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

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

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

Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI)

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

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

We call on the Subcommittee to fund a full spectrum of TBI care and to recognize that care is also needed for patients suffering from mild to moderate brain injuries, as well. The approach to this problem requires resources for hiring caseworkers, doctors, nurses, clinicians and general caregivers if we are to meet the needs of these men and women and their families.

The mental condition known as Post Traumatic Stress Disorder (PTSD) has been well known for over 100 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 facility in Washington, DC, and Gulfport, Mississippi.

And we thank the Subcommittee for the provision of funding that has led to the reconstruction of the Armed Forces Retirement Home in Gulfport, destroyed in 2005 as a result of Hurricane Katrina. And we look forward to the opening of the home scheduled for October 2010. NAUS is informed that when completed (the construction is 96 percent done, May 2010), the facility will provide independent living, assisted living and long-term care to more than 500 residents.

The National Association for Uniformed Services also applauds the 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 home is a historic national treasure, and we thank Congress for its oversight of this gentle program and its work to provide for a world-class 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.

Joint POW/MIA Accounting Command (JPAC)

We also want the fullest accounting of our missing servicemen and ask for your support in DOD dedicated efforts to find and identify remains. It is a duty we owe to the families of those still missing as well as to those who served or who currently serve.

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 2011.

Appreciation for the Opportunity to Testify

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

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

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

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. Next witness, Ms. Elizabeth Cochran. Ms. Cochran.

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

Ms. COCHRAN. Thank you, Mr. Chairman.

Mr. Chairman and Mr. Vice Chairman of the subcommittee, the Associations for America's Defense is very grateful to testify today. We would like to thank the subcommittee for its stewardship on defense issues and setting an example of your nonpartisan leadership.

The Associations for America's Defense is concerned that U.S. defense policy is sacrificing future security for near-term readiness. Most concerning is the vigorous pursuit to cut existing programs.

Admiral Mike Mullen stated during his testimony before the House Armed Services Committee in February that as fiscal pressures increase, our ability to build future weapons systems will be impacted by decreasing modernization budgets, as well as mergers and acquisitions.

A4AD is in agreement, and we are alarmed about the fiscal year 2011 unfunded program list submitted by the services, which continues on fiscal year 2010's list, which was 87 percent lower than 2009's. We are more concerned that unfunded requests continue to be driven by budgetary factors more than risk assessment, which will impact national security.

Additionally, the result of such budgetary policy could again lead to a hollow force whose readiness and effectiveness has been subsequently degraded, and lessened efficiency may not be immediately evident. We support increasing defense spending to 5 percent of the Gross Domestic Product during times of war to cover procurement and prevent unnecessary personnel end strength cuts.

According to the Office of Management and Budget, base defense spending will stay relatively flat for the next 5 years. We disagree with placing such constraints on defense because it could lead to readiness and effectiveness being degraded.

As always, our military will do everything possible to accomplish its missions, but response time is measured by equipment readiness. Last year, due to DOD's tactical aircraft acquisition programs being blunted by cost and schedule overruns, the Air Force offered to retire 250 fighter jets, which the Secretary of Defense accepted.

Until new systems are acquired in sufficient quantities to replace legacy fleets, these legacy systems must be sustained. As the military continues to become more expeditionary, more airlift C–17 and C–130Js will be required. Yet DOD has decided to shut down production of C–17s.

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

We also thank this subcommittee to continue to provide its appropriations for the National Guard and Reserve equipment requirements. The National Guard's goal is to make at least one-half the Army and Air's assets available to Governors and adjunct generals at any given time. Appropriating funds for the Guard and Reserve equipment provides Reserve chiefs and Guard directors with flexibility of prioritizing funding.

Earlier this month, a sustainable defense task force released the report "Debt, Deficits, and Defense: A Way Forward." We are distressed that it recommends cutting up to $443 billion for conventional forces, canceling several programs including the MV–22 Osprey, the expeditionary fighting vehicle, Air Force and Marine Corps F–35, reducing the size of the Navy to 230 ships, 8 air wings, and cutting up to 200,000 military personnel.

Another very worrisome aspect is the recommendation to revert the Reserve components back to a strategic reserve strictly. National security demands both an operational and a strategic reserve. When at war, there is an outstanding threat, and it is not time for a peace dividend.

A4AD members are very concerned about planned cuts as proposed by DOD and this task force. We generally appreciate the support of the subcommittee, particularly at a time when there is growing pressure from other members to cut further programs.

Once again, we thank you for your ongoing support of the Nation, the armed forces, and our fine men and women serving this Nation. Please contact us with any questions.

Thank you.

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

An association of this nature, we would expect that a four-star general testify. But you have done a good job.

Thank you.

Senator COCHRAN. Thank you very much for looking carefully at all aspects of the budget requests submitted by the administration. I think your testimony will be very helpful to the subcommittee as we continue our deliberations.

[The statement follows:]

PREPARED STATEMENT OF ELIZABETH COCHRAN

ASSOCIATIONS FOR AMERICA'S DEFENSE

Founded in January of 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: Air Force Association; Army and Navy Union; Association of the U.S. Navy; Enlisted Assoc. of the National Guard of the U.S.; 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; and 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 twelve 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 Obama Administration's 2010 Quadrennial Defense Review (QDR) advances two objectives: further rebalance the Armed Force's capabilities to prevail in today's wars while building needed capabilities to deal with future threats; and second, reform the 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.

During his testimony before the House Armed Services Committee (HASC) in February, Admiral Mike Mullen stated, ". . . I am growing concerned about our defense industrial base, particularly in ship building and space. As fiscal pressures increase, our ability to build future weapon systems will be impacted by decreasing modernization budgets as well as mergers and acquisitions."

In 2009 Secretary of Defense Robert Gates testified before the Senate Armed Services Committee (SASC) that the United States should focus on the wars that we are fighting today, not on future wars that may never occur. He also asserts that U.S. conventional capabilities will remain superior for another 15 years. Anthony Cordesman, a national security expert for the Center for Strategic and International Studies, says that Gates' plan should be viewed as a set of short-term fixes aimed at helping "a serious cost containment problem," not a new national security policy.

War planners are often accused of planning for the last war. Secretary Gates speaks to enhancing the capabilities of fighting today's wars. A concern arises on whether DOD's focus should be on irregular or conventional warfare, and whether it should be preparing for a full scale "peer" war.

Hollow Force

A4AD could not disagree more by placing such budgetary constraints on defense. Member associations question the spending priorities of the current administration. "Fiscal restraint for defense and fiscal largesse for everything else," commented then ranking member John McHugh at a HASC hearing on the defense budget in May 2009.

The result of such a 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. This process which echoes of the past, raises no red flags and sounds no alarms, and the damage can go unnoticed and unremedied until a crisis arises highlighting how much readiness decayed.

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 in Afghanistan and withdrawing from Iraq, that risk is being accepted as an element of future force planning. Force planning is being driven by current overseas contingency operations, and increasingly on budget limitations. Careful study is needed to make the right choice. A4AD is pleased that Congress and this subcommittee continue oversight in these decisions.

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

Korean Peninsula

Provocatively, North Korea successfully tested a nuclear weapon at full yield, unilaterally withdrew from that 1953 armistice. The Republic of Korea lost a navy ship sunk to a torpedo. South Korean and U.S. troops have been put on the highest alert level in years.

North Korea has 1.2 million troops, with 655,000 South Korean soldiers and 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. The North has prepositioned and could fire up to 250,000 rounds of heavy artillery in the first 48 hours of a war along the border and into Seoul.

China

China's armed forces are the largest in the world and have undergone double-digit increases in military spending since the early 90s. DOD has reported that China's actual spending on its military is up to 250 percent higher than figures reported by the Chinese government, and their cost of materials and labor is much lower. In 2009, China's defense budget increased by almost 15 percent and further increased about 7.5 percent for 2010. DOD's 2009 report to Congress on China's military strength estimated in 2008 that its spending ranged from $105 and $150 billion, the second highest in the world after the United States. It should be noted that these dollars go further within the Chinese economy as well.

China's build-up of sea and air military power appears aimed at the United States, according to Admiral Michael Mullen, the chairman of the Joint Chiefs of Staff. Furthermore China is reluctant to support international efforts in reproaching North Korea, which recently as evidenced by the sunk South Korean naval vessel.

The U.S. military strategy cannot be held hostage by international debts. While China is the biggest foreign holder of U.S. Treasuries with $895.2 billion at the end of March, we cannot be lulled into a sense of complacency.

Russia

While the Obama Administration has been working on a "reset" policy towards Russia, including a new START treaty, there are areas of concern. A distressing issue is their relationship with Iran which the United States and even the United Nations have brought sanctions against. Additionally Russia sells arms to countries like Syria and Venezuela that also have ties to Iran.

Prime Minister Vladimir Putin stated recently that, "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 in an annual report.

Iran

While Iran lobs petulant rhetoric towards the United States, the real international tension is between Israel and Iran. Israel views Tehran's atomic work as a threat, and would consider military action against Iran 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.

Funding for the Future

Since Secretary Gates initiated the practice of reviewing all the services' unfunded requirements lists prior to testifying before Congress the result has been in fiscal restraint. 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. Most notable is that the Air Force in prior

years represented about 50 percent of the total unfunded requirements list and is now proportionate to the other services.

In 2009 Secretary Gates told SASC, "It is simply not reasonable to expect the defense budget to continue increasing at the same rate it has over the last number of years." He went further saying, "We should be able to secure our nation with a base budget of more than half a trillion dollars." Following through on these statements the Secretary has 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, meaning less people. For the 2012 budget, the military services and defense agencies have been asked to find $7 billion in savings.

These impending cuts are in addition to weapon systems cuts from last year which amounted to about $300 billion. Despite the great need to manage budgets in light of the financial situation that the United States faces, we are still conducting two theaters in a war, and should be prepared to fight if another threat challenges U.S. National Security.

Defense as a Factor of GDP

Secretary Gates has warned that each defense budget decision is "zero sum," providing money for one program will take money away from another. A4AD encourages the appropriations subcommittee on defense to scrutinize the recommended spending amount for defense. Each member association supports increasing defense spending to 5 percent of Gross Domestic Product during times of war to cover procurement and prevent unnecessary personnel end strength cuts.

A Changing Manpower Structure

The 2010 QDR recommends incremental reductions in force structure shrinking the fleet to about 250 to 260 ships, reducing 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 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 other military 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 remain in 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. An additional requirement is excess infrastructure which would permit the housing of additional forces that are called-up beyond the normal operational force.

Dependence on Foreign Partnership

Part of the U.S. military strategy is to rely on long-term alliances to augment U.S. forces. 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 2011 budget request included an increase from $350 to $500 million for the Global Train and Equip authority that helps build capabilities of key partners.

The risk of basing a national security policy on foreign interests and good world citizenship is increasingly uncertain because the United States does not necessarily control our foreign partners as 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.

UNFUNDED REQUIREMENTS

The fiscal year 2011 Unfunded Program Lists submitted by the military services to Congress continued in fiscal year 2010's steps, which was 87 percent less than was requested for fiscal year 2009. A4AD has concerns that the unfunded requests continue to be driven more by budgetary factors than risk assessment which will

impact national security. The following are lists submitted by A4AD including additional non-funded recommendations.

Tactical Aircraft

DOD's efforts to recapitalize and modernize its tactical air forces have been blunted by cost and schedule overruns in its new tactical aircraft acquisition programs. For fiscal year 2010 the Air Force offered a plan to retire 250 fighter jets in one year alone, which Secretary Gates accepted.

Yet the HASC observed after approving Navy and Marine Corps procurement, and research and development programs in May, that it's concerned about the unacceptable deficit of approximately 250 tactical aircraft by 2017, warning future budget requests must address this.

Until new systems are acquired in sufficient quantities to replace legacy fleets, legacy systems must be sustained and kept operationally relevant. The risk of the older aircraft and their crews and support personnel being eliminated before the new aircraft are on line could result in a significant security shortfall.

Airlift

Hundreds of thousands of hours have been flown, and millions of passengers and tons of cargo have been airlifted. Their contributions in moving cargo and passengers are absolutely indispensable to American warfighters in overseas contingencies. Both Air Force and Naval airframes and air crew are being stressed by these lift missions. As the military continues to become more expeditionary it will require more airlift. Procurement needs to be accelerated and modernized, and mobility requirements need to be reported upon.

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. Given the C–5's advanced age, it makes more sense to retire the oldest and most worn of these planes and use the upgrade funds to buy more C–5s and modernize current C–5 aircraft. DOD should also continue with a joint multi-year procurement of C–130Js.

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.

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.

Tankers

The need for air refueling is reconfirmed on a daily basis in worldwide DOD operations. A significant number of tankers are old and plagued with structural problems. The Air Force would like to retire as many as 131 of the Eisenhower-era KC–135E tankers by the end of the decade.

DOD and Congress must work together to replace of these aircraft. A contract needs to be offered. A4AD thanks this committee for its ongoing support to resolve this issue.

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 in millions
Air Force:	
C–130 Aircraft Armor (79)	$15.8
C–130 NVIS Windows (64)	1
C–130 Crash Resistant Loadmaster Seat Modifications (76)	19

UNFUNDED EQUIPMENT REQUIREMENTS—Continued

[The services and lists are not in priority order.]

	Amounts in millions
C–17 Armor Refurbishment and Replacement (17)	2
Air Force Submitted Requirements:	
Weapons System Sustainment: Programmed Depot Maintenance (PDMs), High Velocity Maintenance (HVM), Service Life Extension Program (SLEP)/Scheduled Structural Inspections (SSI), and engine overhauls [ANG & AFR included]	337.2
Theater Posture: contract maintenance of Base Expeditionary Airfield Resources (BEAR)/War Readiness Material assets; procure Fuels Operational Readiness Capability equipment (FORCE) sets, fuel bladders/liners	70
DCGS Integrated C3 PED System	55
Battlefield Airmen Equipment/JTAC Modeling & Simulation	28.7
Vehicle & Support Equipment Procurement	57.1
Air Force Reserve (USAFR):	
LITENING Targeting pod (19)	24
C–130 Secure Line of Sight/Beynold Line of Sight (SLOS/BLOS) (63)	22.1
AFRC ATP Procurement & Spiral Upgrade (54)	54
C–130 Aircraft Armor (79)	15.8
C–130 Crash Resistant Loadmaster Seats (76)	19
F–16 All WX A–G Precision Self-Targeting Capability (54)	120
A–10 On Board Oxygen Generating System (OBOGS) (54)	11.1
Air National Guard (USANG):	
F–15 Digital Video Recorder (DVR) (upgrades to ANG F–15 aircraft)	7
C–37B (Gulf Stream) aircraft (4)	256
USANG requires at Andrews AFB to replace the aging C–38A fleet C–17 (5 minimum)	1,000
Requirement identified by NGAUS, EANGUS, AGAUS, and ROA:	
Security Forces Tactical Vehicles:	
HMMWVs (1,700)	170
LTMVs (500)	100
Upgraded Personal Protective Equipment:	
IOTVs (4,600)	3.1
ESAPI Plates (9,200)	7.5
Concealable Body Armor (8,800)	4.4
Air Refueling Tanker replacements	([1])
Army Submitted Requirements:	
Line of Communication Bridge (LOCB)	15
Light Weight Counter-Mortar Radar (LCMR)	47.1
NAVSTAR GPS: Defense Advanced GPS Receiver (DAGR)	51.2
Civil Affairs/Psychological Operations (CA/Psy Ops)	55
Advanced Field Artillery Tactical Data System (AFATDS) Forward Entry Devices	16.2
Patriot	133.6
Test 7 Evaluation Instrumentation	17.7
Army Test Range Infrastructure	22.9
Army Reserve (USAR):	
Helicopter, Attack AH–64D (3)	75.5
MTV 5 Ton Cargo Truck, M108s (448)	57.4
LMTV 2.5 Ton Cargo Truck, M1079 (23)	3.7
HMMWVs (humvees), ARMT Carrier, M1025 (1,037)	78
Night Vision Goggles, AN/PVX–7B (7,740)	28
Weapons:	
Machine Gun, 7.62MM, M240B (3,445)	20.6
Carbine Rifle, 5.56MM, M4 (6,441)	3.7
Next Generation of Loudspeaker System (NGLS) Manpak, NGLS Vehicle (1,344)	86.7
Army National Guard (USARNG):	
ATLAS (All Terrain Lifter-Army System and II), Truck Lift	4.3
Chemical Decontamination (JSTDS–SS, CBPS)	11
Radios, COTS Tactical Radios	10
FMTV (Truck tractor: MTV W/E, Truck Van: Expansible MTV W/E)	507
Joint Assault Bridge (Carrier Bridge Launching: Joint Assault XM1074)	35
Navy Submitted Requirements:	
Aviation Spares: T/M/S, Fleet aircraft	423
Ship Depot Maintenance: deferred surface ship non-docking availabilities	35
Aviation Depot Maintenance: deferred airframes/engines	74
Navy Reserve (USNR):	
C–40A Combo cargo/passenger airlift aircraft (5)	75

UNFUNDED EQUIPMENT REQUIREMENTS—Continued

[The services and lists are not in priority order.]

	Amounts in millions
EA–18G, Growler (2) Additional 3 Growlers will be needed in fiscal year 2012	142.8
Navy Expeditionary Combat Command	20
MPF Utility Boat (3)	3
Marine Corps Submitted Requirements:	
CH–53 Reliability Improvements	34
Warfighter Equipment: KC–130J, UC–35ER, UC–12W	168
Readiness: M88A2 Improved Recovery Vehicle, Mine Roller System, Assault Breacher Vehicle, Family of Field Medical Equipment	131
Modernization of Child Development Center	18
Marine Forces Reserves (MFR):	
KC–130J Super Hercules Aircraft tankers (4)	200
Light Armored Vehicles (LAV)	1.5
Training Allowance (T/A) Shortfalls (To provide most up to date Individual Combat & Protective Equipment: M4 rifles, Rifle Combat Optic (RCO) scopes, Light weight helmets, Small Arms Protective Insert (SAPI) plates, Modular Tactical Vests, Flame Resistant)	145
Logistics Vehicle Replacement System Cargo	([1])

[1] Unkown.

Note: A4AD recommends further investment in the DDG 1000 or a similar concept. This vessel was designed to allow expansion for future systems and technology. Any new construction should permit maximized modernization. Restarting procurement of the DDG 51 (Arleigh Burke) class Aegis destroyers limit the Navy with a 35 year old hull design, which requires 350 people to crew. While higher costs are cited, Congress should find ways to reduce shipbuilding, maintenance and manpower cost, rather than constrain technology.

Reserve Components (RCs)

The National Guard Bureau has stated that the aggregate equipment shortage for the RCs is about $45 billion. Common challenges for the RCs are ensuring that equipment is available for pre-mobilization training, transparency of equipment procurement and distribution, and maintenance.

One of USANG's top issues is modernizing legacy aircraft and other weapon systems for dual missions and combat deployments.

USARNG equipment challenges include, but aren't limited to modernizing both the helicopter and Tactical Wheeled Vehicle (TWV) fleets, and interoperability with the active component. Additionally while the ARNG's total equipment on hand (EOH) is 77 percent, there's only 62 percent of the authorized equipment in the continental United States (CONUS) available to governors. The Army expects ARNG's total EOH will fall to 74 percent during 2010.

The USAFR's primary obstacles are defensive systems funding shortfalls, and modernization of data link and secure communications.

The USAR has concerns about the modernization of equipment and maintenance infrastructure to support ARFORGEN, sustainment of equipment to support deploying units and ARFOGEN, and increases in procurement funding. Additionally Lieutenant General Jack Stultz, chief of the Army Reserve, stated in testimony before the HASC Readiness subcommittee this spring that the USAR is challenged by "still being budgeted as a strategic reserve."

USNR top equipping challenges are aircraft procurement specifically for C–40A, E/A–18G, P–8, and KC–130J; and equipment for civil engineering, material handling, and communications for OCO-related units.

The USMFR is concerned about ensuring deploying members continue to receive up to date individual combat clothing and protective equipment in theater as well as maintaining the right amount of equipment on hand at RC units to train prior to deployment.

Active Components

In DOD's new 30-year aircraft investment blueprint it calls for the Air Force to pause for at least 10 years in production of new strategic airlifters and long-range bombers. The plan also slows the process to purchase F–35s causing it to not meet its force level requirements until 2035.

The Marine Expeditionary Fighting Vehicle (EFV) will be delayed for another year.

The Marine Corps (USMC) face a primary challenge of having been a land force for the last decade. The USMC's naval character has taken a back seat to fighting a virulent resistance in an extended land campaign, and some core competencies are waning.

Family

A consistent complaint from military families across the board is the lack of spaces and/or prolonged waiting lists for child care centers. While the military has built up child care systems, it is still an urgent need by many, especially those with special needs.

Retiree

The fiscal year 2008 early retirement benefit for RC members was passed, but it excluded approximately 600,000 members. This law should be fixed so that RC members' service counts from post-September 11, 2001 rather than from the bill enactment date in 2008.

Health Care

As the operational tempo for our service members continues to be high and they persist to endure repeated deployments, it becomes ever more essential to provide efficient and timely health screenings for pre- and post-deployments.

Achieving and maintaining individual medical readiness standards throughout a service member's continuum of service is necessary for the military services and components to meet mission requirements as an operational force.

Military Voting

Congress legislatively mandated DOD to develop an Internet voting system for military voters, but HASC cut $25 million from DOD's Federal Voting Assistance Program (FVAP).

The House stated it was concerned with the immaturity of the Internet voting system standards being developed by the Elections Assistance Commission, supported by FVAP. Denying DOD the funding could ensure those standards remain immature, and may compel the States to proceed with their own Internet voting systems without Federal voting standards or guidelines in place.

As the SASC reported bill supports, the Senate Appropriations Committee should fully fund these important programs. Without these vital funds, military voters will be condemned to continued disenfranchisement, lost voting opportunities, and reliance on State-run systems unsupported by Federal standards or evaluation.

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. Our next witness is Dr. Jonathan Berman, secretary-treasurer, American Society of Tropical Medicine and Hygiene.

STATEMENT OF JONATHAN BERMAN, M.D., Ph.D. COLONEL (RETIRED), UNITED STATES ARMY MEDICAL CORPS, ON BEHALF OF THE AMERICAN SOCIETY OF TROPICAL MEDICINE AND HYGIENE

Dr. BERMAN. Thank you, Mr. Chairman.

I appreciate this opportunity to testify on behalf of the American Society of Tropical Medicine. I am Dr. Berman, Colonel, Medical Corps, retired from the United States Army.

The American Society of Tropical Medicine and Hygiene is the principal professional membership organization in the United States, and actually in the world, for tropical medicine and global health. ASTMH represents physicians, researchers, epidemiologists, other health professionals dedicated to the prevention and control of tropical diseases.

Because the military operates in many tropical regions, reducing the risk that tropical diseases present to servicemen and women is often critical to mission success and service personnel morale. Ma-

laria and other insect-transmitted diseases, such as leishmaniasis and dengue, are particular examples.

Antimalarial drugs have saved countless lives throughout the world, including U.S. troops during World War II, Korea, and Vietnam. The U.S. military has long taken a primary role in the development of antimalarial drugs and vaccines, and nearly all of the most used antimalarials today were developed at least in part by U.S. military researchers.

Over 350 million people are at risk for leishmaniasis in 88 countries, 12 million infected currently, 2 million new infections each year. Leishmaniasis was a particular problem for Operation Iraqi Freedom, as a result of which 700 American service personnel became infected. As it happens, the Washington Post yesterday had a large article on leishmaniasis built around statements from military personnel here in the Washington area.

Because of leishmaniasis's prevalence in Iraq and Southwest Asia in general, DOD has spent large resources on this disease, and DOD personnel are the leaders worldwide in development of new anti-leishmanial drugs.

Dengue is the leading cause of illness and death in the tropics and subtropics, as many as 100 million people are infected yearly. Although dengue rarely occurs in the United States, it is endemic in Puerto Rico, and periodic outbreaks occur in Samoa and Guam.

The intersection of militarily important diseases and tropical medicine is the reason that 15 percent of ASTMH members are also members of the military. For this reason, we respectfully request that the subcommittee expand funding for DOD's longstanding and successful efforts to develop new drugs, vaccines, and diagnostics to protect service personnel from malaria and tropical diseases.

Specifically, we request that in fiscal year 2011, the subcommittee ensure $70 million to DOD to support its ID research efforts through USAMRIID, WRAIR, and NMRC. Presently, DOD funding for this research is about $47 million. To keep up with biomedical inflation, fiscal year 2011 funding needs to be $60 million, and as said, to fill the gaps that have been created by underfunding, ASTMH urges Congress to fund DOD ID research at $70 million—70—in fiscal year 2011.

Thank you very much, Mr. Chairman and vice chairman.

Chairman INOUYE. I thank you very much, Doctor.

I can assure you that this subcommittee is giving this matter our highest priority.

Senator COCHRAN. Mr. Chairman?

Chairman INOUYE. Our last panel, and I want to thank the panel very much.

Senator COCHRAN. Mr. Chairman, could I put in a word for——

Chairman INOUYE. Yes.

Senator COCHRAN [continuing]. The last witness? I notice in my notes here that the University of Mississippi has this Center for Natural Products Research and is doing some work in collaboration with Walter Reed Army Institute finding safe drugs to use against the parasites that cause malaria, which was one of the topics that you touched on.

Is progress being made in this program? Are you familiar with that?

Dr. BERMAN. Yes, sir, I am. There is work on 8-aminoquinolines as replacement for our present drugs. It is an excellent center and really leads in this total effort.

Senator COCHRAN. Thank you.

Chairman INOUYE. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF JONATHAN BERMAN

The American Society of Tropical Medicine and Hygiene (ASTMH) is the principal professional membership organization in the United States, and in the world, for Tropical Medicine and Global Health. ASTMH represents physicians, researchers, epidemiologists, and other health professionals dedicated to the prevention and control of tropical diseases. We appreciate the opportunity to submit testimony to the Senate Defense Appropriations Subcommittee and I request that our full testimony be submitted for the record.

Because the military operates in many tropical regions, reducing the risk that tropical diseases present to servicemen and women is often critical to mission success.

Malaria and other insect-transmitted diseases such as leishmaniasis and dengue are particular examples.

Antimalarial drugs have saved countless lives throughout the world, including troops serving in tropical regions during WWII, the Korean War, and the Vietnam War. The U.S. military has long taken a primary role in the development of antimalarial drugs, and nearly all of the most used anti-malarials were developed in part by U.S. military researchers.

Over 350 million people are at risk of leishmaniasis in 88 countries around the world. 12 million people are currently infected and 2 million new infections occur annually. Leishmaniasis was a particular problem for Operation Iraqi Freedom, as a result of which 700 American service personnel became infected [Weina 2004]. Because of leishmaniasis' prevalence in Iraq and in Southwest Asia in general, the DOD has spent significant time and resources on this disease and DOD personnel are the leaders in development of new antileishmanial drugs.

Dengue is a leading cause of illness and death in the tropics and subtropics. As many as 100 million people are infected yearly. Although dengue rarely occurs in the continental United States, it is endemic in Puerto Rico, and in many popular tourist destinations in Latin America and Southeast Asia; periodic outbreaks occur in Samoa and Guam. The DOD has seen about 28 cases of dengue in soldiers per year.

The intersection of militarily-important diseases and Tropical medicine is the reason that 15 percent of ASTMH members are members of the military.

For this reason, we respectfully request that the Subcommittee expand funding for the Department of Defense's longstanding and successful efforts to develop new drugs, vaccines, and diagnostics designed to protect servicemen and women from malaria and tropical diseases. Specifically, we request that in fiscal year 2011, the Subcommittee ensure $70 million to the Department of Defense (DOD) to support its infectious disease research efforts through the Army Medical Research Institute for Infectious Diseases, the Walter Reed Army Institute of Research, and the U.S. Naval Medical Research Center. Presently, DOD funding for this important research is at about $47 million. To keep up with biomedical inflation since 2000, fiscal year 2011 funding must be about $60 million. In order to fill the gaps that have been created by underfunding, ASTMH urges Congress to fund DOD infectious disease research at $70 million in fiscal year 2011.

We very much appreciate the Subcommittee's consideration of our views, and we stand ready to work with Subcommittee members and staff on these and other important tropical disease matters.

Chairman INOUYE. And our final panel consists of Dr. George Zitnay, Major General David Bockel, Ms. Joy Simha, and Dr. John Boslego.

Welcome to the subcommittee, and may I recognize Dr. George Zitnay.

STATEMENT OF GEORGE A. ZITNAY, Ph.D., CO–FOUNDER, DEFENSE AND VETERANS BRAIN INJURY CENTER

Dr. ZITNAY. Good morning, Chairman Inouye and Vice Chairman Cochran. It is good to be here.

My name is George Zitnay. I am the co-founder of the Defense and Brain Injury Center. And before I retired last year, I have spent over 40 years in the field of brain injury. And I have been involved, obviously, in the work of the Department of Defense since the Vietnam war.

I have worked very hard on behalf of the military and for wounded warriors and their families, and I come before you this morning to urge funding for the Defense and Veterans Brain Injury Center at the $40 million level for 2011 and for the new National Intrepid Center of Excellence, $45 million.

I am requesting specific line-item status for these agencies, as each is responsible for brain injury care, research, treatment, and training. NICoE, or the National Intrepid Center of Excellence, is having its ribbon-cutting ceremony tomorrow, and I hope that both of you will be able to attend that wonderful ceremony at Bethesda tomorrow.

As you well know, the NICoE is a volunteer effort on behalf of Mr. Fisher and many individuals. And we are hopeful that the NICoE will be able to treat some 500 service members each year, and their families, for whom standard treatment for TBI has not worked. And I am hopeful that the NICoE will push the envelope to develop cutting-edge research and rehabilitation for individuals with traumatic brain injury from the mild level of TBI all the way through to coma.

TBI continues to be the signature injury in the wars in Iraq and Afghanistan, affecting over 10 percent of all deployed service personnel. Blast-related injuries and extended deployments are contributing to an unprecedented number of warriors suffering from TBI, psychological conditions such as anxiety, depression, PTSD, and suicide. The long-term effects of blast injury are yet unknown, and more research is necessary.

Also, we need to really make sure that standard pre-deployment baseline measurement and assessments are being done consistently across the services. In addition, there needs to be a much greater emphasis on connecting injured warriors when they return home to community resources and to provide support and education for family members because they are the first people to recognize the symptoms, particularly of mild TBI and PTSD.

Last year when I came before this subcommittee, I talked about those individuals in the vegetative state and the minimally conscious. I am very unhappy to report that we still have not provided the level of care necessary for these young men and women between the ages of 18 and 25.

You know that the private sector has really moved ahead in this area. Bob Woodruff is a good example. Look at what ABC was able to do by providing him with the best care possible. There is new technology and new opportunities to wake these individuals up with deep brain stimulation and other types of progress. However, that has not been done. We have still not developed a partnership with universities and those major centers.

And I want you to know that the VA has renamed the nursing homes that they operate for these individuals from nursing homes to community living centers. What a nice opportunity, isn't it?

While we know many with severe TBI will not go back to work, I can assure you that they deserve the best. And last year, the late Congressman Jack Murtha brought together in Johnstown a large group of experts in this area and really wanted to have this as one of the things that he was quite interested in. Unfortunately, Mr. Chairman and Vice Chairman Cochran, this has not been done.

And as I know, since I live in Johnstown, Mr. Murtha wanted this to be accomplished. He invited all of the people to come together, and I can assure you that a consortium composed of Harvard, people from MIT, from Cornell Medical Center, from St. Joseph's Hospital, from Rockefeller have all come together, and they know that what can be done to serve these individuals.

But even though he brought them together, this has not been done, and it has been over a year. So I urge you to consider funding at the $40 million level for the Defense and Veterans Brain Injury Center and for those individuals who now will be served by the new Intrepid Center at Bethesda.

And in closing, what I would like to suggest is that since this continuing war in Afghanistan and Iraq, what we have observed is that more and more individuals come home. They seem normal. But it is not until their family members really recognize that something is going on that they need then to have care.

And quite frankly, we need to do a lot more in our communities all across this country, whether it is in Mississippi or Hawaii or wherever it is, to connect up our servicemen and women with the best that is possible in our communities.

Thank you very much for all that you have done, and I urge you to support at the $40 million level for DVBIC and for the new NICoE Center of Excellence.

Chairman INOUYE. I can assure that we will do exactly that.

Dr. ZITNAY. Thank you very much, Mr. Chairman.

Senator COCHRAN. Thank you for the insight that you have given us and also for your unselfish service in trying to personally make a difference for a lot of servicemen and women who have been injured.

Dr. ZITNAY. Well, I am retired now, and I come before you as a volunteer because I am still most interested in what happens to our young men and women in the military.

Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF GEORGE A. ZITNAY

Dear Chairman Inouye, Ranking Member Cochran and Members of the Senate Appropriations Subcommittee on Defense: Thank you for this opportunity to submit testimony in support of funding brain injury programs and initiatives in the Department of Defense. I am George A. Zitnay, Ph.D., a neuropsychologist and co-founder of the Defense and Veterans Brain Injury Center (DVBIC).

I have over 40 years of experience in the fields of brain injury, psychology and disability, including serving as the Executive Director of the Kennedy Foundation, Assistant Commissioner of Mental Retardation in Massachusetts, Commissioner of Mental Health, Mental Retardation and Corrections for the State of Maine, and a founder and Chair of the International Brain Injury Association and the National Brain Injury Research, Treatment and Training Foundation. I have served on the

Advisory Committees to the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), was an Expert Advisor on Trauma to the Director General of the World Health Organization (WHO) and served as Chair of the WHO Neurotrauma Committee.

In 1992, as President of the national Brain Injury Association, I worked with Congress and the Administration to establish what was then called the Defense and Veterans Head Injury Program (DVHIP) after the Gulf War as there was no brain injury program at the time. I have since worn many hats, and helped build the civilian partners to DVBIC: Virginia NeuroCare, Laurel Highlands, and DVBIC-Johnstown. Last year I retired as an advisor to the Department of Defense (DOD) regarding policies to improve the care and rehabilitation of wounded warriors sustaining brain injury.

I am pleased that DVBIC continues to be the primary leader in DOD for all brain injury issues. DVBIC has come to define optimal care for military personnel and veterans with brain injuries. Their motto is "to learn as we treat."

The DVBIC has been proactive since its inception, and what began as a small research program, the DVBIC now has 19 sites,[1] and serves as the key operational component for brain injury of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) under DOD Health Affairs.

I am here today to ask for your support for $40 million for the DVBIC and $45 million for the National Intrepid Center of Excellence (NICoE) in the Defense Appropriations bill for fiscal year 2011. This level of funding is consistent with the request made by 30 Members of the Congressional Brain Injury Task Force to the House Appropriations Committee as well as with the President's budget request. The Administration requested a total of $920 million: $670 million for treatment and $250 million for research. Since DVBIC and NICoE provide both treatment and research, line items are requested for these individual agencies.

As you know, traumatic brain injury (TBI) remains the "signature injury" of the conflicts in Iraq and Afghanistan, affecting over 10 percent of all deployed service personnel. Blast-related injuries from improvised explosive devices and extended deployments are contributing to an unprecedented number of TBIs (ranging from mild, as in concussion, to severe, as in unresponsive states of consciousness) and psychological conditions such as anxiety, depression, post traumatic stress disorder (PTSD) and suicide. TBI-related health issues cost billions of dollars, not including lost productivity or diminished quality of life.

For a myriad of reasons, it is in everyone's best interest—our wounded warriors, their families and loved ones, our national security and military readiness and the nation's taxpayers—to assure that service members with TBI are given the appropriate treatment and rehabilitation as soon as possible. Our country cannot afford to allow service members to fall through the cracks and suffer from the deleterious effects, sometimes life long, of TBI.

After sustaining an initial TBI, a service member is at twice the risk of sustaining another TBI and compounding the injury. This can be particularly devastating in a combat zone especially if not removed from action. A 2009 Consensus group of brain injury specialists (50 civilian and military experts), suggested that troops with mild TBI receive cognitive rehabilitation as soon as possible. (Neurorehabilitation. 2010 Jan 1; 26 (3): 239–55.

On June 7, 2010, National Public Radio and Propublica published the results of an independent investigation which showed that despite the DOD's efforts to detect and treat TBI, a huge number remain undiagnosed. NPR reports that "the nation's most senior medical officers are attempting to downplay the seriousness of so-called mild TBI. As a result, soldiers haven't been getting treatment." (http://www.propublica.org/feature/brain-injuries-remain-undiagnosed-in-thousands-of-soldiers). The report states that "tens of thousands of troops with TBI have gone uncounted."

Consistent Screening is Needed

Four years ago, DVBIC began a comparative study on the efficacy of 6 diagnostic screening tools but for various reasons there has been delay in publishing the re-

[1] Walter Reed Army Medical Center, Washington, DC; Landstuhl Regional Medical Center, Germany; National Naval Medical Center, Bethesda, MD; James A. Haley Veterans Hospital, Tampa, FL; Naval Medical Center San Diego, San Diego, CA; Camp Pendleton, San Diego, CA; Minneapolis Veterans Affairs Medical Center, Minneapolis, MN; Veterans Affairs Palo Alto Health Care System, Palo Alto, CA; Fort Bragg, NC; Fort Carson, CO; Fort Hood, TX; Camp Lejeune, NC; Fort Campbell, Kentucky; Boston VA, Massachusetts; Virginia Neurocare, Inc., Charlottesville, VA; Hunter McGuire Veterans Affairs Medical Center, Richmond, VA; Wilford Hall Medical Center, Lackland Air Force Base, TX; Brooks Army Medical Center, San Antonio, TX; Laurel Highlands, Johnstown, PA; DVBIC-Johnstown, PA.

sults. Since May 2008, a pre-deployment cognitive test is used based on DVBIC's ANAM, but post deployment has been inconsistent. It is my understanding that top DOD officials fear that greater screening may produce false positives and follow up assessments and treatment will be expensive. This is unacceptable. In cases of positive screenings or when there is suspicion of TBI, a neuropsychological battery should be performed. Pending the results of DVBIC's study, DOD should convene a panel of outside experts to reach a consensus on the best post deployment screening tool which has demonstrated efficacy and use it consistently across the board. Amendments have been offered to the DOD Authorization bill currently under consideration that would help achieve this. Brigadier General Loree Sutton, head of the Defense Centers of Excellence for Psychological Health and TBI has repeatedly stated that her goal is to have "consistent standards of excellence across the board." This is an area that desperately needs consistency.

Long Term Effects of Blast Injury Remain Unknown

The lnstitute of Medicine's (IOM) Preliminary Assessment on the Readjustment Needs of Veterans, Service Members and Their Families (March 31, 2010) notes that there is a paucity of information on the lifetime needs of persons with TBI in the military and civilian sectors and recommends funding for additional research into protocols to manage the lifetime effects of TBI.

This issue is compounded by the fact that blast injuries from IEDs are quite different from TBIs sustained in the civilian sector, from sports and car crashes. There is even less information on the long term effects of blasts.

The National Defense Authorization Act for Fiscal Year 2008 specifically directed DVBIC to conduct a 15 year study. Assuring funding of some $40 million specifically for DVBIC would further this goal.

Comorbid Conditions

As I testified last year, the distinction between TBI and PTSD remains a problem. Some senior DOD medical officers continue to argue that symptoms can be treated without regard to the underlying problem. This is wrong. Treatments for PTSD are often contraindicated for TBI and vice versa. A service member with PTSD may be prescribed a beta blocker to address memory of the trauma, but it unknown how these treatments may affect recovery from TBI. Similarly, a stimulant may be prescribed for TBI to enhance certain brain activity, but stimulants may exacerbate certain symptoms of PTSD.

More research must be done to develop evidence-based guidelines for TBI and PTSD, as well as guidelines to address the complexities of comorbid conditions.

Education

The need continues for greater education and training for TBI specialists, particularly neurologists, physiatrists, neuropsychologists, cognitive rehabilitation specialists and physician assistants, occupational therapists, and physical therapists. For the past 3 years, DVBIC has held annual training sessions for some 800 military medics. Continued funding is also needed for multi-media initiatives, development and dissemination of educational materials for providers, as well as informational tools for injured service members and their families and loved ones.

Outreach

Congress should continue funding the DVBIC to improve outreach to service members in remote and underserved areas and follow up. Funding is needed to increase the number of case managers as well as expand DVBIC's TBI Care Coordination program to monitor the continuum of TBI services and connect service members with local and regional TBI-related resources, clinical services, as well as family and patient support services.

The IOM recommended that DOD and the Veterans Administration improve coordination and communication among the multitude of programs that have been created to meet the needs of returning service members and veterans. DVBIC coordination with civilian, private and public, resources and services could help fill the gaps in information and referral and service delivery.

Greater effort needs to be made to create a safety net so that undiagnosed or misdiagnosed service members do not fall through the cracks. National Guard and Reserves are at particular risk as they often return to their civilian lives. In cases where TBI has been indicated, there have been reports of resistance from military treatment facilities in addressing their needs.

A total of $40 million is requested for DVBIC to continue its work and expand and improve as necessary.

NICoE

Scheduled to open this month, the National Intrepid Center of Excellence is expected to "use an innovative holistic approach to the referral, assessment, diagnosis and treatment of those with complex psychological health and TBI disorders" and serve as "a global leader in generating, improving, and harnessing the latest advances in science, therapy, telehealth, education, research and technology while also providing compassionate family-centered care for service members and their loved ones throughout the recovery and community reintegration process." (Testimony of Charles L. Rice, MD, Acting Assistant Secretary of Defense for Health Affairs before HASC hearing April 13, 2010).

NICoE is to provide neurological and psychological treatment to some 500 service members per year, for whom standard treatment is not successful. NICoE holds much promise, as clinical research can be done like never before. What's needed is to push the envelope and develop cutting edge rehabilitation efforts for various levels of TBI and then track long term outcomes. As a Center of Excellence, NICoE should lead the way in redefining the standard of care.

It is envisioned that NICoE would develop specific treatment plan and then seek out community resources in an injured personnel's own community. However, funding is needed not only to encourage innovation but to assure that such treatments will be paid for when service members return to their communities, as new treatments will not likely yet be covered by Tricare.

In order to provide intensive and innovative rehabilitation, research and coordination with consortia of public and private partners will be necessary. $30 million is needed for pilot projects to treat service members with various levels of TBI, including severe TBI and disorders of consciousness.

A total of $45 million for NICoE is requested to be included in the DOD Appropriations bill for fiscal year 2011 for these purposes.

In conclusion, DOD has made some significant strides in addressing the needs of service members with TBI, but more research and innovative treatment is needed. Your leadership and continued support for our wounded warriors is very much appreciated.

Thank you for your consideration of this request to help improve the lives of our wounded warriors.

Chairman INOUYE. Our next witness is Major General David Bockel, executive director of the Reserve Officers Association of the United States.

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

General BOCKEL. Mr. Chairman, Mr. Vice Chairman, the Reserve Officers Association thanks you for the invitation to appear and give testimony.

I am Major General David Bockel. I am the executive director of the Reserve Officers Association, and I am also authorized to speak on behalf of the Reserve Enlisted Association.

A debate is going on whether the Reserve components are becoming too expensive and pricing themselves out of the market as an operational component. It is interesting to note that the argument about the cost of the Reserve and National Guard incentives, benefits, and readiness posture dates back to World War II. At that time, just as now, there were those who said that the Reserve component training, pay, and benefits would be unaffordable and would necessitate long-term costs.

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. There are some who would take cuts from the Reserve rather than the Active Duty force. ROA and REA fully understand that when citizen warriors are used for an extended period, there is a substantial personnel cost. It is a cost of war.

The statement that, while mobilized, a reservist or guardsman costs as much as an active component member isn't in dispute. On the other hand, the citizen warrior cost over a lifecycle, being mobilized only when needed and placed into a trained and ready-to-go posture when not recalled, is far less than the cost of an active component warrior.

Additional cost savings are found when prior service training develop civilian proficiencies in badly needed military skill sets, are retained by having adequate number of Reserve billets across the spectrum of military missions.

National Guard and Reserve members fully understand their duty and are proud to be serving operationally. And not only have they contributed to the war effort, but they have made the difference in maintaining an all-volunteer military force, and in the truest sense, the Reserve components have saved the country from a draft.

Establishing parity in training, equipment, pay, and compensation is only fair when the young men and women in the Reserve components are taking their place on the front, assuming the same risk as the Active Duty force. Over 750,000 men and women have left their homes, schools, and workplaces and have performed magnificently in the overseas operational contingencies in Afghanistan and Iraq.

The condition of the Reserves and Guard today is different than it was 9 years ago. In ways, it is better, as almost every leader now is a combat-tested veteran. In other ways, however, the condition is worse. Equipment has been destroyed, worn out, or left in the theater.

Every defense leader recognizes the need to continue to reset the force. ROA's written testimony includes lists 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 the Reserve components exclusively to train and equip the Reserve components.

We hope, too, that this subcommittee continues to provide appropriations for the National Guard and Reserve equipment authorization. Appropriating funds to the Guard and Reserve equipment provides Reserve chiefs and National Guard directors with the flexibility of prioritizing funding. ROA and REA also hope that NGREA dollar levels are assessed based on mission contribution to make it more proportional.

Another concern ROA and REA share is legal support for veterans and Guard and Reserve members returning from deployment to face the ever-increasing challenges of reemployment. On June 1, 2009, ROA established the Service Members Law Center.

This is a pro bono service that provides legal advice and guidance to Reserve, National Guard, Active, and separated veterans, their families, legal counsel, and as well as providing information to attorneys, bar associations, employers, Members of Congress, and other interested parties. It does not provide legal representation.

In just a year, the law center has received over 2,750 requests for information on legal issues. Nearly 60 percent dealt with employment and reemployment rights. The service may be free, but this important service does cost money. Currently, with ROA's fi-

nancial support, it allows the center to be virtually a one-man shop.

Awareness of the service outside of ROA membership is only by word of mouth. This does not—there is not any outside promotion. With broader awareness, our vision is to grow and increase the staff and the services provided to our veterans from both Reserve and Active component communities, which will make more money—which will take more money. ROA would appreciate the opportunity to meet with your staff to discuss how this subcommittee can provide monetary support.

Thank you again for your consideration of our testimony, and I am available to answer any questions.

Chairman INOUYE. I thank you very much, sir.

We have got a workload. I can assure you we will do it.

Senator COCHRAN. I was just curious about the law center that you mentioned in your testimony, whether or not there is pro bono legal activity. I know when I was practicing law in Mississippi before I came up here to serve in Congress, we had a volunteer legal services program for people who couldn't afford lawyers, the poor, and we didn't have as many built-in programs that provide legal services back then. But now there are quite a few.

I wonder, are you getting support from local bar associations for this center?

General BOCKEL. On a case-by-case basis. The gentleman who runs this law center, his name is Captain (Retired) Sam Wright, Navy Reserve, and he is the source authority on USERRA, Service Member Civil Relief Act, and military voting. When he is invited to speak to bar associations, if they don't offer an honoraria, he asks for it.

Interestingly enough, one of our members of the Reserve Officers Association who is also an attorney is providing an amicus brief to the United States Supreme Court on a case that is going to be heard in the fall. And it is going to be very interesting because it is in I don't know how many years, it is the first time that a USERRA case has made it that far.

Senator COCHRAN. Thank you.

Chairman INOUYE. Thank you.

[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.

President: Rear Admiral Paul Kayye, MC, USNR (Ret.)

Staff Contacts:

Executive Director: Major General David R. Bockel, USA (Ret.)

Legislative Director, Health Care: CAPT Marshall Hanson, USNR (Ret.)

Air Force Director: Mr. David Small
Army and Strategic Defense Education Director: Mr. "Bob" Feidler
USNR, USMCR, USCGR, Retirement: CAPT Marshall Hanson, USNR (Ret.)

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.

Executive Director: CMSgt Lani Burnett, USAF (Ret)

PRIORITIES

CY 2010 Legislative Priorities are:
—Providing adequate resources and authorities to support the current recruiting and retention requirements of the Reserves and National Guard.
—Reset the whole force to include fully funding equipment and training for the National Guard and Reserves.
—Support citizen warriors, families and survivors.
—Assure that the Reserve and National Guard continue in a key national defense role, both at home and abroad.

Issues to help Fund, Equip, and Train:
—Advocate for adequate funding to maintain National Defense during overseas contingency operations.
—Regenerate the Reserve Components (RC) with field compatible equipment.
—Fence RC dollars for appropriated Reserve equipment.
—Fully fund Military Pay Appropriation to guarantee a minimum of 48 drills and 2 weeks training.
—Sustain authorization and appropriation to National Guard and Reserve Equipment Account (NGREA) to permit flexibility for Reserve Chiefs in support of mission and readiness needs.
—Optimize funding for additional training, preparation and operational support.
—Keep Active and Reserve personnel and Operation and Maintenance funding separate.
—Equip Reserve Component members with equivalent personnel protection as Active Duty.

Issues to assist Recruiting and Retention:
—Support continued incentives for affiliation, reenlistment, retention and continuation in the Reserve Component.

Pay and Compensation:
—Provide permanent differential pay for Federal employees.
—Offer Professional pay for RC medical professionals.
—Eliminate the one-thirtieth rule for Aviation Career Incentive Pay, Career Enlisted Flyers Incentive Pay, Diving Special Duty Pay, and Hazardous Duty Incentive Pay.

Education:
—Continued funding for the GI Bill for the 21st Century.

Health Care:
—Provide Medical and Dental Readiness through subsidized preventive healthcare.
—Extend military coverage for restorative dental care for up to 180 days following deployment.

Spouse Support:
—Repeal the SBP-Dependency Indemnity Clause (DIC) offset.

NATIONAL GUARD 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 needs.

Key Issues facing the Armed Forces concerning equipment:
—Developing the best equipment for troops fighting in overseas contingency operations.
—Procuring new equipment for all U.S. Forces.
—Maintaining or upgrading the equipment already in the inventory.
—Replacing the equipment deployed from the homeland to the war.
—Making sure new and renewed equipment gets into the right hands, including the Reserve Component.

Reserve Component Equipping Sources:
—Procurement.

—Cascading of equipment from Active Component.
—Cross-leveling.
—Recapitalization and overhaul of legacy (old) equipment.
—Congressional adds.
—National Guard and Reserve Appropriations (NGREA).
—Supplemental appropriation.

END STRENGTH

The ROA would like to place a moratorium on reductions to the Guard and Reserve manning levels. Manpower numbers need to include not only deployable assets, but individuals in the accession pipeline. ROA urges this subcommittee to fund to support:
—Army National Guard of the United States, 358,200.
—Army Reserve, 206,000.
—Navy Reserve, 66,500.
—Marine Corps Reserve, 39,600.
—Air National Guard of the United States, 106,700.
—Air Force Reserve, 71,200.
—Coast Guard Reserve, 10,000
In a time of war and the highest OPTEMPO in recent history, it is wrong to make cuts to the end strength of the Reserve Components. We need to pause to permit force planning and strategy to catch-up with budget reductions.

NONFUNDED ARMY RESERVE COMPONENT EQUIPMENT

The Army National Guard and Army Reserve have made significant contributions to ongoing military operations, but equipment shortages and personnel challenges continue and if left unattended, may hamper the Reserves' preparedness for future overseas and domestic missions. In order to provide deployable units, the Army National Guard and the Army Reserve have cross-leveled large quantities of personnel and equipment to deploying units, an approach that has resulted in growing shortages in non-deployed units.

Army Reserve Unfunded Requirements

Since 9/11, the Army Reserve has mobilized 185,660 soldiers and currently has about 29,000 deployed. Shortages of equipment on-hand, combined with significant substitute items in the Army Reserve's inventory, compromise units' ability to train in support of the modular Army and to meet surge requirements. The Army Reserve has about 73 percent of its required equipment on-hand, but some critical items remain at less than 50 percent fill. Without a higher level of funding, the Army Reserve is projected to reach 85 percent of its equipment requirements by the end of fiscal year 2015.

The Army Reserve has a fiscal year 2015 equipment requirement of $22.05 billion. Under current base budgeting and additional Overseas Contingency Operation funding the projected programmed funds are only $17.76 billion. This is a shortfall of $4.29 billion for the Army Reserve. The minimum NGREA funding to catch-up would be $944 million. Unresourced equipment includes:

Transportation:
Family of Medium Tactical Vehicles (FMTV)—$1.03 billion
Heavy Tactical Vehicle (HTV)—$503 million
Heavy Expanded Mobility Tactical Truck (HEMTT–LET)—$300 million
Stryker Nuclear Biological and Chemical Recon Vehicle (NBC–RV)—$547 million
C–27A Cargo Aircraft—$26 million each
—The latest addition to the United States Army Reserve Aviation fleet is the C–27J Spartan Joint Cargo Aircraft (JCA). The Army Reserve will be initially receiving 16.
Tactical Quiet Generators [TQG's] PU–807A 100kW (3,036)—$5.8 million
—The Army Reserve requires 8,717 TQG's to perform its wartime mission as well as its HLS/HLD responsibilities, but has only 5,681 on-hand. Of particular concern in an unfunded shortfall of 59 100kW power units (PU's) that exists within Combat Support Hospitals.

Army National Guard Unfunded Equipment Requirements

Army National Guard (ARNG) units deployed overseas have the most up-to-date equipment available. However, a significant amount of equipment is currently unavailable to the Army National Guard in the states due to continuing rotational deployments and emerging modernization requirements. Equipment is need to replace broken equipment and battle loses, train in pre-mob, support the TPE, and to substitute for equipment in transit. To support the mission the ARNG has cross-leveled

equipment. Current equipment procurement averages $5 billion per year. Current equipment levels as of April 2010 are 77 percent of equipment on-hand.

HMMWVs (humvees) (2,063)—$2.4 billion

—ARNG is critically short on certain HMMWV configurations that are essential to domestic and Overseas Contingency Operations.

Transportation—$1.15 billion

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

Warfighter Information Network-Tactical (WIN–T)—$1.2 billion

—Tactical telecommunications system consisting of infrastructure and network components from the maneuver battalion to the theater rear boundary. The WIN–T network provides Command, Control, Communications, Computers, Intelligence, Surveillance, and Reconnaissance (C^4ISR) capabilities that are mobile, secure, survivable, seamless, and capable of supporting multimedia tactical information systems.

Stryker combat vehicles, battalion (1)—$1.4 billion

—Eight-wheeled vehicle that can travel up to 62.5 mph. It comes in 10 variants, including an infantry-carrier vehicle, a medical evacuation vehicle and a command vehicle.

Multi-Temperature Refrigerated Container System (MTRCS)—$7.5 million

—The Army National Guard has no refrigerated container systems on-hand, creating a combat readiness issue for selected quartermaster units and forcing states to lease commercial systems to transport food and medical supplies during HLS/HLD missions and during training. The MTRCS is the Army's new refrigerated container system.

AIR FORCE RESERVE COMPONENTS EQUIPMENT PRIORITIES

Air Force Reserve Unfunded Requirements

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

Infra-Red Counter Measures C–130 (21)—$63 million

—The AN/AAQ–24 (V) NEMESIS is an infrared countermeasure system designed to protect against man-portable (shoulder-launched) infrared-guided surface-to-air missiles.

Infra-Red Counter Measures KC–135 (15)—$15 million

—KC–135 aircraft deployed in support for Operation Iraqi and Enduring Freedom have inadequate protection against the Infrared Missile threat. For the procurement and installation of the Guardian AN/AAQ–24 (V) Large Aircraft Podded Infrared Countermeasures (LAIRCM) system.

Infra-Red Counter Measures C–5B/C–17s (13)—$90 million

—For the procurement and installation of the AN/AAQ–24 V NEMESIS, an infrared countermeasure system designed to protect against man-portable (shoulder-launched) surface-to-air missiles.

Helmet Mounted Integrated Targeting [HMIT] (39)—$6 million

—Upgrade and enhancement to engagement systems.

C–5 Structural Repair (6)—$66 million

—Stress corrosion cracking of C–5A skins and box beam fittings requires fleet-wide replacement to avoid grounding and restriction of outsize cargo-capable to sustain strategic mobility assets.

Security Forces Weapons & Tactical Equipment—$5.5 million

—Also: The USAFR #1 need is MILCON dollars. Of the total fiscal year 2011 USAF MILCON budget, The AF Reserve was only funded with $3.4 million for its top facilities project, but is underfunded by $1 billion.

Air National Guard Unfunded Equipment Requirements

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

C–17 Globemaster III transport aircraft (5)—$1.3 billion

—As highlighted as an ANG airlift requirement.

Infra-Red Counter Measures—$238 million

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

Air Defensive Systems—$49 million

—Continue to install ADS systems onto C–5, C–17, and F–15 aircraft.
Security Force Equipment—$79.4 million
—Crowd control, Tasers, Protective garments, eyewear, goggles, rifles, weapons accessories, traffic control kits, and night vision devices.
Helmet Mounted Cueing System (HMCS)—$30 million
—The addition of a day/night helmet mounted cueing system (HCMS) will significantly increase pilot situational awareness (SA), aircraft survivability, and lethality in every mission area. Needed for F–16 and A–10 aircraft.

NAVY RESERVE UNFUNDED PRIORITIES

Active Reserve Integration (ARI) aligns Active and Reserve component units to achieve unity of command. Navy Reservists are fully integrated into their Active component supported commands. Little distinction is drawn between Active component and Reserve component equipment, but unique missions remain.
C–40 A Combo cargo/passenger Airlift (2)—$170 million
—The Navy requires a Navy Unique Fleet Essential Airlift Replacement Aircraft. The C–40A is able to carry 121 passengers or 40,000 pounds of cargo, compared with 90 passengers or 30,000 pounds for the C–9.
Maritime Expeditionary Security Force—$20 million
—Navy Expeditionary Combat Command has 17,000 Navy Reservists and requires $3.1 billion in Reserve Component (Table of Allowance) TOA equipment.
KC–130J Super Hercules Aircraft tankers (2)—$168 million
—These Aircraft are needed to fill the shortfall in Navy Unique Fleet Essential Airlift (NUFEA). Procurement price close to upgrading existing C–130Ts with the benefit of a long life span. Twenty-four replacements required through 2030.
C–37 B (Gulf Stream) Aircraft (1)—$64 million
—The Navy Reserve helps maintain executive transport airlift to support the Department of the Navy.
Civil Engineering Support Equipment—Tactical Vehicles—$4.4 million

MARINE CORPS RESERVE UNFUNDED PRIORITIES

More than 54,000 Marine Corps Reservists have executed over 70,000 mobilizations. Nearly one-third of the authorized 39,600 end strength have deployed outside the continental United States. The young men and women have become an experienced combat force, but are limited in their mission by the availability of equipment.
KC–130J Super Hercules Aircraft tankers (4)—$200 million
or advanced procurement—$48 million
—These Aircraft are needed to fill the shortfall in Marine Corps Essential Airlift. USMCR needs 28 airframes, and procurement price close to upgrading existing C–130Ts with the benefit of a longer life span. Commandant, USMC, has testified that acquisition must be accelerated.
Light Armored Vehicles—LAV—$1.5 million each
—A shortfall in a USMCR light armor reconnaissance company, the LAV–25 is an all-terrain, all-weather vehicle with night capabilities. It provides strategic mobility to reach and engage the threat, tactical mobility for effective use of fire power.
Training Allowance (T/A) Shortfalls—$145 million
—Shortfalls consist of over 300 items needed for individual combat clothing and equipment, including protective vests, poncho, liner, gloves, cold weather clothing, environmental test sets, took kits, tents, camouflage netting, communications systems, engineering equipment, combat and logistics vehicles and weapon systems. USMCR goal is to ensure that the Reserve TA contains the same equipment utilized by the active component.
Obtain latest generation of Individual Combat and Protective Equipment including: M4 rifles; Rifle Combat Optic (RCO) scopes; Light weight helmets; Small Arms Protective Insert (SAPI) plates; Modular Tactical Vests; and Flame Resistant Organizational Gear.

NATIONAL GUARD AND RESERVE EQUIPMENT APPROPRIATION

The Reserve components that were once held as a strategic force are now also being employed as an operational asset as well as a strategic reserve; stressing an ever greater need for procurement flexibility as provided by the National Guard and Reserve Equipment Appropriation (NGREA). Much-needed items not funded by the respective service budget are frequently purchased through NGREA. In some cases it is used to bring unit equipment readiness to a needed state for mobilization.

The Reserve and Guard are faced with ongoing challenges on how to replace worn out equipment, equipment lost due to combat operations, legacy equipment that is

becoming irrelevant or obsolete, and, in general, replacing that which is gone or aging 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.

ROA thanks Congress for approving $750 million for NGREA for fiscal year 2010, but even more dollars are needed. ROA urges Congress to continue the authorization and appropriate for a modern equipment account proportional to the missions being performed, which will enable the Reserve Component to meet its readiness requirements.

SERVICE MEMBERS LAW CENTER

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

In almost a year of operation (June 1, 2009 through May 6, 2010), the Service Members Law Center has advised 2,150 individuals, by telephone and/or e-mail, and in a few instances in person. Of those 2,150, approximately 1,720 (80 percent) were Active or Reserve Component (overwhelmingly Reserve Component) members of the Armed Forces. Of those who have contacted us, the ROA Service Members Law Center has referred about 5 percent to attorneys.

The ROA Service Members Law Center has also heard from and has provided information to attorneys, employers, congressional staffers, state legislators and staffers, reporters, and veterans who are not currently Active or Reserve Component members of the Armed Forces but have been in the past.

The legal center helps encourage new members to join the Active, Guard and Reserve components by providing a non-affiliation service to educate prior service about the Uniformed Services Employment and Reemployment Rights Act (USERRA) and Servicemember Civil Relief Act (SCRA) protections, and other legal issues. It helps retention as a member of the staff works with Active and Reserve Component members to counsel those who are preparing to deploy, deployed or recently deployed members facing legal problems.

The Legal Center refers names of attorneys who work related legal issues, encouraging law firms to represent service members, and educate and training lawyers, especially active and reserve judge advocates on service member protection cases. The center is also a resource to Congress.

The Supreme Court has granted a discretionary review of its first Supreme Court case under (USERRA). The Service Members Law Center will file an *amicus curiae* (friend of the court) brief in July.

ROA sets aside office spaces and has already hired a lawyer to answer questions of serving members and veterans. The goal is to hire two additional staff with a paralegal and an administrative law clerk and provide suitable office equipment and workspace to help man the Service Members Law Center to expand counsel individuals and their legal representatives.

Anticipated overall cost fiscal year 2011: $505,000.

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 a nonpolitical, independent confederation 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 and is its 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. These contests emphasize combined and joint military actions relevant to the multinational aspects of current and future Alliance operations.

Language Academy.—The two official languages of NATO are English and French. As a non-government body, operating on a limited budget, it is not in a position to afford the expense of providing simultaneous translation services. The Academy offers intensive courses in English and French as specified by NATO Military Agency for Standardization, which affords international junior officer members the opportunity to become fluent in English as a second language.

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 that 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. Our next witness is a member of the board of directors of the National Breast Cancer Coalition, Ms. Joy Simha.

STATEMENT OF JOY SIMHA, MEMBER, BOARD OF DIRECTORS, NATIONAL BREAST CANCER COALITION AND CO–FOUNDER, YOUNG SURVIVAL COALITION

Ms. SIMHA. Thank you.

Thank you, Mr. Chairman and members of the Appropriations Defense Subcommittee for the opportunity to testify here today about the Department of Defense Breast Cancer Research Program. As successful as this competitive peer-reviewed program is, it warrants level funding.

I am Joy Simha. I am a 16-year breast cancer survivor, a wife, a mother, and one of the co-founders of the Young Survival Coalition and, as you said, a board member of the National Breast Cancer Coalition. In addition, I sit on the integration panel of the Breast Cancer Research Program with three other survivors and about a dozen scientists.

Chairman Inouye and Ranking Member Cochran, we truly appreciate your longstanding support of this innovative, successful program, which represents a meaningful, true way for women to fight breast cancer. Women and their families across the country are depending on this program.

The program has a unique structure, which brings scientists, trained consumers, policymakers, and the Army together to collaborate toward ending breast cancer. There is no bureaucracy, and the Army is so efficient and effective in implementing the program. They should be applauded for using less than 10 percent of funds for administrative costs.

The program is truly transparent and accountable to the taxpayer. The Era of Hope, which is a biennial meeting where scientists report back on their research results, provides opportunity for others to hear about and collaborate on innovative research re-

sults. In addition, all information about who gets funded can be found at the Department of Defense Breast Cancer Web site.

The partnership with educated consumers, scientists, the Army, policymakers helps keep the science relevant to women. It ensures the program's sense of urgency at fulfilling its mission.

This program pushes science to new levels. The focus is in changing the status quo by creating new models of research. The collaborators are not afraid to ask the very difficult, complex questions and fund unique models of research while maintaining the peer review model.

As a true testimony to our success, the mission, the mechanisms, and the structure of the program have been used for models in other programs in other research and scientific research programs. This program has been applauded by the Institute of Medicine and others as an exemplary model of funding research.

The program works. It not only saves women's lives, but it changes the status quo about how we do research. The Department of Defense Breast Cancer Research Program is a true means to an end. People across this country believe in the program and its ability to end breast cancer. I come to you as a survivor representing those people and the many wonderful women we have lost to breast cancer.

I wish to dedicate my testimony today to two women who were once chairs of the integration panel who lost their lives recently to breast cancer—Carolina Hinestrosa, who is just about a 1-year—we lost her about 1 year ago, and Karin Noss. We continue our work to honor women as amazing as these two so that we can move forward and try to end breast cancer and save lives in the future.

Thank you for your support and the opportunity to testify.

Chairman INOUYE. I thank you very much for your testimony. We will do our best.

Senator COCHRAN. I want to congratulate you on the quality of your presentation, too. You would be a professional in many, many areas, but particularly the convincing way you presented your remarks I thought was worthy of praise.

I noticed that in 2004, there was a report that reviewed this program and gave it very high marks and talked about the scientific breakthroughs that were occurring because of the things that your organization is doing. Congratulations.

Ms. SIMHA. Thank you.

[The statement follows:]

PREPARED STATEMENT OF JOY SIMHA

INTRODUCTION

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 Joy Simha, a 16-year breast cancer survivor, communications consultant, a wife and mother, co-founder of The Young Survival Coalition, and a member of the board of directors of the National Breast Cancer Coalition (NBCC). I am also a member of the Integration Panel of the Department of Defense Breast Cancer Research Program. My testimony represents the hundreds of member organizations and thousands of individual members of the Coalition. NBCC is a grassroots organization dedicated to ending breast cancer through action and advocacy. The Coalition's main goals are to increase Federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; im-

prove 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.

Chairman Inouye and Ranking Member Cochran, we appreciate your long-standing 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 the National Breast Cancer Coalition, 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 eradicating 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 2011. 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 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. Because of its specific focus on breast cancer, it is able to rapidly support innovative proposals that reflect the most recent discoveries in the field. It is responsive, not just to the scientific community, but also to the public. The 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 science funded by the program fill 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.

Last year, 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 last year 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 advocates 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 3010 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 also.

Innovator awards invest in world renowned, outstanding individuals rather than projects, by providing funding and freedom to pursue highly creative, potentially groundbreaking research that could ultimately accelerate the eradication of breast cancer. 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 Award 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, now the Director of the National Cancer Institute (NCI), said the following about the Program when he was Director of the University of Wisconsin Comprehensive Cancer Center in April, 1999:

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

Scientists and consumers agree that it is vital that these grants continue to support breast cancer research. To sustain the Program's momentum, $150 million for peer-reviewed research is needed in fiscal year 2011.

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 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.stopbreastcancer.org/ to learn more about the exciting research reported at the 2008 Era of Hope. The next Era of Hope meeting is being planned for 2011.

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

COMMITMENT OF THE NATIONAL BREAST CANCER COALITION

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

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

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 3 million women living with breast cancer in this country today. This year, more than 40,000 will die of the disease and more than 240,000 will be diagnosed. We still do not know how to prevent breast cancer, how to diagnose it 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 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. Our final witness represents the Program for Appropriate Technology in Health, Dr. John W. Boslego.

STATEMENT OF JOHN W. BOSLEGO, M.D., DIRECTOR, VACCINE DEVELOPMENT GLOBAL PROGRAM, PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH

Dr. BOSLEGO. Good morning. My name is John Boslego. I am the director of the Vaccine Development Global Program at PATH.

I would like to begin by thanking Chairman Inouye and Ranking Member Cochran. I would also like to thank Senators Patty Murray and Dick Durbin for their ongoing championship of global health, and Senator Brownback for his leadership in ensuring access for lifesaving tools for neglected diseases in low-income countries.

PATH is an international nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public and private sector partners, we help provide appropriate health technologies and vital strategies that change the way people think and act.

We wish to take this opportunity to recognize the specific and unique areas of expertise that the Department of Defense brings to bear in advancing innovation that ensures that people in low-resource settings have access to lifesaving interventions and technologies.

The global health research effort of DOD responds to diseases many Americans may never see up close, but which military personnel stationed in the developing world experience alongside local communities. PATH requests that in fiscal year 2011 the subcommittee provide robust support for DOD research and development programs aimed at addressing health challenges, particularly for military malaria vaccine research, as well as research at the Defense Advanced Research Project Agency, or DARPA.

For malaria vaccine, more than one-third of the world's population is at risk of malaria, with approximately 250 million cases occurring every year. And most of the nearly 1 million deaths from malaria are among children in Africa under the age of 5.

According to a 2006 IOM report, malaria has affected almost all military deployments since the American civil war and remains a severe ongoing threat. The same report noted that a vaccine would be the best method of averting the threat of malaria, given the likely increasing number of deployments to high-risk areas.

Military researchers within the Military Infectious Disease Research Program are at the forefront of efforts to develop a malaria vaccine. One example of DOD's impact in malaria research is the most promising vaccine candidate in existence today, RTS,S. Research at the Walter Reed Army Institute of Research contributed to the development of the vaccine candidate, and early testing of RTS,S—created by GlaxoSmithKline—was done in collaboration with the U.S. military.

Today, thanks to an innovative partnership between GSK Bio and PATH Malaria Vaccine Initiative—a PATH program that works to accelerate development of malaria vaccines and ensure their availability and accessibility in the developing world—RTS,S is now in a large-scale phase 3 trial, typically the last stage of testing prior to licensure. The U.S. Army is assisting in this trial by supporting one of the field sites in Kenya.

Unfortunately, current funding levels are nowhere near what is needed to develop urgently needed countermeasures against malaria. PATH recommends $31.1 million in malaria R&D funding for DOD in fiscal year 2011.

Another program making great contributions to health research and development is DARPA. DARPA has identified as a priority the development of health technologies that can help both the U.S. military and be of use in DOD-sponsored humanitarian and relief operations in regions emerging from conflict.

One of the technologies pioneered by DARPA has led to electrochemical generators of chlorine. PATH has partnered with Cascade

Design, Inc., on a new generation of smart electrochlorinators that inactivates bacteria, viruses, and some protozoa to create safe drinking water. The generators can be powered by solar-charged batteries, making them accessible to communities that do not have electricity infrastructure.

In conclusion, in light of the critical role that DOD plays in global health research and development, we respectfully request the subcommittee provide the resources to maintain this important core capacity, including $31.1 million in malaria R&D funding.

We thank you.

Chairman INOUYE. I thank you very much, Doctor, and you may be assured we will seriously consider your request.

Senator COCHRAN. Thank you very much.

I think malaria is one of those diseases that worldwide is probably the most aggressive and probably causes more deaths and illnesses than any other one malady. Is that right? Is that an accurate assessment?

Dr. BOSLEGO. Certainly, it is among the top killers, particularly in Africa.

Senator COCHRAN. Well, thank you very much for reminding us of this and your assistance to the subcommittee.

[The statement follows:]

PREPARED STATEMENT OF JOHN W. BOSLEGO

PATH appreciates the opportunity to submit written testimony regarding fiscal year 2011 funding for global health research and development to the Senate Defense Appropriations Subcommittee. PATH is an international nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, we help provide appropriate health technologies and vital strategies that change the way people think and act.

We wish to take this opportunity to recognize the specific and unique areas of expertise that the Department of Defense (DOD) brings to bear in advancing innovation that ensures that people in low-resource settings have access to life-saving interventions and technologies. Through DOD, the U.S. Government is able to apply this core capacity to improving health throughout the world.

The global health research efforts of DOD respond to diseases many Americans may never see up close, but which military personnel stationed in the developing world experience alongside local communities. Medicines, vaccines, and diagnostics for health threats that disproportionately affect the developing world are critical for their protection. Health is also an important factor in global stability and security. The heavy burden of disease in the developing world hinders economic and social development, which in turn perpetuates conditions that breed political instability. DOD health research therefore benefits not only the U.S. military but also has the potential to reduce this health burden, and by doing so, reduce the likelihood of physical conflict.

PATH requests that in fiscal year 2011, the Subcommittee provide robust support for DOD research and development programs aimed at addressing these health challenges, particularly two important programs. First, we request that the Subcommittee provide increased support for military malaria vaccine development efforts. Second, we request that the Subcommittee support research at the Defense Advanced Research and Projects Agency (DARPA) aimed at delivering healthcare to military personnel and civilians in remote, resource-poor, and unstable locations. PATH also requests that no funding cuts be made to DOD research and development.

Malaria and Vaccines

Malaria is a parasitic infection transmitted by mosquitoes. More than one-third of the world's population is at risk of malaria, with approximately 250 million cases occurring every year. Most of the nearly 1 million annual deaths from malaria are among children in Africa under the age of five. A malaria vaccine is desperately needed to help prevent these deaths. While consistent use of effective insecticides,

insecticide-treated nets, and malaria medicines saves lives, eradicating or even significantly reducing the impact of malaria will require additional interventions, including vaccines. Immunization is one of the most effective health interventions available. Just as it was necessary to use vaccines to control polio and measles in the United States, vaccines are needed as part of an effective control strategy for malaria. Furthermore, vaccines are typically the most efficient means of protecting military personnel from disease threats. When troops are deployed, and particularly under combat conditions, compliance with drug regimens or other disease-protection protocols can be difficult, if not impossible. Vaccination, in contrast, can be performed prior to deployment, and allows deployed personnel to remain focused on mission success, rather than chemoprophylaxis, bed nets, or insecticide application.

Malaria and the U.S. Military

A 2006 Institute of Medicine (IOM) report[1] found that "malaria has affected almost all military deployments since the American Civil War and remains a severe and ongoing threat." For this reason, the military has historically taken an active and leading role in the development of health technologies to protect military personnel from malaria, or to treat them if they become infected with the disease. This work includes a robust, cutting-edge program aimed at developing a highly-efficacious malaria vaccine, suitable for use by military personnel. The aforementioned IOM study noted "the fact that a vaccine would be the best method of averting the threat of malaria given the likely increasing number of deployments to high-risk areas." An effective vaccine would provide unparalleled protection to servicemen and women serving in malaria-endemic countries and regions, and would significantly reduce the impact of noncompliance, drug resistance, and other significant obstacles that currently limit the military's ability to provide protection from malaria. Military researchers within the Military Infectious Disease Research Program, including the U.S. Army Medical Research Institute of Infectious Diseases, U.S. Naval Medical Research Center, and the Walter Reed Army Institute of Research (WRAIR), are at the forefront of efforts to develop a malaria vaccine.

Research at WRAIR, for example, contributed to the development of the most promising vaccine candidate in existence today, RTS,S. Early testing of RTS,S—created by GlaxoSmithKline Biologicals (GSK Bio)—was done in collaboration with the U.S. military. Today, thanks to an innovative partnership between GSK Bio and the PATH Malaria Vaccine Initiative (MVI)—a PATH program that works to accelerate the development of malaria vaccines and ensure their availability and accessibility in the developing world—RTS,S is now in a large-scale Phase 3 trial, typically the last stage of testing prior to licensure. Although the efficacy of RTS,S is unlikely to prove adequate for military purposes—despite its potential benefit to young children in Africa—it has shown that developing a vaccine against malaria is possible and paved the way for other development efforts that could ultimately allow the military to vaccinate men and women against malaria before deploying them to endemic regions. Since its establishment in 1999, MVI has partnered with the military in a number of malaria vaccine development projects, including the preclinical development of an adenovirus-vectored malaria vaccine candidate developed by GenVec, Inc. that used a modified common cold virus to deliver multiple malaria antigens.

Unfortunately, DOD spending on malaria research has been declining for several years from levels that were already comparatively small given the historic impact of malaria on overseas deployments. PATH requests that the Subcommittee reverse this trend, and provide the resources needed to develop the necessary tools—including vaccines—to protect soldiers, sailors, airmen, and marines from this deadly and debilitating disease threat. This would make possible a continuation of the kind of collaboration—characterized by joint funding—that currently exists between MVI and the U.S. Military Malaria Vaccine Program. In particular, PATH recommends $31.1 million in malaria R&D funding for DOD in fiscal year 2011.

DARPA and DTRA

The Defense Advanced Research Projects Agency (DARPA) is DOD's primary research and development component and performs work on the cutting edge of multiple scientific disciplines, providing a wide range of critical new technologies and products for use by the military. DARPA has made and could make additional contributions in one area it has identified as a priority: developing health technologies that can both help the U.S. military, and be of use in DOD-sponsored humanitarian relief operations in regions emerging from conflict. Military personnel operating in

[1] *Battling Malaria—Strengthening the U.S. Military Malaria Vaccine Program*. National Academy of Sciences Press, Washington, D.C. 2006.

developing countries face many of the same challenges to healthcare delivery as do the residents of those countries: electricity and transportation interruptions that can threaten the integrity of temperature-sensitive medicines and vaccines; lack of access to trained medical personnel and facilities; and an absence of infrastructures and technologies that allow for the rapid manufacture and delivery of medicines and vaccines for the treatment of unexpected infectious disease threats. Increased support for this research would help the United States to more effectively assist developing countries that need vaccines and other basic health technologies, while ensuring that health products are delivered as efficiently as possible.

DARPA's investments in austere healthcare delivery systems—through their focus on disaster medicine in projects such as "Real World," "Rapid Altitude Climatization," and "SAVE II Ventilators"—represent a commitment to interventions that could have positive and profound health implications for populations in low-resource settings. For example, DARPA pioneered technology that has led to electrochemical generators of chlorine that may be able to fulfill a community's needs for effective disinfectants for water or surfaces by using just salt water and a simple battery source, such as a car or motorcycle battery.

The Smart Electrochlorinator provides a chlorine solution used to treat water from a variety of sources, bringing safe water into small-community households. The devices effectively inactivate bacteria, viruses, and some protozoa to create safe drinking water. Since the generators can be powered by solar-charged batteries, they are accessible to communities that do not have an electricity infrastructure. The only resources required are 75 g of table salt and 0.1 kWh per person per year, both potentially renewable. These costs are significantly less than required for the current large-scale community systems, resulting in break-even points that are within reach of very poor, small communities. PATH has partnered with Cascade Designs, Inc. on a new generation of smart electrochlorinator that has the potential to expand the project initiated by DARPA to broader community reach for both military and civilian benefit.

The Defense Threat Reduction Agency (DTRA) is also doing groundbreaking work as it investigates innovations in vaccine and chemical reagent thermo-stabilization and point of care diagnostic tests for infectious diseases that has positive implications for global health and U.S. military support in low-resource settings. Such technologies will enable rapid pathogen identification in the field and threat zone to more rapidly enlist targeted interventions. PATH requests that the Subcommittee maintain funding for the DARPA and DTRA research aimed at developing solutions to these and other health challenges.

Conclusion

In light of the critical role that at DOD plays in global health research and development, and the fact that investments in this area have been falling, we respectfully request that the Subcommittee provide the resources to maintain this important core capacity. We thank you for your consideration, and hope that you will consider PATH as a resource and partner on this issue.

ADDITIONAL SUBMITTED STATEMENTS

Chairman INOUYE. On behalf of the subcommittee, I would like to thank all of you, the witnesses, for the testimony today.

The subcommittee has received some additional statements which will be inserted into the record at this point.

[The statements follow:]

PREPARED STATEMENT OF THE AMERICAN MUSEUM OF NATURAL HISTORY

Overview

Recognizing its potential to aid the Department of Defense in its goal to support research to prepare for and respond to the full range of threats, the American Museum of Natural History seeks in $3.5 million in fiscal year 2011 to contribute its unique resources to the advancement of research in areas of science closely aligned with DOD's research priorities and to extend the research effort with an associated STEM (science, technology, engineering, mathematics) education component, to help build a workforce adequate to meet the nation's security needs.

About the American Museum of Natural History

The American Museum of Natural History (AMNH) is one of the nation's preeminent institutions for scientific research and public education. Since its founding

in 1869, the Museum has pursued its mission to "discover, interpret, and disseminate—through scientific research and education—knowledge about human cultures, the natural world, and the universe." The AMNH research staff numbers over 200, with tenure track faculty carrying out cutting-edge research in fields ranging from molecular biology and genome science to earth and space science, anthropology, and astrophysics. Museum scientists publish nearly 450 scientific articles each year and enjoy a success rate in competitive (peer reviewed) scientific grants that is approximately double the national average. The work of its scientists forms the basis for all the Museum's activities that seek to explain complex issues and help people to understand the events and processes that created and continue to shape the Earth, life and civilization on this planet, and the universe beyond.

Advancing Research Aligned With National Security Goals

The Department of Defense (DOD) ensures the nation's security and its capacity to understand and respond to threats in this new era of complex defense challenges. DOD is committed to the research, tools, and technology that will achieve these goals, and to ensuring that the nation's 21st century science, technology, engineering, and mathematics (STEM) workforce is prepared to meet U.S. preparedness and security needs.

The American Museum of Natural History (AMNH), in turn, is a preeminent research and public education institution, home to leading research programs in biocomputation, comparative genomics, and the life, physical, environmental, and social sciences—programs that are positioned to advance the Nation's capacity to prepare for and respond to security threats. AMNH is also a recognized leader in STEM education—in both out-of-school settings and with formal education partners—with local, regional, and national reach, and, with the recently launched Richard Gilder Graduate School, became the first American museum authorized to grant the Ph.D. degree.

In fiscal year 2005, AMNH and DOD launched a multi-faceted research partnership via DARPA that leverages the Museum's unique expertise and capacity. Since that time, AMNH has been carrying out research that directly relates to DARPA goals by increasing our capacity to predict where disease outbreaks might occur and to effectively monitor disease-causing agents and their global spread. This research project has been centered on the development of a computational system to rapidly compare genetic sequences of pathogens, and, utilizing the computational system, generating a global map showing the spread of disease-causing viruses over time and place.

Throughout this partnership, DARPA program managers have supported AMNH's work, have made the research known to other DOD-supported scientists, and have invited AMNH scientists to participate in DARPA conferences. With DARPA support to date, the project has: advanced understanding of emerging infectious disease through the analysis of the origins and genomic evolution of SARS coronavirus; studied re-assortment and drug resistance among influenza strains; and developed methods for mapping the spread of pathogens over time and geography. We are now able to track global evolution of pathogenic viruses such as avian influenza, and can identify, for any geographic region, the major and minor sources of pathogenic viruses. The research has investigated progressively more complex systems, moving from viruses to the study of bacteria, including ecological data into the realm of biogeographical and host-pathogen research.

In fiscal year 2011, the Museum seeks DARPA support to advance its research in this and other high-priority areas for the Agency, and to enhance the research program with an associated STEM education component, providing diverse urban students with science content, research experiences, and mentoring in the project's STEM areas. In so doing, AMNH hopes to help meet the need for a well-educated population of college-level graduates in STEM fields. With this support, which AMNH will leverage with funds from non-Federal and Federal sources, AMNH will be able to continue to draw on its unique research, training, and education capabilities to advance goals critical to DOD and our national preparedness and security.

PREPARED STATEMENT OF FLORIDA STATE UNIVERSITY

Summary: Florida State University is requesting $5,500,000 from the Research, Development, Test and Evaluation, Navy, Force Protection Applied Research (PE# 0602123N, Line 5) for the Integration of Electo-kinetic Weapons into the Next Generation Navy Ships Program; $4,000,000 from the Defense, Research, Development, Test and Evaluation, Defense-wide, Government/Industry Co-Sponsorship of University Research (PE# 0601111D8Z, Line 3) for the Integrated Cryo-cooled High Power

Density Systems; $3,800,000 from the Research, Development, Test and Evaluation, Navy, Defense Research Sciences (PE# 0601153N, Line 3), for the Jet Engine Noise: Understanding and Reduction program, and $4,500,000 from the Research, Development, Test and Evaluation, Army University and Industry Research Centers Program (PE# 0601104A, Line 4) for the Nanotubes Optimized for Lightweight Exceptional Strength (NOLES)/Composite Material Program.

Mr. Chairman, I would like to thank you and the Members of the Subcommittee for this opportunity to present testimony before this Committee. I would like to take a moment to briefly acquaint you with Florida State University.

Located in Tallahassee, Florida's capitol, FSU is a comprehensive Research university with a rapidly growing research base. The University serves as a center for advanced graduate and professional studies, exemplary research, and top-quality undergraduate programs. Faculty members at FSU maintain a strong commitment to quality in teaching, to performance of research and creative activities, and have a strong commitment to public service. Among the current or former faculty are numerous recipients of national and international honors including Nobel laureates, Pulitzer Prize winners, and several members of the National Academy of Sciences. Our scientists and engineers do excellent research, have strong interdisciplinary interests, and often work closely with industrial partners in the commercialization of the results of their research. Florida State University had over $200 million this past year in sponsored research awards.

Florida State University attracts students from every state in the nation and more than 100 foreign countries. The University is committed to high admission standards that ensure quality in its student body, which currently includes National Merit and National Achievement Scholars, Rhodes and Goldwater Scholars, as well as students with superior creative talent. Since 2005, FSU students have won more than 30 nationally competitive scholarships and fellowships including 3 Rhodes Scholarships, 2 Truman Scholarships, Goldwater, and 18 Fulbright Fellowships.

At Florida State University, we are very proud of our successes as well as our emerging reputation as one of the nation's top public research universities. Our new President, Dr. Eric Barron, will lead FSU to new heights during his tenure.

Mr. Chairman, let me summarize our primary interest today. The first project involves improving our nation's fighting capabilities and is called the Integration of Electro-kinetic Weapons into the Next Generation Navy Ships Project.

The U.S. Navy is developing the next-generation integrated power system (NGIPS) for future war ships that have an all-electric platform of propulsion and weapon loads and electric power systems with rapid reconfigurable distribution systems for integrated fight-through power (IFTPS). On-demand delivery of the large amounts of energy needed to operate these types of nonlinear dynamic loads raises issues that must be addressed including the appropriate topology for the ship electric distribution system for rapid reconfiguration to battle readiness and the energy supply technology for the various nonlinear dynamic load systems. The goal of this initiative is to investigate the energy delivery technologies for nonlinear dynamic loads, such as electro-kinetic weapons systems, and investigate the integration and interface issues of these loads on the ship NGIPS through system simulations and prototype tests using power hardware-in-the loop strategies. To meet these research goals, the FSU facilities will be expanded with a 5 MW MVDC power converter and upgrade of the large scale real-time simulator. The results of this effort will provide the Navy's ship-builders with vital information to design and de-risk deployable ship NGIPS and load power supplies.

With significant support from the Office of Naval Research (ONR), FSU has established the Center for Advanced Power Systems (CAPS), which has integrated a real time digital power system simulation and modeling capability and hardware testbed, capable of testing IPS power system components at ratings up to 5MW, offering unique hardware-in-the-loop simulation capabilities unavailable anywhere in the world. FSU is partnering with Florida Atlantic University, Florida International University, and General Atomics to combine the best talents for modeling and simulation of ship power systems, hardware-in-the-loop testing, power supplies for present and future electro-kinetic systems, and interfacing of the weapon to a ship power system. General Atomics will provide the power requirements for the weapons interface to the shipboard power distribution system. The National High Magnetic Field Laboratory (NHMFL) will utilize its research expertise and infrastructure for the proposed development. NAVSEA will be an advisor to the project for weapon system integration. We are requesting $5,500,000 for this important program.

Our second project is also important to our nation's defense and involves our Integrated Cryo-cooled High Power Density Systems program. The objective of this program is to approach the goal of achieving high power densities through systems in-

tegration, management of heat generation and removal in the electrical system and minimize energy consumption and capital expenditures of large scale advanced power systems through cryo-cooled superconducting systems. The research activities are as follows:

Systems Analysis.—Extensive system modeling and simulation of the integrated electrical and thermal systems to understand dynamic performance under normal and adverse conditions is necessary to achieve an optimal system configuration. Develop prototypes of key technologies and test in hardware-in-the-loop simulations at levels of several megawatts (MW) to validate and demonstrate the advanced technologies.

Materials—Advanced Conductors, Semi-conductors and Insulation.—Characterization of conductor materials (both normal and superconducting), semi-conductors (for use in power electronic components) and insulating materials (both thermal and electrical) at cryogenic temperatures to obtain the data needed to model system performance and design components for medium voltage dc (MVDC).

Cryo-thermal Systems.—Optimize thermal system options, including conductive heat transfer and gas phase and fluid phase heat transfer systems. Modeling to understand effects from heat leaks from the ambient to the low temperature environment and internal heat generation are critical to successful performance. Adaptability to economical fabrication technologies is a major issue for investigation.

System Components.—Consider new concepts for design of system components and interfaces to achieve optimum system integration. A 30 meter, 10KV DC cable based on 2G HTS wire will be designed, fabricated and tested to prove the concept of a MVDC superconducting shipboard power distribution system and provide validated design parameters to the Navy. NAVSEA will be a scientific adviser to the project.

We are seeking $4,000,000 for this important program in fiscal year 2011.

Third, I would like to tell you about our Jet Engine Noise: Understanding and Reduction Program. Engine noise from most modern tactical aircraft is dominated by the jet noise due to the exhaust of very high-speed (supersonic in most cases) gases from the jet engines; this portion of the noise is often referred to as jet noise. Noise levels in the vicinities of these aircraft are extremely high—often as high as 150 dB. This poses considerable risk to the health and safety of the personnel on carrier decks or near aircraft runways. These very high noise levels are also a problem due to their impact on the communities near military bases. If not properly addressed, the jet noise issue will continue to worsen since the noise footprint of future aircraft will likely be much higher due to higher exhaust velocities from their engines. Recently, the Naval Research Advisory Committee (NARC) released a report identifying aircraft exhaust noise as a major problem that requires immediate attention.

Under this proposal, FSU proposes a comprehensive program with the short- and long-term goals of (a) developing jet noise suppression technologies that can be retrofitted in the current aircraft fleet; (b) undertaking a sustained research effort to better understanding the jet noise sources and fundamentals which will lead to the development of reduction capacities; and (c) to improve noise suppression technologies that will become an integral part of the propulsion systems in future aircraft.

This will be achieved by leveraging our significant and unique resources and expertise in the study of jet noise and control. Leveraging resources provided by this program by the State of Florida, FSU will make appropriate improvements to our test and diagnostic facilities to provide the needed fundamental understanding for controlling jet noise. We will use our considerable expertise in Active Flow and Noise Control to rapidly develop and test many of the promising noise control concepts; maturing, then transitioning to the field, the most practical and promising ones. Our team has significant expertise in both the study and control of jet noise and collectively represents some of the best scientists and engineers presently working in this area. Given the interdisciplinary nature of this problem, we are ideally suited to making a notable impact in solving the jet noise suppression problem. We are asking for $3,800,000 to initiate this vital program.

Our final project involves Nanotubes Optimized for Lightweight Exceptional Strength (NOLES) Composite Materials. The U.S. Army's objective of developing effective personnel protection and a lighter, stronger fleet of fighting vehicles may be achieved through the diminutive nanotubes that (1) are the strongest fiber known, (2) have a thermal conductivity two times higher than pure diamond, and (3) have unique electrical conductivity properties and an ultra-high current carrying capacity. For producing lightweight multifunctional composites, resins impregnated with nanotubes hold the promise of creating structures, which will be the strongest ever known, and hence offer maximum personnel and vehicle protection. Benefits are apparent not only to defense, but also throughout the commercial world.

Partnered with the Army Research Laboratory, FSU's team of multi-disciplinary faculty and students has developed unique design, characterization and rapid prototyping capabilities in the field of nano-composite research, leading to vital defense applications. The NOLES research team is developing high performance thermal management materials utilizing nanotubes. The NOLES team is using nanotube composites for shielding against electromagnetic interference. Also, FSU's composites are being tested for missile wings, UAVs and missile guidance systems by various defense contractors.

Three core programs are envisioned for fiscal year 2011: (1) innovative lightweight personnel protection based on integrating cutting-edge technology and commercially available, proven materials for enhanced safety and security of war fighters; (2) developing nanotubes as a material platform and supporting manufacturing processes for a new generation of devices and structures, giving special attention to the design and demonstration for Army and defense applications; and (3) utilizing nanotube buckypaper and optically transparent nanotube thin films initially for liquid crystal display backlighting and eventually for flexible displays. We are seeking $4,500,000 to continue this program in fiscal year 2011.

Mr. Chairman, we believe this research is vitally important to our country and would greatly appreciate your support.

PREPARED STATEMENT OF THE INTERSTITIAL CYSTITIS ASSOCIATION

Chairman Inouye, Ranking Member Cochran, and distinguished members of the Subcommittee, thank you for the opportunity to discuss Interstitial Cystitis (IC) and to share my story to the Subcommittee. My name is Lauren Snyder, and I am a 29-year-old special needs teacher from Haddon Township, New Jersey. I am also a volunteer with the Interstitial Cystitis Association (ICA), the nation's foremost nonprofit organization dedicated to improving the quality of life for people living with IC. The 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 one or more years delay between 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 one 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 (QoL) studies have found that the impact of IC can equal the severity of rheumatoid arthritis and end-stage renal disease. Health-related QoL 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.

After sustaining permanent damage to my gastrointestinal tract as the result of salmonella poisoning and developing pelvic floor dysfunction, I underwent a number of surgical procedures that revealed the extent of damage to my bladder. After other conditions were ruled out, I finally received the diagnosis of IC and was able to begin meaning and appropriate treatment. In addition to medications, I receive Botox injections into my pelvic floor, as well as bladder instillations. In my case, these treatments, as well as the multiple surgeries I have undergone, require general anesthesia, hospitalization, and extended recovery time, causing me to miss

work and other activities. As a person living with a disability, my work with special needs children is particularly rewarding. Unfortunately, my job requires bending, lifting, and repositioning my students, which is painful and challenging with my IC symptoms. In addition to teaching, I am also a swimming coach, but I have had to reduce my hours as extended exposure to the chlorine in the pool aggravates my bladder.

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 the President's fiscal year 2011 budget request does not include renewed funding for the CDC's IC Education and Awareness Program.

On behalf of the 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 year 2010 DOD Appropriations bill. 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 2011 DOD Appropriations bill, as the number of current military members, family members, and veterans affected by IC increases alongside the general population.

CONCLUSION OF HEARINGS

Chairman INOUYE. This subcommittee will take these issues under serious consideration as we develop our fiscal year 2011 Defense appropriations bill, and this concludes our scheduled hearings for the fiscal year 2011 defense budget.

And accordingly, the subcommittee will stand in recess, subject to the call of the Chair.

[Whereupon, at 11:56 a.m., Wednesday, June 23, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]